OUR MISSION

The mission of Central Regional Hospital is to provide high quality, integrated, person-centered treatment to children, adolescents, and adults with psychiatric disorders with a focus on safety while promoting wellness and offering support to patients and their families consistent with the principles of recovery and trama informed care.

CENTRAL REGIONAL HOSPITAL

300 Veazey Road
Butner, NC 27509

919.764.7200

CRH
CENTRAL REGIONAL HOSPITAL

Partnering with Patients for Safety and Recovery

附錄：Central Regional Hospital 之文宣

Private Visiting Room

Private Bedroom and Bath

Library

Treatment Mall

Indoor and Outdoor Leisure Areas

Central Regional Hospital *seeks to be a model state hospital using* ***evidence-based practices, research, education, and technology*** *to provide* ***quality*** *clinical care in the safest environment.*

PATIENT INFORMATION

Central Regional Hospital takes very seriously it's responsibility for providing quality patient care and a safe Environment for it's patients and staff. Please alert staff on the unit or a member of the treatment team if you have any concerns.

If anyone has concerns about patient care or safety at Central Regional Hospital that has not been appropriately addressed by a member of our staff, they are encouraged to contact:

The Hospital's Director's Office:
(919) 764-7300.

If the concerns cannot be resolved using the above noted channels in the hospital, the Joint Commission's Office of Quality Monitoring may be contacted at any time to report concerns or register complaints.

The Joint Commission may be contacted by calling:
1-800-994-6610

OR

eMailing to:
complaint@jointcommission.org

CRH
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Our Mission

The mission of Central Regional Hospital is to provide high quality, integrated, person-centered treatment to children, adolescents and adults with psychiatric disorders with a focus on safety while promoting wellness and offering support to patients and their families consistent with the principles of recovery and trauma informed care.

Our Vision

Central Regional Hospital seeks to be a model state hospital using evidence-based practices, research, education, and technology to provide quality clinical care in the safest environment.

Our Values

People-Focused

Our focus is on the patients we serve, providing quality treatment and making a positive impact on their lives and the communities we serve.

Teamwork

We are all one hospital, one team - all working towards one goal to improve the health, safety and well-being of the patients we serve.

Proactive Communication

We maintain an open and trusting environment for collaboration and continuous improvement with our team, stakeholders and the patients we serve.

Transparency

We share our expertise, information and honest feedback at all levels within the hospital and those we serve. Ask for help when needed.

Stewardship

We strive to be good stewards of our resources and time to create a positive impact to those we serve.

Joy

We strive to have joy and balance at work to be our best for our team and the patients we serve.

附錄：Community Care of North Carolina之文宣

THE UPDATE

August 2018

Community Care OF NORTH CAROLINA

IN THIS ISSUE

Community Care of Lower Cape Fear hosts Medicaid reform meeting

CCNC's research published in peer-reviewed journal shows majority of primary care physicians find value in enhanced pharmacies

Advisory Board points out how CCNC's care management helps surmount EHR barriers

View the digital copy of this issue online at:

http://ccnc.care/august2018update

CCPN, UnitedHealthcare to serve NC Medicaid beneficiaries together

COMMUNITY CARE PHYSICIAN NETWORK + UnitedHealthcare

Community Care Physician Network (CCPN) and UnitedHealthcare have announced plans to work together when North Carolina's new Medicaid managed care system launches in 2019. UnitedHealthcare will contract with CCPN's 2,200 independent primary care providers in more than 700 practices across the state to enhance patient care and reduce health care costs.

UnitedHealthcare is a major provider of public sector health care, serving Medicaid recipients in 25 states plus Washington D.C., including over six million beneficiaries.

"We're excited to bring the benefits of CCPN's high-performing primary care practices to UnitedHealthcare's Medicaid beneficiaries with this new relationship," said Steve Wegner, M.D., J.D., CEO of CCPN. "We're ready to work hand-in-hand with UnitedHealthcare to enhance quality, patient experience, health outcomes and physician satisfaction."

"We believe our work together will lead to innovative approaches to meeting the needs of the people we serve across the state," said Anita Bachmann, CEO of UnitedHealthcare Community Plan of North Carolina. "CCPN delivers high-quality health care and, most importantly, understands its patients, their unique health care needs and the communities it serves. We believe CCPN's physician-driven and patient-focused care will complement UnitedHealthcare's local and national experience and innovative programs."

To view the joint news release, go to http://ccnc.care/united.

England's National Health Service seeks insights from CCNC impactability

The British National Health Service, which covers more than 64 million in England and the UK, is bringing CCNC's Dr. Carlos Jackson to London to present on the concept of the Impactability Score™. The British interest was piqued by the peer-reviewed study published in Population Health last fall detailing CCNC's strong return-on-investment with this targeted approach to care management.

The NHS, which recently celebrated its 70th anniversary, is struggling with rising costs and scarce health care resources, so allocating those resources more efficiently is a top priority. Also, as a single-payer system, the NHS has a tremendous amount of detailed data on UK residents, providing vast quantities of raw data to run through the impactability process.

Dr. Jackson will be discussing his work with CCNC on August 7th in London at a "working party" (workgroup) of thought leaders of Integrated Care Organizations – the British equivalent of Accountable Care Organizations (ACOs). The group is led by Geraint Lewis, the Chief Data Officer for NHS England.

CCNC's approach to leveraging community pharmacies featured in industry publication

In an article by *MultiBriefs*, CCNC is recognized for its work in expanding the role of community pharmacists through collaboration with medical practices to lower the cost of care.

The article details the creation of a Community Pharmacy Enhanced Services Network (CPESN) in early 2014 and the establishment of common protocols for data transmission, quality assurance, and care management services – such as delivery, medication synchronization, and patient education – to broaden capacity for patient-centered care and prevent readmissions.

"By tracking the cost of care across the network, CPESN revealed that while complex patients had double the healthcare spending of other patients in the system, that rate leveled off after pharmacists began coordinating care with medical practices," reports Lia Novotny, consultant at athenahealth. "Patient outcomes also improved — patients who were customers of member pharmacies consistently scored 4 to 5 percent higher on medication adherence than those of other pharmacies."

Find the full article at: http://ccnc.care/i.

Community Care OF NORTH CAROLINA

Community Care of Lower Cape Fear hosts Medicaid reform meeting

Community Care of the Lower Cape Fear (CCLCF) held a meeting to help local physicians learn more about North Carolina's upcoming Medicaid transformation. More than 100 local clinicians attended the event at the Terraces on Fir Tyler in Wilmington. Details of what will change in Medicaid and likely timelines for the transition to managed care were discussed. Information on how CCLCF and Community Care Physicians Network (CCPN) can support practices and patients through the transformation was also presented.

"We want our independent practices to understand that CCPN, a physician-led, clinically integrated network, can help them prepare and thrive as North Carolina Medicaid transforms," said Randy Barrington, Director of Provider Services for CCLCF.

Speakers for the event included Jay Ludlam, Assistant Secretary for Medicaid Transformation, NC Department of Health and Human Services. Mr. Ludlam detailed the State's plans for Medicaid Transformation. Patricia Lewis, RHIT, CHTS-PW, with the Coastal Connect Health Information Exchange (CCHIE) discussed the strategic use of a regional Health Information Exchange (HIE). The perspective of a practicing, independent physician was provided by Gregory L. Adams, M.D., FAAP, Blue Ridge Pediatric & Adolescent. Dr. Adams, who serves on the CCPN Board of Managers, emphasized the importance of independent primary care physicians working together to manage the changes need to survive and thrive in the new managed care system.

"We want to help you manage populations," Dr. Adams told clinicians in the audience, "because ultimately that's where were going to be graded and where the money is going to flow. The way we're paid is going to change... and physicians need to know where they are at financially in a timely manner, so they can make adjustments... That's why we need a network like CCPN."

This meeting was important now more than ever because depending on state and federal approvals, Medicaid and NC Health Choice programs will shift from a predominantly fee-for-service delivery model to managed care which will include providing whole person, value-based care.

Pictured left to right: Robert Lee "Chuck" Rich, Jr. MD; Gregory Adams, MD, FAAP; Jay Ludlam, JD; Randy Barrington, MBA, CPHQ

Inside the event

Community Health Partners recognizes "Shining Stars"

Community Health Partners (CHP), CCNC's local network serving Gaston and Lincoln Counties, recognized outstanding employees with their inaugural "Shining Star" awards at a meeting on July 26 in Gastonia. Shining Star awards recognize employees performing above and beyond expectations with an exceptional work ethic and positive attitude.

See "Shining stars" on page 4

NC Medical Journal features CCWNC in article on integrated behavioral health providers

The *NC Medical Journal*'s latest issue, "Team-Based Care in North Carolina," published an article by Eric Christian, MAEd, LPC, NCC, director of behavioral health integration at Community Care of Western Carolina, on how chronic medical and common behavioral health conditions have been shown to benefit from team-based care approaches that include integrated behavioral health providers (BHPs).

"Integrated care allows BHPs to receive 'warm handoffs' of patients from primary care providers and perform brief interventions," writes Christian. "This permits face-to-face discussions to relay concise medical and psychosocial histories and clear goals of care in the presence of the patient."

For BHPs, he says that integrated care requires a team-based approach in both implementation and execution, and "has the ability to promote the Quadruple Aim: encompassing health care outcomes, patient satisfaction, provider work/life experience, and the cost of care."

Successful integrated care allows BHPs to be involved in activities outside of typical mental health and/or substance use concerns, Christian says. "Shared space, exposure to daily clinical encounters, interprofessional education, brief lectures, case presentations, and shared common psychoeducational materials allow team members to learn about one another's skill and build team cohesion."

To view the article, go to http://ccnc.care/n.

CCNC's research published in peer-reviewed journal shows majority of primary care physicians find value in enhanced pharmacy services

More than 85% of primary care practice responders agree that working with a CPESN pharmacy can help improve patient health outcomes, a study by Trista Pfeiffenberger, director of quality assurance and improvement for CPESN, and Kristin Lundeen, director of pharmacy at CCNC, found. Their research on the perceived values and barriers of enhanced pharmacy services from care managers and primary care practice responders was recently published in the *Journal of the American Pharmacists Association*.

Practice responders reported statistically less familiarity with enhanced pharmacy services than care managers did, Pfeiffenberger says. "When provided with a list of CCNC's CPESN pharmacies in their county, 71% of care managers stated that they collaborated with these enhanced pharmacies to provide care to patients beyond traditional dispensing. For primary care practice responders, this number was only 44%."

To achieve a deeper integration of community pharmacists into the larger healthcare team, Pfeiffenberger says establishing relationships between pharmacists of CPESN pharmacies and providers beyond traditional dispensing activities is important. "Provider outreach and education around these enhanced services offered by community-based pharmacies are necessary to maximize this collaboration."

Find the full article here: http://ccnc.care/o.

Advisory Board points out how CCNC's care management helps surmount EHR barriers

CCNC patient with care manager

CCNC's care management system has gained recognition nationally for its impact on reducing admissions and emergency department (ED) visits. The program is led by Jamie Philyaw, MSW, senior vice president of population health solutions at CCNC.

In *Managed Healthcare Executive*, Philyaw discusses how CCNC's care managers go above and beyond to build trust between patients and care teams. "Care managers help engage patients in improving their health, leading to better outcomes, and fewer ER visits and readmissions," says Philyaw.

Significant factors in reducing readmissions are patient's location, living situation, and receptiveness, but according to Kristen Barlow, senior consultant at The Advisory Board, EHR costs can also play a role. "EHR vendors charge for their software based on a per-user license basis and post-acute care providers can't afford access to all of their healthcare partners' EHR platforms," says Barlow.

"This is why CCNC's approach of embedding care managers in hospitals and physician practices is key," says Philyaw. "Embedded staff have access to providers' EHRs, which gives them greater insight into what's happening with patients. It's a win-win."

CCNC's approach clearly has advantages: for 2017, inpatient admissions for CCNC enrollees are 28% below expected, and ED visits are 8.4% below expected.

To read the article in its entirety, go to: http://ccnc.care/m.

"Shining Stars"

continued from page 2

Pictured left to right: Abeer Elkhouly, Mary Ellen Pike, and LaShana Owens

The first awards went to:

Abeer Elkhouly, Network Pharmacist – for an eagerness to learn that over her two years with CHP led her to become one of the top performers in CCNC and catapulted CHP to the top spot for overall productivity in medication reviews across the CCNC system.

LaShana Owens, OB Care Manager –
A master of Motivational Interviewing, LaShana is known for her ability to diffuse difficult situations through a calm demeanor and systematic approach to problem-solving. She was recently recognized by CCNC for outstanding productivity and performance in reaching 97.7% her patients with a 95.5% rate of patient engagement.

Mary Ellen Pike, CHP Accreditation Specialist and Lead Care Manager –
Mary Ellen was recognized for her work on the statewide workgroup managing CCNC's NCQA accreditation. Mary Ellen serves as a subject matter expert on accreditation, working closely with both CHP staff and other CCNC Networks to answer questions and provide technical support on this complex process. Her work ensures that CHP's policies, procedures, and workflows meet all NCQA requirements.

Find CCNC on social media!

fb.me/communitycarenc

@communitycarenc

linkedin.com/company/communitycarenc

Community Care OF NORTH CAROLINA

Community Care of North Carolina

Committed to Improving the Health of Our Communities

The New CCNC

We've streamlined our operations, adapted our program to serve new populations, developed new cost structures to meet marketplace needs, and expanded our capabilities to serve multiple payers and their members.

Our long-term mission remains the same, but our new approach is state of the art. We are committed to improving the health and quality of life of all North Carolinians through person-centered care and community collaboration.

Who We Are

Community Care of North Carolina is the nation's largest and longest-running medical home system.

Care teams led by physicians, focused on local patients across 100 counties

We're your family's doctor and your child's pediatrician. We're partners with North Carolina's largest independent physician network, Community Care Physician Network. We're the care manager who stays connected to you. We're your home-town pharmacist. We're paramedics and public health workers and community health workers. CCNC is embedded in hospitals, both large and small, across all 100 counties in North Carolina.

Our physician-led, multi-disciplinary care teams coordinate care across settings and over time.

CCNC is nationally accredited by the NCQA and is one of the first to earn this credential in complex care management.

Together we know North Carolina's communities from the mountains to the coast in ways that are unmatched and that produce better patient outcomes, higher patient and physician satisfaction, and lower health care costs.

What We Do

We build on decades of experience working collaboratively with physicians to develop best practices.

CCNC transforms quality reporting and patient data into actionable strategies to raise HEDIS scores, improve health outcomes, and lower costs for the patient, the payer, and the community.

Accountability **Collaboration** **Excellence** **Innovation**

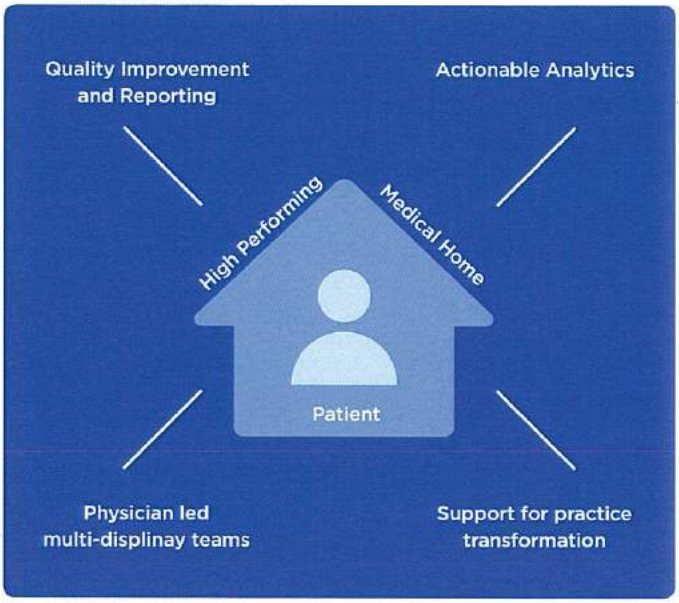
Community Care OF NORTH CAROLINA

ACCREDITED NCQA CASE MANAGEMENT

CCNC identifies complex patients having multiple doctors and taking many medications for timely, appropriate care management.

We help keep people out of the emergency department, and post-discharge, CCNC reduces chances of hospital readmission.

We provide home visits to patients needing special assistance, watch out for drug interactions, and help remove barriers to better outcomes such as transportation, lack of secure housing, or poor nutrition.



We identify behavioral health issues and integrate a mental health component into primary care practices.

CCNC's Pregnancy Medical Home program, the only statewide pregnancy medical home program in the nation, reduces pre-term births and the need for neonatal care.

Our proven approach to population health management delivers better health outcomes at lower costs with higher physician and patient satisfaction ratings.

Problems We Solve

Targeted interventions: Focusing care management on high-cost/high-need patients isn't enough; we focus on impactable patients.

Infrastructure and Relationships: We're ready to introduce you to the communities we serve so you can develop the relationships you need for success. CCNC is the largest system of medical homes and we've been doing this work longer than anyone else. In fact, more than 6,000 providers, 1.7 million patients, and 9 million taxpayers benefit from CCNC's work today.

Statewide Coverage: Participating physicians, pharmacists, and care managers serve all 100 counties. CCNC core program standards are consistent across the state with modifications tailored to meet specific community resources and needs.

> "The return on investment from care management intervention is 2- to 3- fold higher with (CCNC's) impactability-based targeting..."
>
> *—Population Health Management, 2017*

Reputation and Experience: Decades of innovation, collaboration, and experience count. CCNC will help your company control its costs, boost patient and physician satisfaction scores, and improve patient outcomes.

For more information, please contact:
Paul Mahoney
Vice President for Communications
2300 Rexwoods Drive, Suite 140
Raleigh, NC 27607
919-745-2434
ccnccommunications@n3cn.org

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CCNC: Results-Driven. Industry-Validated.

Making a Difference in North Carolina—County by County, Community by Community

As the nation's largest and longest-running medical home system, CCNC brings advanced primary care and comprehensive management of complex patients to all 100 counties in North Carolina.

- *We resolve problems at the community level and expand practical solutions throughout the state, resulting in reduced costs and improved outcomes*
- *We provide documented benefits to payers, clinicians, and patients*

Proven Success by the Numbers

It's one thing to *have* a goal of reducing costs and improving care. But, for CCNC, *achieving* that goal day in and day out is our constant focus. And our numbers prove it.

Reduced Hospital Utilization by High-Risk Patients

- Inpatient rates – 28% below expected

Improved Patient Satisfaction

- 94.7% patient satisfaction for care management
- 98% patient satisfaction regarding care coordination among providers when a CPESN pharmacy is utilized

Satisfied and Engaged Physicians

- Positive, long-term relationships with 1,800 participating practices and 6000+ providers
- 91.6% provider satisfaction for care management services

Saving Millions of Dollars

- Five industry-published evaluations concluded CCNC produces substantial savings
- Three external evaluations considering CCNC's total enrollment found savings of $3 for every $1 invested

An Approach to Care Validated by National Experts

CCNC's work is recognized and validated by industry experts nationwide. The accolades are welcomed—but we're most proud of the acknowledgement that our approach to care truly makes a difference.

Fully Accredited Statewide

- Full three-year accreditation from NCQA in Case Management
- Networks covering all 100 North Carolina counties

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Meeting and Exceeding Industry Quality Metrics

Diabetes:

- 26.1% of beneficiaries with poor diabetes control – *20 percentage points* better than the HEDIS mean
- 60.9% of beneficiaries with good diabetes control- *15 percentage points* above HEDIS mean

Blood pressure:

- 69.5% of beneficiaries have adequate control of their blood pressure – *15 percentage points* above HEDIS mean

Pediatrics:

- 82% of 13-year-olds receive the recommended immunizations for adolescents - *10 percentage points above* HEDIS mean
- 70% of children receive the recommended six well-child visits by 15 months of age
- Over 90% of children receive appropriate early childhood developmental and behavioral screening at well visits (North Carolina is national leader in this area)

Maternal Health:

- 78% of PMH deliveries received a risk screening
- Unintended pregnancy rate has dropped to 45.4% from 50.3% in FY14

Peer Reviewed Journals Confirm CCNC Benefits

- Health Affairs
- Population Health Management
- NC Medical Journal
- The Advisory Board

National and State Awards

2016 Distinguished Service Award, NC Academy of Family Physicians

2016 Hearst Health Prize, Hearst Health and the Jefferson College of Population Health

2013 Wellness Frontiers Award, Healthcare Leadership Council

2007 Annie E. Casey Innovations Award, Harvard University's John F. Kennedy School of Government

For more information about how you can bring the proven benefits of CCNC to your members, contact:

W. Stan Taylor, M.B.A.
Senior Vice President for Business Development
staylor@n3cn.org

CCNC Care Management

Lowering Costs and Improving Care for Patients with Complex Needs

If patients are living in unstable housing, is it possible for them to manage their condition consistently?

Will patients lacking a support system be able to successfully manage their chronic condition?

For patients impacted by medical, social, and/or behavioral health issues, the answers to these questions would typically be "no." However, for those who receive care management services from Community Care of North Carolina—the answer is much more likely to be "yes." CCNC offers a financially-sustainable care management program specifically designed for your most complex patients.

An Approach to Care Management Validated by Peer-Reviewed Publications and National Experts

CCNC's approach to care management has been studied and validated by industry experts. Using data from more than 20,000 patients, CCNC determined where intervention had the greatest impact and constructed a predictive model that identified the "impactable" patients most likely to benefit from care management.

Medication adherence and historical utilization that was unexplained by disease burden proved to be the most important predictors of impactability. Compared to traditional targeting strategies, CCNC's impactability approach generates a two- to three-fold higher return on investment.

Patients with high impactability scores represent less than 1% of North Carolina's Medicaid population — but the savings per patient can be has high as $6,000 annually.

When We Remove the Barriers to Care, We Improve the Impact of Care

Social and environmental barriers can prevent many high-risk patients from getting the care they need.

These barriers can include:

Lack of an adequate social support system	Lack of adequate transportation
Unstable housing	Substance use
Unmet nutritional needs	Trauma or abuse
Illiteracy or low health literacy	

Our community-based CCNC care managers identify and engage patients with multiple chronic conditions to address barriers that impact their healthcare outcomes.

An individualized care plan is developed for each patient, improving quality of care while reducing avoidable hospital admissions and readmissions.

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ACCREDITED NCQA CASE MANAGEMENT

Benefits provided by CCNC's targeted care management include:

Stronger return-on-investment for patient intervention and more efficient allocation of care management resources

Connecting the dots with PCMH and other providers to improve communication and continuity within a patient's network of care

Providing comprehensive medication management that improves adherence

Delivering patient education and self-management support to create greater independence

Linking patients to helpful local resources in their communities

By Knowing North Carolina, We Know How to Deliver Better Care Management

With a statewide infrastructure that includes regional affiliates and care managers across all of North Carolina's 100 counties, CCNC knows this state's patient population better than anyone. This positions us to help you meet your goal of achieving better health outcomes for high-risk, impactable patients, while also reducing costs. The challenges in your local community are unique to you. To answer them, you need a partner who understands the nuances of those challenges—and who has proven solutions built to meet them. That's CCNC.

Bring Better Care Management to Those in Your Community Who Need It Most

High-risk patients can sometimes get lost in the system. Crucial opportunities to improve the trajectory of their health can be missed, leading to more extensive and expensive care than necessary. By relying on CCNC to help manage these risks, you can achieve higher-quality, better coordinated care that is better for the patient and cuts your costs, too.

For more information about how you can bring the benefits of CCNC's care management to your organization, contact:

Jamie Philyaw, MSW, CCM
Vice President of Care Management
jphilyaw@n3cn.org

CCNC Behavioral Health Integration

Helping Practices More Seamlessly Integrate On-Site Behavioral Health Services

Behavioral Health Integration (BHI) services can be a tremendous resource to medical practices as they seek to identify and address behavioral health conditions in their populations. We begin with a readiness assessment and then assist the practice in implementing screening protocols for mild to moderate behavioral health conditions (depression, anxiety, and risky substance use). We help practices more seamlessly integrate on-site behavioral health services.

BHI services give practices new tools to improve patient outcomes and help prepare them for value-based reimbursement and emerging quality improvement standards.

CCNC-led integrated care helps further the goal of the "quadruple aim": better experience of care, better health in our community, improved provider satisfaction, and lower per capita cost

How We Work

- We break BHI down into clear, attainable steps. We will work with practices "where they are," and help choose an integration model best suited to the practice site.
- We work to implement Evidence-Based Models of Integrated Care, including Primary Care Behavioral Health consultant model (PCBH); Screening, Brief Intervention and Referral to Treatment (SBIRT); or Collaborative Care, a registry-based intervention model.
- Direct support is given to providers and clinical staff to promote BHI best practices for care coordination and patient co-management workflows within multidisciplinary patient care teams.
- We provide behavioral health subject matter and billing expertise to support workflows that integrate behavioral health into the medical home. We emphasize the adoption of evidence-based pathways and utilization of behavioral health specialty providers.
- Support is provided through multiple technical assistance contacts per month based on the needs of practices. Both on- and off-site consulting services are available.

Menu of Core Behavioral Health Offerings

Child/Adolescent and Adult Depression (Depression Toolkits)

- Screening tools, Suicide Risk and Assessment, Assist practice with a standardized work flow processes
- Medications
- Algorithms of care
- Billing
- Referral pathways
- Practice snapshots for depression

Care Management

- Support to patients with complex medical and comorbid behavioral health needs
- Motivational Interviewing/Patient Engagement Techniques

Opioid Safety

- SBIRT
- Naloxone education/training
- Practice snapshots for opioid utilization/ prescribing
- Urine drug screening education
- Narcotic lock-in assistance

Psychopharmacological Considerations

- Practice snapshot for specific projects using CareImpact℠
- Assistance with Medicaid BH Pharmacy Programs (A+KIDS, ASAP, Preferred Drug List (PDL))

Referral Pathways for BH diagnoses not treated in Primary Care

- Help to bridge the gap between primary care and the BH Specialty system
- Provide referral forms to enhance communications between Providers

For more information about Behavioral Health Integration, contact:

Andrew Clendenin, MSW
Director of Behavioral Health Integration
aclendenin@communitycarenc.org

More information on the web at:
http://ccnc.care/bhintegration

CCNC Transitional Care

Active handoffs and shared data lead to coordinated care and better outcomes

Why Transitional Care?

A 62-year-old man with a developmental disability is discharged from a North Carolina hospital after a two-month stay for multiple medical conditions and a nonhealing wound. Team meetings coordinated discharge plans and follow up care: home health, palliative care, medical supplies, appointments with multiple specialists, and in-home care.*

Yet when a CCNC care manager visits the patient two days after discharge, she finds the home health agency has not done dressing changes, he has no wound care supplies, in-home personal care has not yet begun, and pain medication has been denied at the pharmacy.

Despite the best efforts of the hospital team and Medicaid coverage for needed follow-up, this patient was on a fast track to readmission. Quickly, the CCNC care manager established a plan for services needed across settings and providers, incorporating Social Determinants of Health (transportation, social support, nutrition, etc.). For patients of this complexity, the home visit is a critical tool for timely identification of problems and ultimately improving health outcomes.

*See NCMJ Vol. 73, No. 1

CCNC's Singular Focus

- Patients are assigned a Transitional Care Impactability Score™ to identify those most likely to benefit from an intensive transitional care intervention following a hospital discharge.
- Research shows patients with multiple chronic conditions need a different level of management intervention.
- Targeting this population with specific interventions pays off for patients, providers, and payers.

Preventing Readmissions

- The key statistic is the "number needed to treat" (NNT) to prevent one inpatient admission in the coming year. For the patient population with a low Transitional Care Impactability Score™, CCNC must intervene with **133 patients to prevent one readmission**.
- But for the population with a high Transitional Care Impactability Score™, CCNC needs to intervene with only **6 patients to prevent one readmission**.

This focus creates an extremely efficient allocation of care management resources.

NNT 133 vs NNT 6

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The CCNC Difference

- CCNC's "on the ground" care managers keep the primary care medical home informed of what's happening and coordinate a broad spectrum of community-based care.
- In hospitals with a high volume of Medicaid patients, embedded care managers meet with the patient while still in the hospital.
- For priority patients, we provide timely face-to-face home visits and follow-up with multiple providers. Interventions improve the likelihood of a successful transition to home and greatly reduce the risk of readmission to the hospital.

Patients with multiple chronic conditions who receive a CCNC home visit are on average *half as likely* to have a 30-day readmission compared to those receiving less intense forms of transitional care

Core Components of CCNC Transitional Care

Face-to-Face Patient Encounters

- Support to patients with complex medical and behavioral health needs.
- Timely in-home visits to priority patients provide a wealth of information and opportunities to improve care.
- Identification of barriers and Social Determinants of Health.

Medication Management

- Comprehensive review and reconciliation of lists, including admission and discharge medication, medications listed in the PCP record, fill history from claims data, patient/family interviews and "brown bag" review.

Patient and Family Education

- Summarize goals, medications and treatment needs using CCNC Self-Management Notebook and motivational interviewing.

Cultivation of Local, Cross-Agency Partnerships

- Help to bridge the gap between primary care and specialists, Departments of Social Services, inpatient and rehabilitation facilities, and community resources.

Data Support and Information Exchange

- Target outreach using Transitional Care Impactability™ scoring.
- Identify patients most likely to be helped by intensive care management.
- Thrice-daily ADT reports from 85% of NC hospitals provide "real time" data.
- Clinical information shared across the care team – multiple locations, licenses and organizations.

Transitional Care Gets Results

27%↓ Reduction in inpatient admissions.

48%↓ Reduction in potentially preventable readmissions.

$128M↓ 2017 savings for CCNC beneficiaries compared to unenrolled population.

For more information about Transitional Care, contact:

Jamie Philyaw, MSW, CCM
Senior VP of Population Health Solutions
jphilyaw@communitycarenc.org

More information on the web at:
http://ccnc.care/transitionalcare

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ACCREDITED NCQA CASE MANAGEMENT

CCNC Provider Services

Support that Results in Practices that Thrive

CCNC Provider Services: The Difference Maker

With a focus on supporting the growth and development of 1,800+ practices throughout North Carolina, CCNC has developed a suite of services that specifically address the challenges providers face, turning obstacles into opportunities.

Supporting Practices through Connection, Knowledge, and Action

CCNC supports practices by providing services in two primary areas:

Provider Relations that enable physician leaders to implement cutting-edge strategies and tactics that lead to better access, lower costs, and more qualified clinicians.

Practice Support and Quality that transforms reporting into actionable strategies for improving health outcomes and lowering costs for patients, payers, and communities.

As part of the CCNC network, you'll benefit from:

- **Comprehensive provider support** across practice settings—from primary care, to behavioral health, to OB/GYN care
- **Access** to consistent, measurable, industry-standard services that drive improvement and ensure high-quality care
- **Assistance** in meeting contract deliverables, avoiding penalties, and hitting quality targets
- **Guidance** in gaining PCMH/APCMH status
- **Assistance** with improving HEDIS measures and Medicare Star ratings

CCNC Support for Advanced Medical Homes

Your advanced medical home has many different components that demand your attention. And, in order to operate at the very highest levels, all of these facets must work well and work together.

Accountability | Collaboration | Excellence | Innovation

Community Care OF NORTH CAROLINA

ACCREDITED NCQA CASE MANAGEMENT

Practice Transformation

Intensive coaching by CCNC facilitates the transformation and sustainability of practices that are operating in a value-based care environment.

Ways We're Making It Happen:

- Assisting in moving to a quality-based reimbursement system
- Rethinking excess utilization as cost—not revenue
- Empowering a proactive, population-based approach to care

Provider Education

CCNC works with you on payer/plan contracts, ensuring deliverable requirements are met. Then, we stay engaged to keep you updated about policy changes and new payer programs.

Ways We're Making It Happen:

- Ensuring contract obligations are met
- Providing guidance regarding appeals
- Collaborating in the creation of new clinical programs
- Developing MOC and CME measures

Practice Support

Delivering exceptional customer service is key to practice success. CCNC helps you resolve workflow issues and provide training in operational best practices.

Ways We're Making It Happen:

- Training staff and providers to deliver quality customer service
- Assisting with billing/coding procedures
- Reducing administrative burdens
- Ensuring compliance with prior authorizations and preferred drug list procedures
- Supporting EHR & self-reporting

Quality Improvement

You have an engaged network of clinicians who are committed to providing the best care to their patients. CCNC works with them to reach quality targets and improve outcomes.

Ways We're Making It Happen:

- Helping practices meet contract deliverables, improve screening rates, avoid penalties
- Enabling practices to meet MIPS, BQPP, MCO quality targets
- Providing peer review and support with local physician leaders

Bringing CCNC Provider Services to Your Practice Community

CCNC Provider Services have been designed to support your efforts to deliver the best possible healthcare to those in your community. We'll help you manage all of the moving parts—from practice management to payer relations to quality control—allowing clinicians to focus on what they do best: improve the lives of the patients they care for.

For more information about accessing CCNC Provider Services, contact:

Denise Levis-Hewson, RN, BSN, MSPH
Senior Vice President Physician Partnerships
dlevis@n3cn.org

Community Care Physician Network

Connecting Physicians to Improve Care. Eliminating Disconnects that Obstruct Care.

What if *those who provide care to patients were seamlessly connected in a way that ensured continuity of care?*

What if *these clinicians—from physicians and pharmacists to care managers and community-based support specialists—were accountable to each other and engaged in ongoing collaboration that resulted in better care?*

And what if *patients had easier access to the care they need when they need it?*

Within the Community Care Physician Network, "what if" has become what is. The result is higher quality and more efficient care for patients throughout North Carolina.

This Is What Happens When Clinicians Have a Proven Way to Work Together

With more than 2,000 primary care physicians in 600+ practices, Community Care Physician Network (CCPN) is North Carolina's largest independent physician network. From the mountains to the coast—these physicians treat one out of every three Medicaid patients in the state.

The clinicians within this Clinically Integrated Network are committed to delivering improved quality of care and to being collectively accountable for increasing value to both patients and payers. Through their efforts, significant progress is being made in:

- Improving outcomes
- Increasing patient satisfaction
- Reducing hospital readmissions
- Improving quality with fewer costs
- Expanding access to cost-effective care

Accountability | **Collaboration** | **Excellence** | **Innovation**

Community Care OF NORTH CAROLINA

ACCREDITED NCQA CASE MANAGEMENT

Success is Supported at Every Step by Community Care of North Carolina

As members of CCPN, clinicians work closely with Community Care of North Carolina (CCNC) care managers and practice support staff who assist with:

Streamlining workflows	Improving medication compliance
Driving quality improvement initiatives	Engaging physician leaders
Managing transitions in care	Integrating behavioral care

Success within CCPN isn't left to chance. Instead, it's put into the hands of individuals who are dedicated to providing better and more cost-effective care—and who have the expertise required to make it happen.

A Network Led by Engaged Physician Leaders

The members of CCPN's Board of Managers are practicing primary care physicians who understand the values and needs of independent primary care physicians.

Make a Difference Where It Matters Most by Bringing CCPN to Your Members

The key to making high-quality and cost-effective healthcare available is having a primary care network that is optimized for peak performance. This is what CCPN delivers.

For more information about how you can bring the benefits of CCPN—including better care and expanded accessibility—to your members, contact:

Denise Levis-Hewson, RN, BSN, MSPH
Chief Operating Officer for CCPN
dlevis@n3cn.org

Community Pharmacy Enhanced Services Network

A Different Kind of Pharmacy for Patients Who Need a Higher Level of Care

CPESN℠ pharmacies bring a new dimension to the delivery of healthcare. Community pharmacists have unrivalled access to the complex patients that are your biggest challenge.

CPESN North Carolina pharmacists see their complex patients on average **35 times per year.** These same patients see their primary care physician only about **3.5 times per year**. Every one of these interactions is an opportunity to get more value from medications and alert physicians when new issues arise that could lead to readmission or a worsening of the patient's condition.

What is "enhanced" about CPESN North Carolina pharmacies?

Services

CPESN pharmacies provide specialized services key to managing complex patients, such as medication reconciliation, non-English-labeling, adherence coaching, daily dose multi-medication blister packaging, 24-hour emergency service, and home delivery/home visits.

Relationship to the care team

Our pharmacists work hand-in-hand with primary care physicians, care managers, and behavioral health providers, sharing information, improving compliance, and contributing to a shared, patient-centered care plan.

Relationship with the patient

Community pharmacists know their local complex patients well, and enjoy a high degree of patient trust. This can open doors to non-compliant patients who aren't doing well but are reluctant to accept additional help. CPESN pharmacies are focused on interventions that change patient behavior and lead to improved outcomes.

How can CPESN North Carolina pharmacies help you?

Reduce readmissions by identifying problems with complex patients in time to make changes in treatment or medications.

Boost value by removing barriers to better medication adherence, such as low health literacy or cognitive impairment.

Improve patient satisfaction – 98 percent of patients utilizing a CPESN pharmacy felt their care was coordinated among multiple providers.

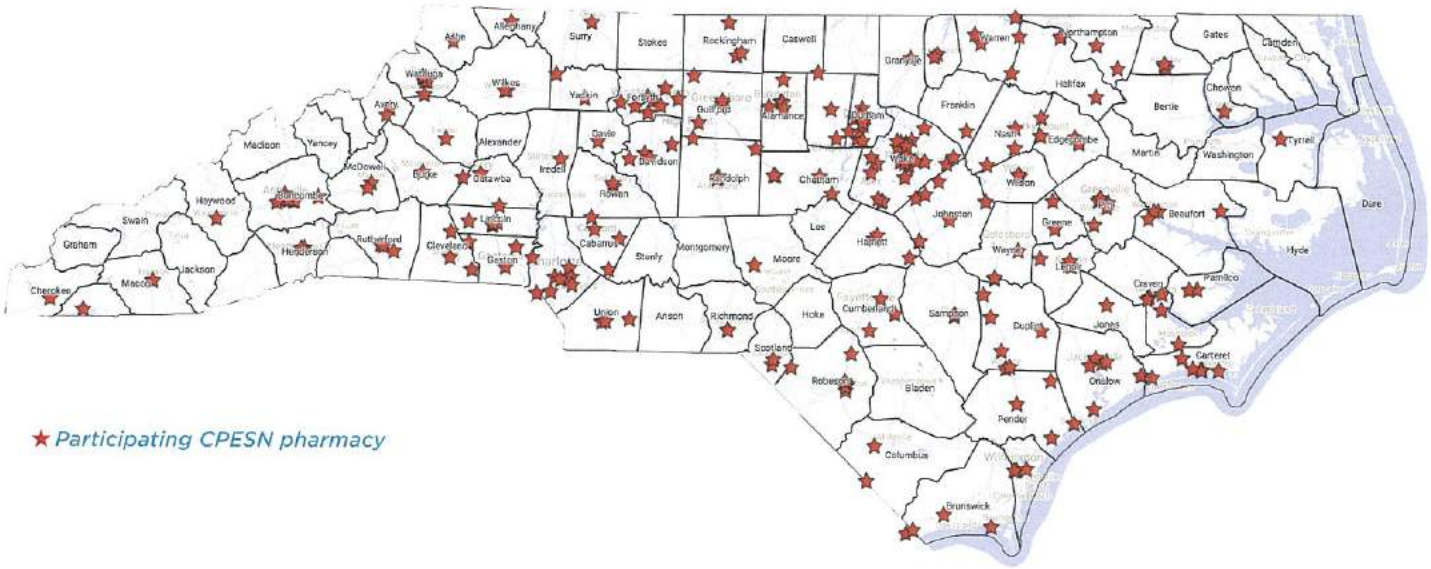
Improve budget predictability by working closely with complex patients to get more value from your pharmaceutical spend.

Improve Care and Maximize Your Impact

CPESN delivers more attention, more care, and more resources to complex patients in a cost effective, sustainable way that improves outcomes and lowers costs.

For more information about how you can bring the benefits of CPESN to your members, contact:

Troy Trygstad, Pharm.D, M.B.A., Ph.D.
Vice President of Provider Pharmacy Partnerships
ttrygstad@cpesn.com



★ *Participating CPESN pharmacy*

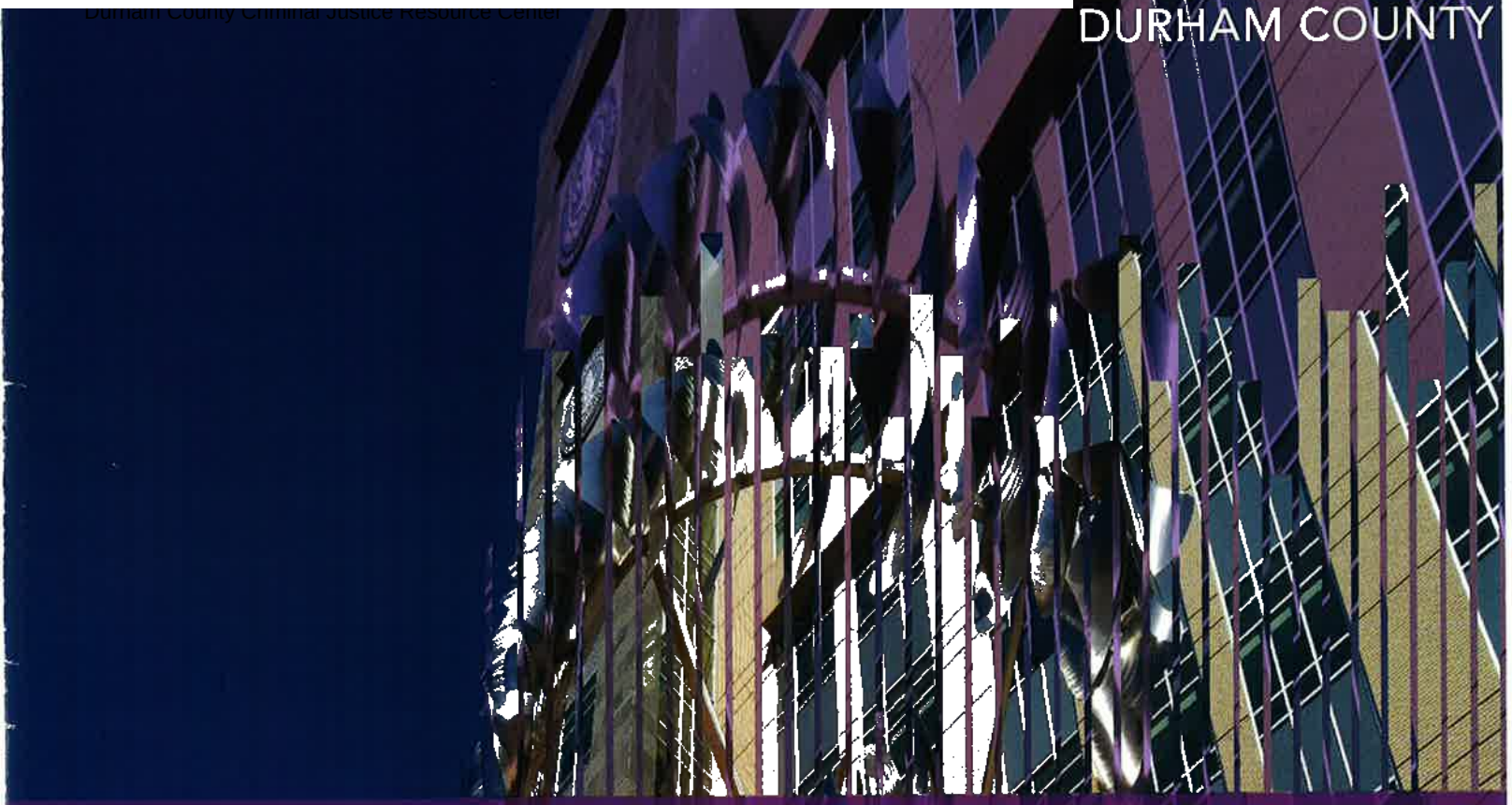
Accountability | **Collaboration** | **Excellence** | **Innovation**

CPESN

ACCREDITED NCQA CASE MANAGEMENT

附錄：Durham County Criminal Justice Resource Center 之文宣

DURHAM COUNTY



CRIMINAL JUSTICE RESOURCE CENTER

COMPASSION AND INNOVATION AT WORK

FISCAL YEAR 2017 IN REVIEW

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DIRECTOR'S MESSAGE

The Criminal Justice Resource Center provides many services for persons along the continuum of the criminal justice system.

On behalf of the staff at the Durham County Criminal Justice Resource Center, it is my pleasure to bring you this report, highlighting some of our programs and activities in Fiscal Year 2016-17.

The Criminal Justice Resource Center provides a variety of services for persons along the criminal justice system continuum. These services are as diverse as preventing arrest and criminal records, to providing substance use disorder and mental health services for inmates in the Durham County Detention Center. We offer rehabilitation, treatment and support services for those on probation and post release supervision as well. In FY17, we were able to enhance some of these services, while also adding new ones. At all times, our work is guided by compassion for the individuals we serve, with an orientation towards improving our department and community through innovative programs and approaches.

Reducing the number of individuals in detention with mental illness was a special focus for us in FY17. To facilitate that effort, we developed and implemented a Mental Health Court Diversion Program and we expanded our mental health services in the jail.

Thanks to a Safety and Justice Challenge grant award from the MacArthur Foundation, we created a Court Date Reminder Service to reduce the number of individuals arrested due to failures to appear for court. An award from the NC Department of Public Safety established our department as the Intermediary Agency for the newly created Local Durham Reentry Council to develop an even broader network of services for citizens returning from incarceration.

In this report, you will read about the experience of some clients who utilized our services on their path to becoming productive members of the community. Also featured are some of our partnerships with other local and state agencies that collaborate with us daily to provide the most effective and appropriate services. We are grateful for their willingness to work together and provide compassionate, evidenced based and innovative services to our clients and the greater community.

For more information about our services and programs, please visit us at www.dconc.gov/cjrc

REENTRY SERVICES

"I can handle it. Show me what I need to do and I'll do it!"

It's a busy afternoon at the Durham County Solid Waste Container Site on Redwood Road. Between monitoring the drop-off bins and giving instructions to container truck drivers, Durham native Sherikia (Dee Dee) Myers takes a few minutes to talk about her experience with the Criminal Justice Resource Center.

"I was referred to CJRC by my Probation Officer, and after class one day, a staff member, Mr. Pompey mentioned that if a person was drug/alcohol free they could attend the employment program. He gave me a referral"

Dee Dee was skeptical about her job options given some of her past history, but enrolled in the employment program with Program Manager Robin Heath. ***"Robin helped me with my interviewing skills, and helped me build a resume. She always answered my texts and emails promptly and made herself available".***

Opportunities in the County's General Services department interested Dee Dee, and she appreciates the fact that CJRC staff did not try to steer her in a different direction. **"I told them that I could handle the work. They just needed to show me what to do and I would do it"**, she says.

The full-time employment has given Dee Dee confidence in herself, and she has begun thinking about her long-term future. She would like to remain working with Durham County, and, if she can complete the training at some point, perhaps fulfill her dream of being an Emergency Medical Technician (EMT).

Charles Horry likes to think of the **Reentry Services** he received at CJRC as a building foundation. **"The great people I worked with at the CJRC told me they could help me build a new foundation, but the rest of the work was up to me"**

Born in Durham, Charles attended Whitted Middle School and then Hillside High School. In and out of trouble much of his adult life, while incarcerated once again, he was visited by Joel Wright, a CJRC Counselor, who believed that Charles had the potential to benefit from Reentry Services.

"As I approached release from prison, I had no job, no housing and no plan. CJRC placed me in their transition house, and I enrolled in some of their classes and programs. Really, it was like a miracle and I'll never forget the patience and kindness they showed me".

Charles explains that his success was not always easy. ***"I had to grind, and I had to consciously make the right decision every time, but the Reentry program gave me the tools to do that."***

With a strong foundation in place, and constant assistance from his faith team, Charles has begun building on it. He has his own house, stability and the security that comes knowing his friends at the CJRC are behind him one hundred percent.

DURHAM REENTRY COUNCIL (LRC)

In Dec 2016, CJRC was awarded a $150,000 contract from the NC Dept of Public Safety to establish a Reentry Council for Durham County. Reentry councils are networks of community-based organizations that cooperate to assist ex-offenders, returning citizens and criminal justice involved individuals with necessary local services like housing, employment, food, clothing, treatment, transportation and mentoring. Their mission is to develop and coordinate resources in their communities for the support of ex-offenders in order to reduce recidivism and victimization.

During the first months, Durham LRC focused on educating the community about the purpose and goals of the LRC and identified partner agencies through networking events. Durham LRC is managed by a Coordinator and has a part-time Job Placement Specialist. Durham LRC hosts a Service Provider Committee composed of community agencies in Durham. For more information about Durham's Local Reentry Council visit **durhamreentrycouncil.org.**

Torrey Green and the Formerly Incarcerated Transition (FIT) Program

One of the many obstacles faced by those returning from prison is access to health care. To address this need, Evan Ashkin, MD, a professor of family medicine at the UNC School of Medicine, founded the Formerly Incarcerated Transition (FIT) program. The program is designed to help chronically ill former individuals, recently released from prison, connect with primary care medical services.

FIT began partnering with the Lincoln Community Health Center, and the Durham and NC Departments of Health. In FY 2017, Durham Public Health hired Torrey Green (pictured) as a community health worker for FIT.

An additional core partner is the Criminal Justice Resource Center where Torrey spends half of his work week. Torrey is very pleased with FIT's partnership with the CJRC. **"CJRC's Reentry Services have been so supportive of the FIT program. I'm a part of their monthly staff meetings, and they have been a major source of FIT referrals."**

Torrey believes that preventing serious medical complications after release from prison is a community obligation, and **"our partnership with the CJRC helps us meet this obligation."**

Reentry Services provide community based programs for justice involved individuals who are Durham County residents and on supervised probation, post-release supervision or parole by NC Department of Public Safety, Division of Community Corrections.

Services include Cognitive Behavioral Interventions (CBI), Case Management, Employment Readiness, Computer Instruction, GED/Adult Basic Education and many wrap around services. Sherikia (Dee Dee) Meyers explored the employment services CJRC offers because sustainable employment is key to reduced criminal activity. Charles Horry used CJRC Reentry Services to get back on his feet after many years of incarceration.

- 269 individuals received CBI, 37 received Post-Release Services
- 122 persons received Employment Services
- Staff provided 292 referrals for supportive services

DRUG TREATMENT COURT

"Now I have a bank account, insurance and a place to call my own"

Erica Leak was born in New York and moved to Durham at the age of two. School was a struggle for her and she dropped out before her senior year.

Using and selling drugs was a way of life for Erica, and as a result she found herself facing charges. CJRC's Drug Treatment Court was an alternative to jail time but she was concerned about the 1-year commitment. ***"Kamesha (Kamesha Falana – Drug Treatment Court Coordinator) built a bond with me at this time, kept me in a positive frame of mind and stayed by my side through the entire process. She pointed to others who had completed the program and asked if I didn't want the same thing for myself. This was an inspiration to me"*** she says.

Erica had a couple starts and stops while going through the Drug Treatment Court program. "It wasn't easy" she says. "But it taught me the important things. Don't use today. Don't use tomorrow. Deal with your issues and don't mask them with drugs". With new stability in her life, Erica is now looking at completing her education goals.

Drug Treatment Court is an intensive, highly structured program designed to identify and treat individuals whose criminal activities are generally connected to substance use. This is a post-conviction program and well suited for probationers facing violation due to continued drug use. Participants must have an underlying active sentence of at least four months. Some eligibility criteria apply.

- 49 Drug Treatment Court clients were served
- 25 cases were closed with 5 clients completing all program requirements.

COMPASSION AT WORK

STARR PROGRAM

"I'm learning to separate myself from the wrong people, places and things"

Shawn Hayes acknowledges that his immediate future is unclear. He is currently incarcerated at the Durham County Detention Center on pending charges.

One thing that Shawn is clear about is his desire to live the rest of his life free of substance abuse.

He was born in Durham and attended Riverside High School, but did not graduate.

Drugs played a part in Shawn's current circumstances, but he found help in CJRC's STARR (Substance Abuse Treatment and Recidivism Reduction) Program. His enrollment was voluntary, and upon completion he enrolled in an additional four-week program (STARR GRAD) that he is currently working through.

"The people who work for STARR really care about you on an individual level. I've learned so much in this program and hope that at some point in the future I can take what I've learned and help others."

After release, Shawn intends to get a Commercial Driver's License. With that in hand, he hopes to find local employment that will allow him to spend ample time with his children.

CJRC provides substance use disorder treatment for persons at the Durham County Detention Facility and outpatient treatment for supervised and court ordered individuals living in Durham County.

The Substance Abuse Treatment and Recidivism Reduction Program (STARR) is a four-week treatment program provided to inmates in the Durham County Detention Facility. The majority of STARR participants are ordered to attend by the Courts or Probation.

- 555 inmates received substance use disorder treatment, 78% graduated

The Second Chance Program is a substance use treatment program designed for persons 18 years old or older. Individuals are referred through TASC, the Courts or other service providers. Participants receive intensive outpatient treatment or regular outpatient treatment based on the assessed level of care.

- 377 individuals received substance use disorder treatment
- 242 cases were closed with 63 clients completing all program requirements.

MENTAL HEALTH COURT DIVERSION PROGRAM

The Durham County Board of Commissioners approved the creation of a Mental Health Court (MHC) in FY 2017. CJRC established the court and is also the court coordinator.

The MHC Diversion Program is designed to reduce the recidivism of individuals with Serious and Persistent Mental Illness by offering them treatment and the chance to have their criminal charges dismissed.

MHC program staff works closely with participants to coordinate, monitor and provide specialized treatment to improve mental health outcomes and reduce the rate of recidivism.

The Durham County Mental Health Court Diversion team includes a Durham County District Court Judge, an Assistant District Attorney, an Assistant Public Defender and the Mental Health Court Coordinator.

The Durham County Mental Health Court Diversion Program offers:

- A specialized court docket, which employs a problem-solving approach to court processing in lieu of more traditional court proceedings.
- Supervised, person-centered treatment plans for each defendant participating in the court supported by an interdisciplinary team.
- Regular status hearings occur at which treatment plans and other conditions are periodically reviewed for appropriateness.
- Incentives offered to reward adherence to court conditions. Participation is jeopardized when there is no adherence to the conditions.

JAIL MENTAL HEALTH SERVICES

CJRC staff provide mental health services and discharge planning for inmates with mental illnesses, targeting those with Severe and Persistent Mental Illness (SPMI) and Severe Mental Illness (SMI). The jail mental health practitioners also monitor suicide precautions, respond to sick calls, and provide psycho-social education groups for dually diagnosed (mental health and substance use) individuals.

In FY17, CJRC was able to add a case management assistant to the team to reduce jail recidivism and improve connection to services after release. The enhanced team works to ensure clients receive a 30 day supply of psychotropic medication at release, attend treatment appointments and assist with finding housing at release.

The **Court Psychologist's** primary services include independent psychological evaluations of youth and adults in the criminal justice system with recommendations for follow up treatment.

Jail Mental Health staff identifies inmates with severe mental illness and works with a psychiatrist to approve necessary medication while in jail, monitors them while they remain in jail, notifies their treatment provider and assists with discharge plans.

- Screened 1,403 inmates to identify needed mental health medications and treatment and connection to a treatment provider upon release
- Offered 578 hours of psychiatric services
- Assisted 177 inmates with discharge plans

Opioid related deaths in North Carolina have increased 73% from 2005 to 2015. In Durham, the increase was 183% (6 to 17 deaths).

Accordingly, the Durham County Jail has seen an increase in the number of inmates that are opioid users. To improve supportive services, county agencies (Public Health, Sheriff, CJRC), medical staff and the NC Harm Reduction Coalition have teamed up to provide Naloxone kits (overdose reversal kit) to inmates upon release. As a result, inmates that are identified as opioid users can request a Naloxone kit at release from to prevent a future drug overdose.

Durham's Department of Public Health also makes Naloxone available at their pharmacy. The program started in the Summer of 2017.

PRETRIAL SERVICES

Pretrial Services provides a systematic approach for recommending release and community supervision for defendants who are unable to post bond and do not pose a risk to the community as they await trial. Pretrial staff assesses eligible persons and makes recommendations to the Court for release. Pretrial Services supervises individuals based on a validated risk assessment and special conditions set by the Courts.

Pretrial Services provides arrest and court summaries for all defendants to the presiding judge at the Jail First Appearance Court. In addition, when inmates are unable to contact friends and family members regarding bond and their release, Pretrial staff contacts them for the inmate.

IN FY 2017 PRETRIAL SERVICES

Prepared 4,392 Court summaries for First Appearance

Assessed 2,101 inmates for pretrial Release Supervision

Contacted 1,221 families & friends on behalf of inmates

Supervised 451 individuals

MISDEMEANOR DIVERSION PROGRAM (MDP)

Representative Marcia Morey, the former Durham Chief District Court judge, stated she envisioned the Misdemeanor Diversion Program (MDP) because she became tired of seeing young people in court for offenses that were not serious with lasting negative consequences affecting college and employment opportunities later in life.

The diversion program started in March 2014 for 16- and 17-year-olds and was expanded to include up to 21-year-olds by October 2015. Through June 30, 2017,

- **352 16-21 y.o. participated in the program, 99% completed MDP**
- **89% of MDP graduates did not have additional contact with the criminal justice system in the year following program completion.**

C.D., an honor roll student, was charged with misdemeanor larceny for stealing a drink from her school. Through the Misdemeanor Diversion Program, C. D. learned about NC laws which place youth ages 16 and up in the adult criminal system and the collateral consequences she could have faced if charged as an adult. She also attended a leadership skills program to help her make better decisions in the future. C.D. completed the MDP program and will be attending college on an academic scholarship which she would not have been eligible for with an arrest record.

GANG REDUCTION STRATEGY

In Durham, a coordinated, community-wide approach has been in place for several years to reduce criminal activity committed by gang members. Durham adopted and implemented the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Comprehensive Gang Model in 2008. Policy related to this approach is crafted by members of the Gang Reduction Strategy Steering Committee.

The Steering Committee has established two subcommittees. The Prevention/Intervention Team meets quarterly providing a venue for stakeholders to learn more about the Comprehensive Gang Model, and to coordinate resources. The Suppression Team, consisting of law enforcement, probation, juvenile justice and the District Attorney's office, meets regularly to share intelligence, coordinate efforts and to plan events such as probation searches and youthful offender call-ins.

Activities of the GRS Steering Committee in FY 2017 included

- Reviewed data on violent deaths occurring in Durham
- Invited representatives from Cure Violence, YouthBuild, StepUp and the Local Reentry Council to present information to the group
- Endorsed a structured communication policy for information sharing between law enforcement, courts, correctional institutions and probation
- Examined metrics related to employment for justice-involved individuals
- Received a report from ATF on firearm traces in Durham
- Reviewed the Durham Gang Crime Report (2009 – 2016)
- Reviewed all recommendations of the Updated Gang Assessment and identified several for special focus in FY 2018

Additional information, including research and reports, can be found on the GRS website

CRIMINAL JUSTICE SYSTEM SUPPORT

Juvenile Crime Prevention Council (JCPC)

The NC Department of Public Safety (NCDPS), Division of Adult Correction and Juvenile Justice, collaborates with the Juvenile Crime Prevention Councils (JCPC) in all North Carolina counties to galvanize community leaders, locally and statewide, to reduce, and prevent juvenile crime. JCPC works to develop community-based delinquency prevention strategies and programs to divert at-risk juveniles from becoming court involved. The Council assesses local youth service needs annually and addresses gaps in services.

Members of the Juvenile Crime Prevention Council listen to presentations by funded service providers in FY 2017

Each year the JCPC reviews data from juvenile Risk and Needs Assessments. This data is used to identify the most current and pressing needs of at-risk juveniles in Durham County, these needs are foundational to the JCPC Annual Plan.

To view the Durham Risk Needs Assessment and JCPC Annual Plan and Report, visit the JCPC website.

In FY 2017, Durham JCPC recommended allocating $536,600 from NCDPS to nine programs serving delinquent and at-risk youth in Durham County. The funding recommendations were unanimously approved by the Durham Board of County Commissioners.

Criminal Justice Advisory Committee (CJAC)

The purpose of the Criminal Justice Advisory Committee (CJAC) is to develop a comprehensive continuum of services for the adult criminal justice system, identify services gaps, and develop intervention strategies and comprehensive solutions. The CJAC members represent the many agencies and organizations in Durham that are part of the criminal justice system and advocate for justice involved persons.

In FY 2017, CJAC focused discussions on:

- Bail Bond policy and Pretrial Procedures
- Domestic Violence Batterer Intervention Services
- Reducing the number of jail inmates with mental illness
- Local efforts to combat opioid use
- Community efforts to reduce violent crime

To learn more about CJAC, visit the CJAC website.

COURT REMINDERS

With funding from the Safety and Justice Challenge Innovation Fund, CJRC has established an automated notification system aimed at preventing failure-to-appear warrants and arrests. By utilizing this innovative service, people involved with the Durham County Criminal Courts can receive text, phone, or email notices regarding scheduled court dates. There are approximately 2,800 criminal cases each month scheduled for appearance in Durham County. Of these, approximately 10%, or 280 individuals fail to appear.

Durham County hopes to decrease the number of people taken to jail because of a missed court date by sending reminders 72 and 24 hours ahead of scheduled court dates. Metrics are in place to determine savings in court administration and jail costs as this new program reduces the percentage of criminal cases that result in failure to appear charges.

Court Date Reminders is a joint effort led by the Criminal Justice Resource Center, in partnership with the Durham County Clerk of Superior Court, NC Administrative Office of Courts, Durham Public Defender's Office, Durham District Attorney's Office, Durham County Sheriff's Office and Durham County IS&T.

The project is funded by the Safety and Justice Challenge Innovation Fund, supported by the John D. and Catherine T. MacArthur Foundation.

AWARDS & RECOGNITIONS

- Safety & Justice Challenge Innovation Fund Award for Court Date Reminder Project
- 2016 Achievement Award by National Association of Counties for Misdemeanor Diversion Program
- Peaceful Presence Award from the Religious Coalition for a Non-Violent Durham
- Awarded the Intermediary Agency Contract by State of North Carolina for the Local Reentry Council

STAFF ACHIEVEMENTS, CHANGES

high five

High-5 Awards are given to staff who go above and beyond their usual job duties. To win this exclusive award a staff member must be nominated by one or more of their peers. Some winners have volunteered to stay late to help with troubled clients, while others have logged long hours to work on special projects. 17 staff were acknowledged for their exceptional service. Congratulations and thanks for all you do!

Three long time employees retired. CJRC congratulates and thanks them for their efforts for staff and clients alike. CJRC wishes them nothing but the best in their future endeavors.

Robert Thomas, Quality Assurance Coordinator

Dr David Vandevusse, Psychologist

Annie Woyee, Substance Abuse Counselor

CRIMINAL JUSTICE RESOURCE CENTER
FISCAL YEAR 2017 IN REVIEW

CJRC
326 E. Main St
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Email: cjrc@dconc.gov
Web: dconc.gov/cjrc

HOURS
Monday - Thursday
8:30am - 8:30pm

Friday
8:30am - 5:00pm

DURHAM COUNTY

The mission of the Criminal Justice Resource Center is to promote public safety through support for the local criminal justice system and to supervise and rehabilitate justice-involved individuals through a wide array of supportive services so that they may achieve their full potential as contributing members of their community.

The Criminal Justice Resource Center's vision is to inspire every court-involved individual to become a productive and responsible citizen in our community. We will support their efforts through continuous improvement driven by the integrity, teamwork, and innovation of CJRC Staff.

For additional information on Community Based Corrections please contact:

Roshanna Parker,
Assistant Director
rparker@dconc.gov
Phone (919) 560-0550
Fax (919) 560-0504

For additional information on Jail and Court Services please contact:

Gudrun Parmer,
Director
gparmer@dconc.gov
Phone (919) 560-0500
Fax (919) 560-0504

Durham County
Criminal Justice Resource Center
326 East Main Street
Durham, NC 27701
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Fax: 919-560-0504
www.dconc.gov/cjrc

Criminal Justice Resource Center

Providing Positive Opportunities for Justice - Involved Individuals

Community Based Corrections provide community based programs for justice involved individuals who are Durham County residents and on supervised probation, post-release supervision or parole.

Services include Substance Use Treatment, Cognitive Behavioral Interventions, Case Management, Employment Readiness, Computer Instruction, GED/Adult Basic Education and many wrap around services.

Recidivism Reduction Services (RRS) provides cognitive behavioral programming, substance use treatment services, and linkage to community resources to individuals referred by Durham Probation.

The Second Chance Program is a substance use treatment program designed for persons 18 years old or older. Individuals are referred through TASC, the Courts or other service providers. Participants receive intensive outpatient treatment or regular outpatient treatment based on the assessed level of care.

The Employment Readiness Program assists individuals with a criminal record develop skills needed to become employable through employment readiness and computer classes. Interested individuals do not have to be currently justice involved to attend. Contact: Robin Heath, 919-560-0551

Jail and Court Services provide support services to the court system, to court involved individuals and those in the Durham County Detention Facility.

Pretrial Services create a systematic approach for recommending release and community supervision for defendants who are unable to post bond and do not pose a risk to the community as they await trial.

The **Substance Abuse Treatment and Recidivism Reduction Program (STARR)** is a four-week chemical dependency treatment program provided to inmates in the Durham County Detention Facility. The majority of STARR participants are ordered to attend by the Courts or Probation.

Drug Treatment Court is an intensive, highly structured program designed to identify and treat individuals whose criminal activities are generally related to substance use. This is a post-conviction program and well suited for probationers facing violation due to continued drug use. Participants must have an underlying active sentence of at least four months. Some eligibility criteria apply.

The **Court Psychologist's** primary services include independent psychological evaluations of youth and adults in the criminal justice system, with recommendations for follow up treatment.

The **Mental Health Court Diversion Program** provides some individuals the opportunity to have criminal charges dismissed by connecting to mental health treatment and other services.

The **Local Reentry Council** connects anyone returning to Durham from incarceration to needed services and resources. A network of Durham providers is ready to address a multitude of needs. Services include short-term housing, child care, transportation and employment assistance.

The Misdemeanor Diversion Program (MDP) helps 16 to 21 year old individuals with first time, non-violent, misdemeanor offenses remain out of the adult criminal justice system. Referrals come through Durham law enforcement in lieu of arrest. MDP participants go through programming with the Courts and CJRC community partners.

All services at the Criminal Justice Resource Center are free of charge.

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS
Collaborative Approaches to Public Safety

BJA
Bureau of Justice Assistance
U.S. Department of Justice

DEVELOPING A MENTAL HEALTH COURT
An Interdisciplinary Curriculum

learning.csgjusticecenter.org

What is *Developing a Mental Health Court*? It's a **free online multimedia curriculum** for individuals and teams seeking to start, maintain, or just learn more about mental health courts.

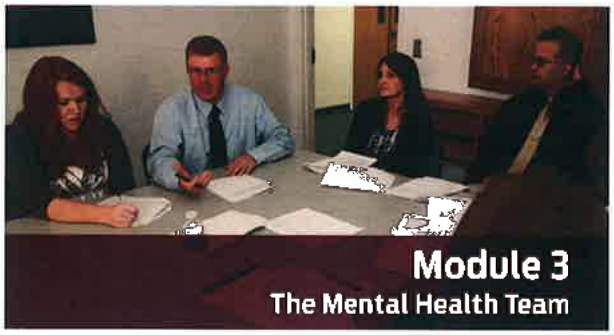
***Developing a Mental Health Court* is the first single resource with the information teams need to translate current research and best practices into program design and operation.** It includes a series of self-paced presentations and accompanying quizzes, individual and group activities, and access to additional resources that translate the experience of dozens of experts and practitioners into an accessible resource for diverse audiences.

Organized into freestanding modules, the curriculum **can easily be customized** for users' specific needs and time considerations. Its multimedia content includes interviews with a wide range of experts, including researchers, judges, court coordinators, treatment providers, probation officers, and more. A multi-part video case study with a discussion guide follows a real mental health court team through many common situations faced by teams.

The curriculum was developed by the Council of State Governments Justice Center with the support of the Bureau of Justice Assistance in partnership with the National Center for State Courts, SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, the National Judicial College, and the Center for Court Innovation and with the guidance of a steering committee of national experts.

Who is it for? It's for anyone interested in learning about mental health courts and other collaborations between courts and mental health systems, including:

* Judges
* Prosecutors and defense attorneys
* Mental health and substance use treatment providers and administrators
* Court managers and judicial educators
* Probation, pretrial services, and law enforcement officers
* Case managers



The Bonneville County (ID) Mental Health Court Team, pictured above, appears throughout the curriculum addressing fictional but realistic situations.

The curriculum can be used by sites interested in starting new mental health courts or retooling existing programs. It can also be used by individuals joining existing teams.

How do I use it? Sites should consider working with their states' judicial educators or problem-solving court coordinators, who can customize the curriculum based on state-specific guidelines. Alternately, the curriculum can be used locally with facilitation by a team member. While the full curriculum is designed to take about 32 hours to complete, groups can also use individual modules to complement their existing knowledge. Available entirely online, ***Developing a Mental Health Court*** is accessible to users wherever they are.

What does it cover?

Developing a Mental Health Court:

* Introduces mental health courts in the context of the criminal justice and mental health systems
* Helps users decide whether to start a mental health court based on their jurisdictions' needs and resources
* Describes best practices for designing a program, including how to identify the population the program will serve and set the terms of program participation
* Provides guidance on developing and monitoring individualized treatment and supervision plans
* Offers insights on maintaining a program, including managing public expectations and sustaining funding

Curriculum Module Contents

Module	Learning Objectives
Introduction to Behavioral Health	1. Describe the components of the mental health and substance abuse systems 2. Understand the symptoms and basic terminology of mental illnesses and co-occurring substance use disorders (CODs) 3. Describe the principles of effective treatment for mental illnesses and CODs
Introduction to Criminal Justice	1. Identify the common stakeholders in the criminal justice system 2. Describe how a criminal case proceeds through a typical criminal justice system 3. Understand certain legal concepts, types of cases, and principles for recidivism reduction
Module 1: ***Understanding Mental Health Courts***	1. Articulate why a community may decide to start a mental health court 2. Describe the mental health court model and the state of research on program outcomes 3. Identify program models other than mental health courts that have been shown to improve outcomes for individuals with mental illnesses involved in the criminal justice system
Module 2: ***Your Community, Your Mental Health Court***	1. Identify local- and state-level stakeholders who should help plan your mental health court 2. Articulate common mental health court goals and ways of measuring these goals 3. Understand how to build on local resources and priorities to shape your program
Module 3: ***The Mental Health Court Team***	1. Describe the roles and responsibilities of the core mental health court team members 2. Identify ethical issues that mental health courts present for yourself and other team members 3. Develop approaches for handling conflict within your mental health court team
Module 4: ***Target Population***	1. Understand the current state of research on who benefits from mental health courts 2. Understand how local conditions can shape criminal justice and clinical eligibility criteria 3. Analyze factors for and against requiring a plea for program participation
Module 5: ***Designing Policies and Procedures for Program Participation***	1. Understand how a mental health court program can be designed to protect legal rights 2. Describe how to design a referral process for your program 3. Identify considerations for determining the duration of an individual's participation
Module 6: ***Case Planning***	1. Understand what a case plan and its main components are 2. Describe the relationship between the treatment plan and supervision conditions 3. Understand how to develop treatment plans and supervision conditions based on comprehensive assessments and available supports
Module 7: ***Facilitating the Success of Mental Health Court Participants***	1. Articulate principles that research shows are effective in modifying behavior 2. Describe how these principles inform your role on the mental health court team 3. Develop policies and procedures that apply these principles to your mental health court
Module 8: ***Launching and Sustaining Your Program***	1. Identify common strategies for funding your program at the outset 2. Describe the role of data collection and evaluation in managing and sustaining your program 3. Describe strategies for engaging your advisory group and team members in continuously improving the program

Module 1: Understanding Mental Health Courts features an audio interview with Judge Tamara Curry of the Charleston (SC) Mental Health Court.

How do I access it?

Developing a Mental Health Court is available at learning.csgjusticecenter.org.

Users will need Internet access and Adobe Flash Player to play the curriculum's audio and video features.

Visit the CSG Justice Center's Criminal Justice/Mental Health Consensus Project website ***(www.consensusproject.org)*** *to subscribe to our newsletter for updates on the curriculum.*