Nash County Information Session
August 29, 2017




Transforming Lives

Trillium HEALTH RESOURCES

CENTRAL REGIONAL DIRECTOR

DAVE PETERSON, MA

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Why is Nash County Joining Trillium?

- Under N.C. General Statute 122C-115(a3), the Secretary of the Department of Health and Human Services has authorization to approve a county's request to leave its managed care organization.
- On November 22, 2016 the Nash County Board of Commissioners voted to leave Eastpointe, and asked for permission to join Trillium.
- On November 28, 2016 the Trillium Health Resources governing board voted to accept Nash County, if the Secretary granted their request.
- The Secretary notified Trillium on December 6, 2016 that Nash County was granted the request to leave Eastpointe and join Trillium. The effective date of the change was July 1st , **2017**. Trillium had a work group dedicated to the tasks associated with this move.

Overview

Trillium Health Resources is a local management entity/managed care organization (LME/MCO) that is responsible for fiscal management of mental health, substance use and intellectual/developmental disability services in eastern North Carolina. Trillium resulted from the consolidation of East Carolina Behavioral Health and Coastal Care in 2015, but through the legacy organizations has been coordinating services for years.

We are responsible for managing resources (federal and state funded services and a Provider Network) for people who receive Medicaid, are uninsured or cannot afford services.

Trillium **does not** provide direct care.

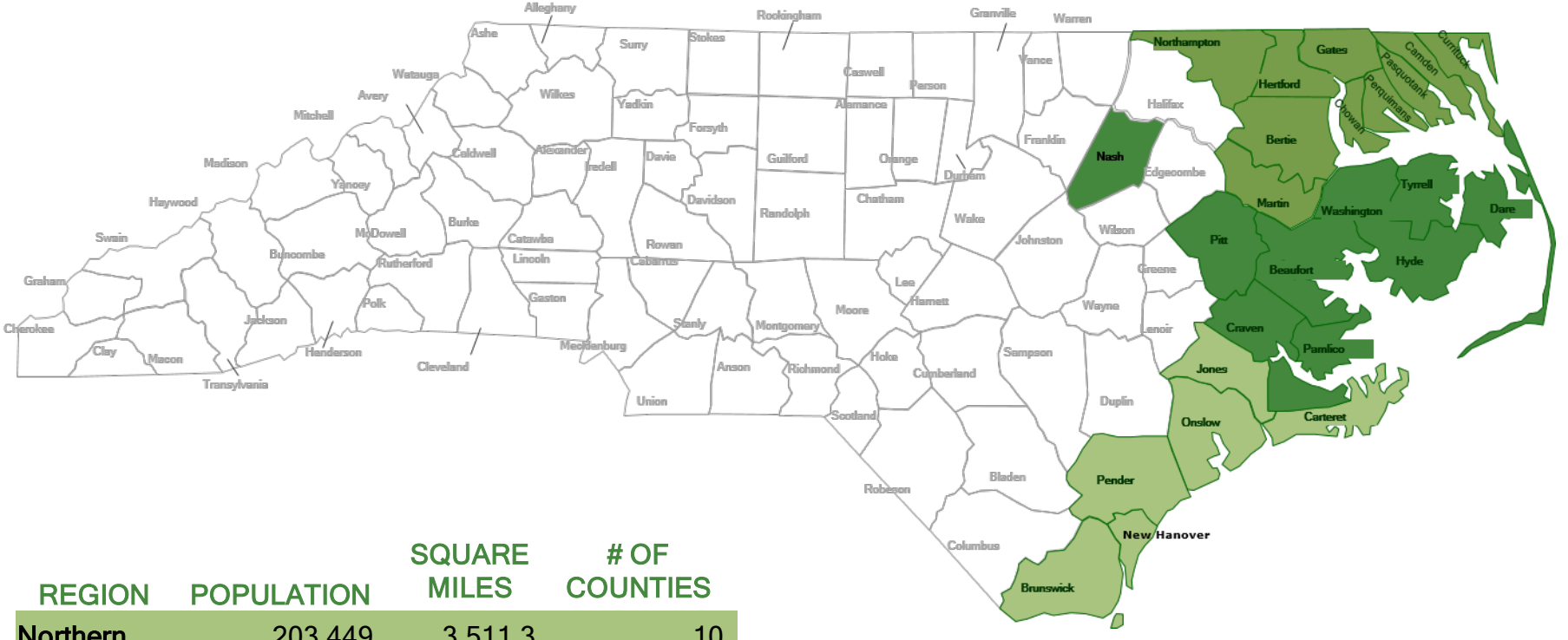
Instead, we partner with agencies, licensed clinicians and other medical and allied professionals in our Provider Network to offer services and supports to people in need in or near their own communities.

Trillium's Mission ***is transforming the lives of people in need by providing them with ready access to quality care***.

Who We Are

- 25 counties, stretching from Virginia to South Carolina
  - Largest LME/MCO in terms of number of counties and geography
- Total population of 1,383,854; approximately 200,000 Medicaid-eligible; Nash County – approximately 95,000
- 13.6% of State's total population, 16% of Medicaid enrollees
- 11,993 square miles, roughly the size of Maryland, or bigger than 8 states!
- Widely varying population density
  - Wilmington and Greenville are 8th and 10th largest cities, respectively
  - Most of catchment area very rural – includes NC's 2 lowest populated counties, Hyde and Tyrrell

Population and Miles



REGION	POPULATION	SQUARE MILES	# OF COUNTIES
Northern	203,449	3,511.3	10
Central	493,731	5,260	9
Southern	657,955	3,222.8	6

Current Statistics for 2016

- Managed care of approximately 50,000 people
  - 81% with mental health disorders
  - 21% with substance use disorders
  - 11% with intellectual and developmental disabilities
- Total amount paid to providers for services and supports = $340,242,416.01
- Approximately 400 Providers

2 Tiered Governance Structure

- Regional Advisory Boards
  - One county commissioner or designee from each county, one other member appointed by the county who fits one of the criteria of G. S. 122C-118.1
  - Chair of the Regional CFAC
  - Duties:
    - Monitor performance at regional level,
    - Identify gaps and needs,
    - Maintain connection to counties and communities,
    - Participate in evaluation of regional directors,
    - Recommend priorities of state and county funds
    - Monitoring resolution of issues
    - Appoint members of the Governing Board
    - Meet every other month
  - Northern = 21 members; Central = 19; Southern = 13
- Regional CFACs
  - All duties outlined in statute for CFAC, including advise Regional Advisory Board. Chair or designee sits on Regional Board and Governing Board

Governing Board

- 13 Member Board
  - CFAC chair or designee, one commissioner or designee, and 2 other members who meet criteria outlined in G. S. 122C-118.1 from each Region
  - Provider Network Council Chair or designee
  - Duties:
    - Determining policy
    - Strategic Planning
    - Overall performance and financial management
    - Governmental affairs
    - Responding to concerns and feedback from Regional Advisory Boards
    - And all other responsibilities outlined in Statute 122C-118
    - Meet every other month

Infrastructure

- 440 Total staff
- Executive Team
- 18 Departments
- Current Office Locations: Ahoskie, Camden, Greenville, Jacksonville, and Wilmington

System Of Care (SOC)

- Each County has a System of Care Coordinator- Keith Letchworth (keith.letchworth@trilliumnc.org) is assigned to Nash County. Please contact Keith if interested in Collaborative involvement or additional questions about SOC involvement.
- Community Collaborative- Diverse groups of people that foster cooperative partnership to identify services and supports for individuals who may need/receive services.
- The System of Care Coordinators provide support to the leadership of the Collaborative, provide technical assistance to the community and partners.
- SOC Coordinators serve on various committees i.e. Juvenile Crime Prevention, Child Fatality Review Teams, Juvenile Justice Substance Abuse Mental Health Partnerships, etc.

Questions?

CALL CENTER AND CUSTOMER SERVICES

ASHLEY RHEA, CALL CENTER OPERATIONS

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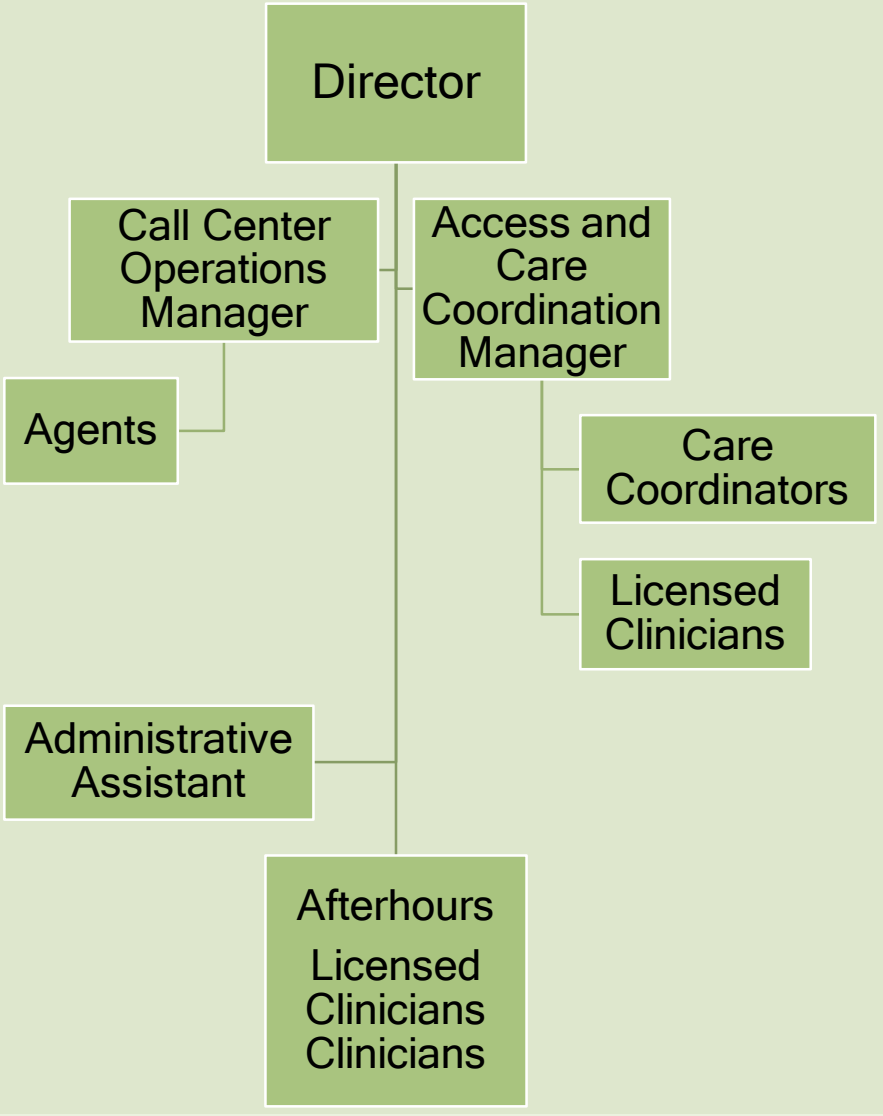
Today's Topics

- Staff
- Business Line and Access to Care Line
- Accessing Services
- Referrals to Care Coordination and Care Coordination in the Call Center
- Registry of Unmet Needs
- Crisis Services

Call Center and Customer Services Staff



Incoming Calls

Business Line- 1-866-998-2597

- Contact Trillium Staff
- Complaints and Grievances
- Need Information or some other type of assistance

Access to Care Line- 1-877-685-2415

- This line is specifically for individuals seeking services that includes crisis services
- This line is answered 24/7/365

Accessing Services

"NO WRONG DOOR"

Individuals may seek services with any provider within the Trillium network.

If a provider does not offer the specific service the individual needs, they can refer them to someone who does.

How to Access Services

- Individuals may contact a provider directly to schedule an appointment
- Some providers offer same day access or the opportunity to walk-in
- Trillium's Access to Care Line 1-877-685-2415 to receive assistance in scheduling an appointment

How can someone find information on providers, services and resources?

- Contact Trillium's Call Center
- Online
  - Trillium Website
    - Enrollee Handbook
    - General Information
    - Information on Providers
  - Social Media
    - Facebook
  - NC 211-Can also dial 211
- Printed Material, Newsletter, TV, Radio, Newspaper
- Word of Mouth (Friends, Family, Doctor, Teacher, DSS…)

When You Call Our Business or Access Line

Name, Number and Nature of the Call

- Is this an emergency? If yes, a clinician is conferenced into the call
- What county are you calling from?

When You Call Our Business or Access Line (cont.)

For those Individuals seeking services

- Gather demographic information
- Other questions (tied to funding, legislation or planning & development)
- Screening, Triage and Referral
  - Brief telephonic screening to identify the need and the urgency of need
    - If emergency, will have care within 2 hours
    - If urgent, must have care within 48 hours
    - Routine needs will have referral to a provider for appointment within 14 days
  - **Discuss options for accessing care**

Care Coordination and The Call Center

- In the Call Center both Coordinators and Clinicians perform short term care coordination for enrollees not already assigned to a Care Coordinator in another department.
- We can and do make referrals to Care Coordination but first we are going see if it's something we can help with.

Care Coordination and The Call Center (cont.)

- In the Call Center we ask a lot of questions to help us better understand the experiences and needs of our enrollees and their families.
- We are charged with connecting individuals to the most effective/clinically appropriate services.
- Besides services we connect callers with other possible resources within their community

We Are A Resource For You

Registry Of Unmet Needs

- The Registry of Unmet Needs for the Innovations Waiver consists of Individuals who are potentially eligible for Innovations services and funding.
  - Individuals and families must apply for Innovations through a written application process to include the most recent psychological evaluation.
  - The application can be obtained by calling Trillium's Call Center at 1-866-998-2597. Ask to speak to a Coordinator or Clinician.
  - The Registry of Unmet Needs committee reviews applications monthly.

Registry Of Unmet Needs

- In addition to reviewing requests for Innovations, Call Center staff and committee members will share information on possible resources, services and supports whenever possible understanding that even if an individual is placed on the Innovations waitlist we have no way of knowing how long an individual will wait for Innovations Waiver funding.
- New Innovations Waiver funding is allocated by the state. Innovations Waiver funding will be distributed on a first come-first served basis using your date of waiting and other variables determined by the state.

Mobile Crisis in Nash County

Integrated Family Services

Offices located across the Trillium region

- Mobile Crisis

1-866-437-1821

- Crisis Chat

www.integratedfamilyservices.net

Contact Information

Myra Felton, BS: Call Center Operations Manager
Myra.Felton@trilliumnc.org
Ashley Rhea, MSW, LCSW: Access and Care Coordination Manager
Ashley.Rhea@trilliumnc.org
Benita Hathaway, MS, RN, LPC: Call Center and Customer Services Director
Benita.Hathaway@trilliumnc.org

All Trillium Health Resources Staff can be reached at:
1-866-998-2597

Questions?

CARE COORDINATION
MENTAL HEALTH/SUBSTANCE USE

NANCY CLEGHORN, SENIOR DIRECTOR

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What is Care Coordination?

Mental Health/Substance Use (MH/SU) Care Coordination is the clinical oversight to certain members receiving mental health and/or substance use services within the Trillium catchment area.

The Clinical Care Coordinator seeks to link to the best and most effective/clinically appropriate services that will assist the member to achieve or maintain wellness and meet their goals.

What is Care Coordination?

- Available to children and adults, typically those hospitalized, having to go to the ED, or when out of home services for youth are discussed.
- Person Centered to meet the member's preferences and needs
- Integrates both mental health and primary health care services
- Examines both paid support services and natural/community supports
- Ensures the development of a comprehensive plan and crisis plan and monitors that the services provided match the strategies listed on that plan

Care Coordination as a function of the LME/MCO

The Care Coordinator ensures that the provider completes:

- Assessment
- Person Centered Plans (PCP)

The Care Coordinator provides:

- Linking
- Education/Communication
- Monitoring

Assessments

Assessments are completed **by provider agencies** to review clinical/social history and the member's current symptoms. The assessment ends with clinical recommendations for services needed.

The Clinical Care Coordinator:

- Reviews existing clinical assessments
- May recommend further assessments such as a psychological or review of treatment history to address trauma or substance abuse.

Treatment Planning

Treatment Planning by a Care Coordinator may include:

- Involvement in treatment team meetings -- Child and Family Team meeting (CFT) or hospital discharge planning meeting
- Assisting with the development of the Person Centered Plan (PCP) by recommending goals/interventions, including a thorough crisis plan
- Recommending evidence-based services that might assist in helping the member achieve or maintain wellness and meet their treatment goals
- Coordinating services and supports among multiple provider and service agencies, including family doctor/primary care provider

Linking

The Care Coordinator works with the member being served (and their family) and may link to:

- Mental Health/Substance Use provider agencies
- Physical Health Services–general practitioners & specialists
- Community Resources - Salvation Army, food pantries, DSS, transportation services, housing services, Wellness Cities
- Advocacy Groups & Support Networks --NAMI, AA, NA
- Natural Supports - churches, Boys and Girls Club, Parks and Recreation programs

Education and Communication

The Care Coordinator provides education and communication in multiple ways:

- A new diagnosis and symptoms, etc.
- The array of services and agencies available to meet their needs
- Primary health care services to meet their physical health needs
- Self advocacy regarding their treatment and service needs

Monitoring

The Care Coordinator may monitor:

- That the recommended services indicated in the assessment and the PCP are being provided
- That the member is satisfied with services, with their provider agency and are following up with the services.
- That there is a decreased use of emergency rooms, crisis services and hospitals
- That the member is making progress towards goals
- That the PCP and services are modified if progress is not evident

The Out of Home Process for Youth

- Updated Comprehensive Clinical Assessment
- Completion of the Out Of Home request form
  - www.trilliumhealthresources.org
  - For Providers>Provider Documents and Forms>under Care Coordination Forms (Out of Home Request form)
  - Instructions are on the form
  - Sent to Rob Heubel (preferably emailed)

Working Together with Members and/or Parents/Guardians

- Care Coordinators participate in Child and Family Team meetings with the youth and parents/guardians.
- Care Coordinators assist with any barriers or roadblocks to keeping schedule appointments with providers.
- Care Coordinators will talk with you about any questions or concerns with your treatment.
- We will work together to talk by phone or return phone calls.

What the Trillium Care Coordinator needs from the Community Hospital?

- Hospital staff to coordinate the discharge with the Trillium Care Coordinator to ensure services have been arranged following discharge. Trillium Care Coordination is not meant to replace discharge planning at the hospital.
- Hospital Staff to provide at least 24 hour notice of discharge planning meeting and notify Care Coordinator by phone and/or email of discharge planning meeting date and time.
- Hospital staff to provide information pertinent to the development of Person Centered Plan (PCP) and Crisis Plan for a member and/or directly participate in the planning process.
- Hospital staff to provide documentation to the Trillium Care Coordinator related to recommendations for treatment services, discharge plans and discharge appointments. Trillium Care Coordinator will assist with referral appointment scheduling if needed.

What the Trillium Care Coordinator needs from providers?

- Notify the Care Coordinator of any changes, incidents, other information of significance related to the member supported
- Ensure that members are appropriately linked to primary health care
- Assist with referrals to natural and community supports
- Follow-up whenever a member considered at high risk misses an urgent or emergent appointment
- Contact Trillium Care Coordinators whenever an member receiving Care Coordination misses two appointments

Contact Information

Rob Heubel, MS, LMFT: Comprehensive Manager of Child Care Coordination

Robert.Heubel@trilliumnc.org

Holly Cunningham, M. Ed., LPCS: Residential Manager of Child Care Coordination

Holly.cunningham@trilliumnc.org

Darlene Webb, MSW, LCSW: Director of Adult MHSU Care Coordination

Darlene.webb@trilliumnc.org

Jackie Beck, LPCS, NCC, LCASA: Director of Transitions to Community Living Initiative

Jackie.Beck@trilliumn.org

Nancy Cleghorn, LPA, LCAS: Senior Director of MHSU Care Coordination

Nancy.cleghorn@trilliumnc.org

All Trillium Health Resources Staff can be reached at: 1-866-998-2597

Questions?

CARE COORDINATION
INTELLECTUAL/DEVELOPMENTAL DISABILITIES (I/DD)

ROSE BURNETTE, SENIOR DIRECTOR

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What is Care Coordination?

- **Person-centered**: based on persons needs and preferences
- **Assessment based**: Assess person's needs to determine services/supports
- **Interdisciplinary Team approach**: integrating behavioral health services, primary health care, natural and community supports;
- **Planning**: Using all the information learned from the person, Team and assessments to develop a Individual Support Plan.
- **Coordination of services/supports**
- **Monitoring Services/Supports**

Goals of Care Coordination

- To support individuals to have the life they choose (live, work, play, etc.).
- To ensure individuals are referred to and appropriately engaged with providers that can meet their needs for Mental Health/Intellectual and Developmental Disability/Substance Use (MH/DD/SU) services and primary medical care.
- Routine monitoring to ensure satisfaction with services and health and safety.
- Integration of MH/DD/SU services and primary and specialty health care.

Who is Eligible for I/DD Care Coordination?

- Receives Innovations Waiver funding
- Lives in an Intermediate Care Facility-IDD setting and needs coordination to transition to services in the community.
- Resides in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP)

Who at Trillium provides I/DD Care Coordination?

- 80.5 I/DD Care Coordinators-Qualified Professionals
- Specialty Areas include: Autism, IDD/MI, Young Adults in Transition, Child/Adolescent, Older Adults, Complex Medical, etc.
- Includes: Sr. Director, 2 Regional Directors, 9 Managers

Supports Intensity Scale(SIS)

- Devita Phelps-Manager
  - 6 SIS Evaluators
- SIS is a standardized tool used throughout the state to identify support needs of individuals served through Innovations Waiver.
- Complete SIS assessments throughout the Trillium geographic area.
- A new SIS is not required based solely on Nash County joining Trillium. SIS assessments will be completed per state requirements (Adult-every 3yrs, Children every 2 yrs)

Who Receives I/DD Care Coordination?

1,693 people with Innovations Waiver (IW)funding

- Please note: number of individuals receiving IW funding is determined by the state.

Transition for Nash-Innovations Waiver

- Assigned Care Coordinators to individuals based on specialty area, geographic location, etc.
- We have notified individuals, parents, guardians regarding their assigned Care Coordinator.
- In some cases we are still asking members/parents/guardians/providers for additional clinical information.
- Since July 1 we have been actively providing care coordination for individuals who receive Innovations Waiver Funding.
- In most cases the transition was seamless.

Transition Issues

- Respite requires a goal in the ISP
  - ISP Revisions required to include goal for Respite
- Resource Allocation (RA)/Individual Budgets (IB)
  - Care Coordinators are providing education to members to understand their IB and what it means to live within their assigned individual budget amount
- Psychological Evaluations must be completed per state requirements
  - Every 3 years for children
  - Every 5 years for adults

I/DD Care Coordination Contact Information

Regina Manly-Southern Region Director

regina.manly@trilliumnc.org

Juanita Murphy-Northern/Central Region Director

juanita.murphy@trilliumnc.org

All Trillium Health Resources Staff can be reached at:

1-866-998-2597

Questions?

COMMUNICATIONS AND MARKETING

JENNIFER MACKETHAN, DIRECTOR

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Communications & Marketing Department

- New Member Welcome Letters and other mailings
- Web Site:
  - Member Handbook
  - Rights and Responsibilities
  - Provider Directory
  - Educational Opportunities and Calendar
  - Hard copies of information shared on website can be requested through call center

- Press Releases
- Translations (Spanish and as requested)
- info@trilliumnc.org
- NashCounty@trilliumnc.org
- Social Media
- Brochures and Flyers
- External Newsletters
- Event sponsorships

Our Logo

Mission statement:

Transforming the lives of people in need by providing them with ready access to quality care.

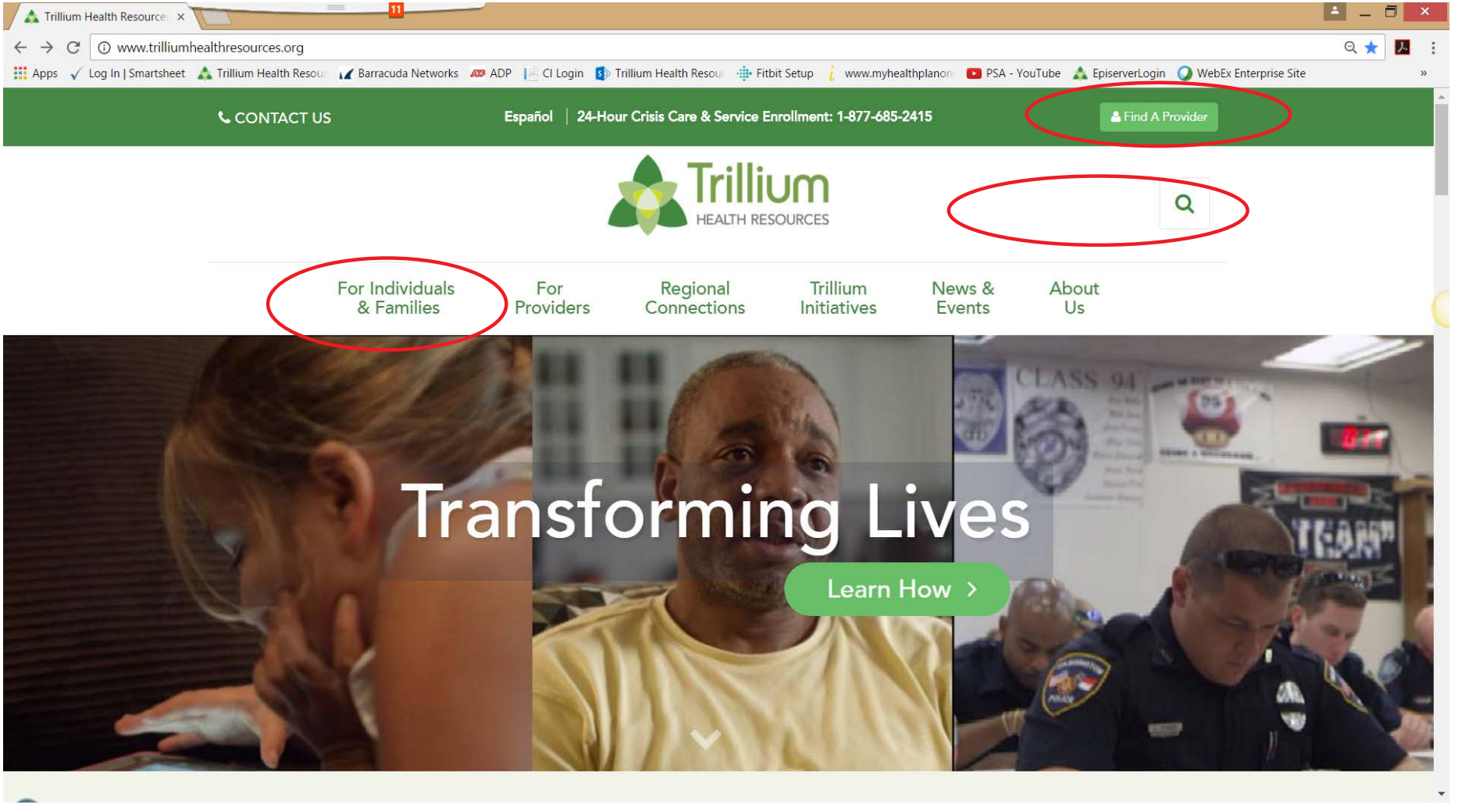
Trillium Web Site Tour

www.TrilliumHealthResources.org

- Home Page
  - Find a Provider
  - Contact Us
  - Transforming Lives
  - Blocks & Events
  - Footer

- Landing Pages
  - For Individuals & Families
  - For Providers
  - Regional Connections
  - Trillium Initiatives
  - News & Events
  - About Us
    - Specific page for Nash County members to share information.

Trillium Website Tour



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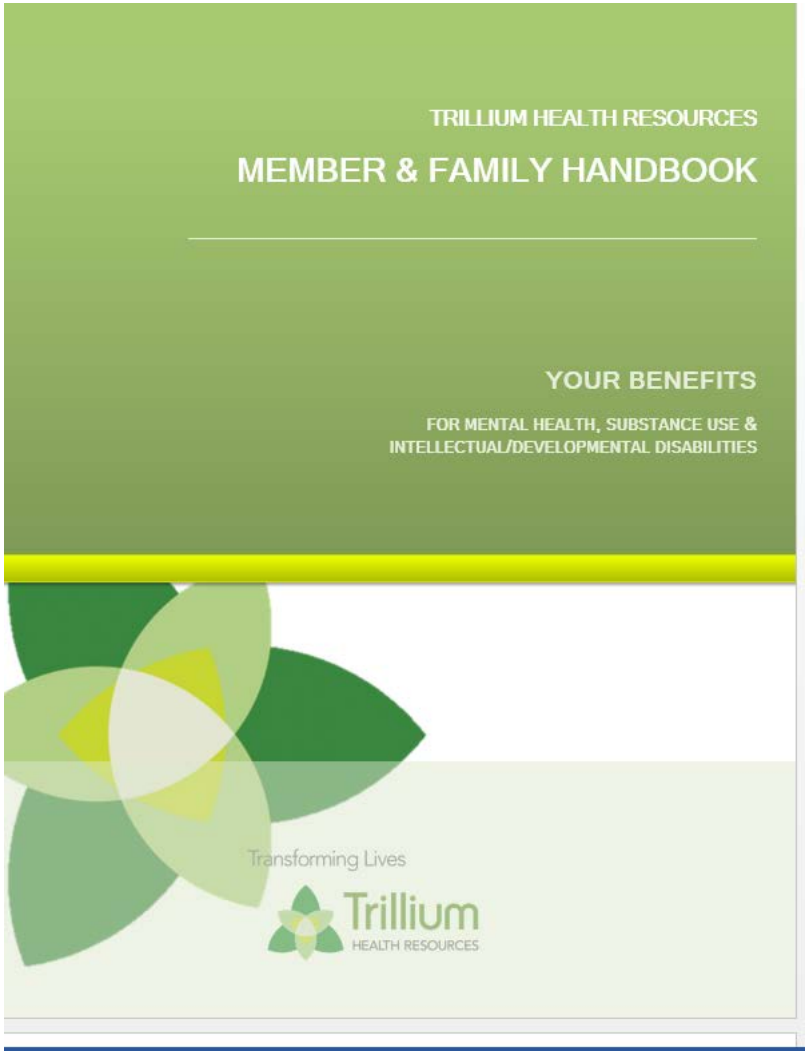

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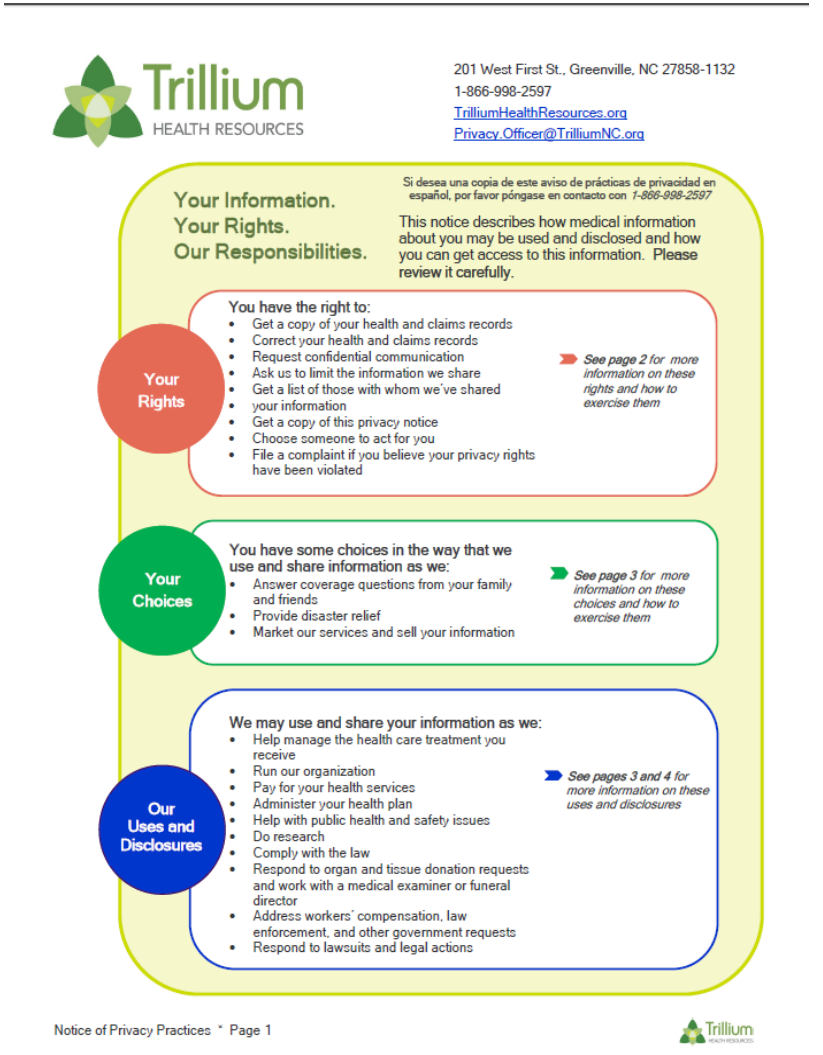


Trillium HEALTH RESOURCES

201 West First St., Greenville, NC 27858-1132
1-866-998-2597
TrilliumHealthResources.org
Privacy.Officer@TrilliumNC.org

Your Information. Your Rights. Our Responsibilities.

Si desea una copia de este aviso de prácticas de privacidad en español, por favor póngase en contacto con *1-866-998-2597*

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

See page 2 for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

See page 3 for more information on these choices and how to exercise them

Our Uses and Disclosures

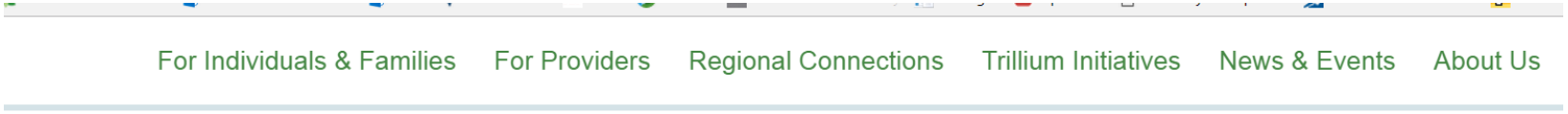
We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

See pages 3 and 4 for more information on these uses and disclosures

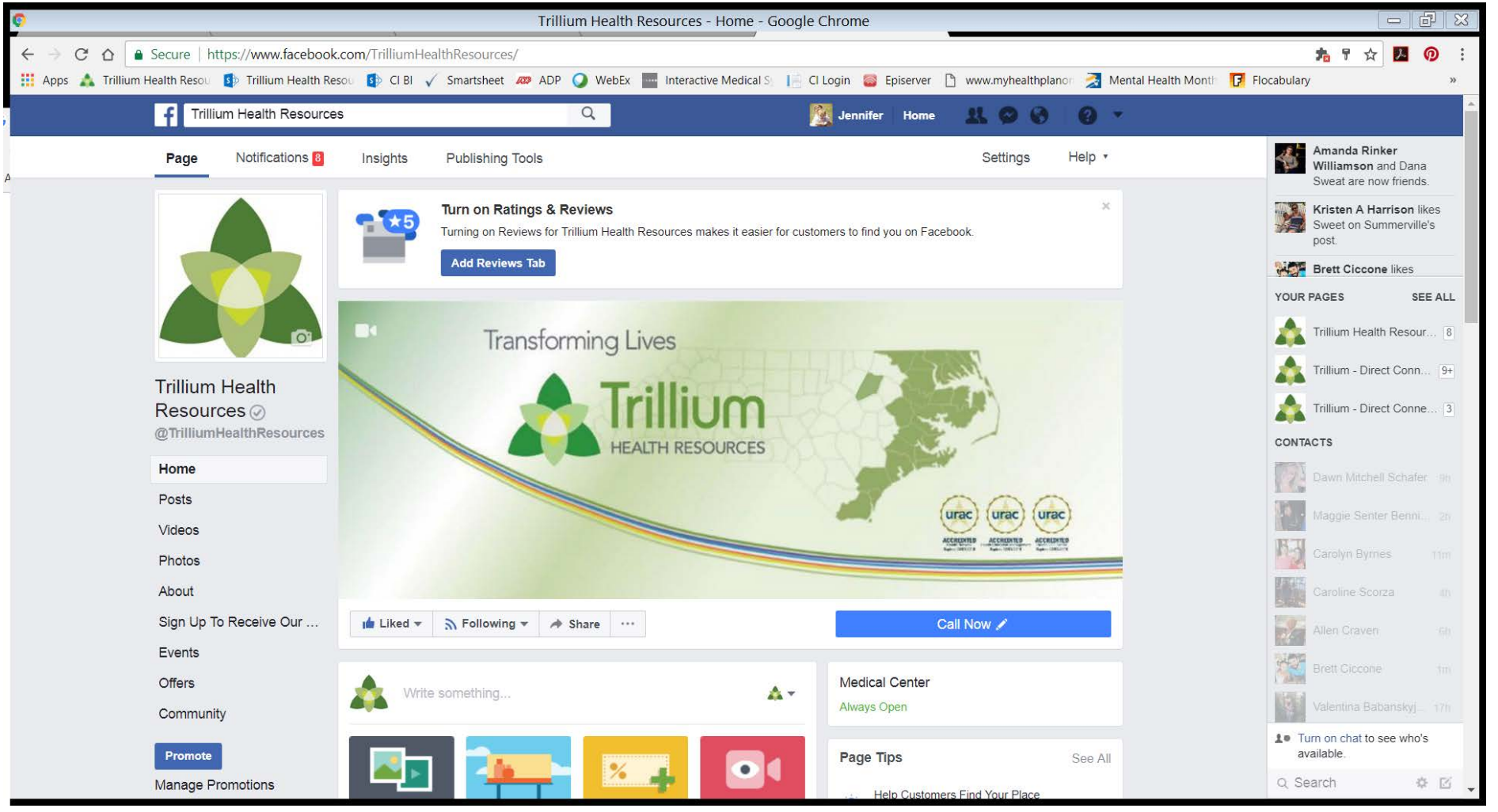
Notice of Privacy Practices * Page 1

Trillium HEALTH RESOURCES

Trillium Website Tour



Trillium Social Media



Communications & Marketing Team

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Rebbecca Basden
Provider Communication Specialist
Rebbecca.Basden@TrilliumNC.org

Frankie Glance
Administrative Assistant
Frankie.Glance@TrilliumNC.org

Questions?

NETWORK DEPARTMENT

KATHY MATHIS, NETWORK DEVELOPMENT MANAGER

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Network Department

- The Network Department is responsible for the development and maintenance of the Provider Network to meet the needs of members, while ensuring choice and best practices in services.

- The Network Department oversees the following:
  - Provider Monitoring
  - Provider Enrollment and Credentialing
  - Provider Network Development

Network Department

Provider Enrollment and Credentialing Questions:

Credentialing@TrilliumNC.org

Provider Network Development Questions:

NetworkDevelopment@TrilliumNC.org

All Trillium Staff may be reached at:

1-866-998-2597

INTEGRATED FAMILY SERVICES

BRIGIDA MORRIS, NORTHERN REGION MOBILE CRISIS DIRECTOR

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Integrated Family Services

Mobile Crisis Team:
1.866.437.1821 / 24 hours a day / 7 days a week
Brigida Morris:

- (252) 428-7160 (Office)
- bmorris@integratedfamilyservices.net

Link to video

Questions

Thank you for attending.

We look forward to working with you.