NC TIDE

North Carolina Training, Instruction, Development, and Education (NC TIDE)

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Inside This Issue:

Special Interests:

As we say goodbye to 2013, the NC TIDE Committee would like to thank all the individuals, local and state agencies, conference speakers, exhibitors, community groups, contributors to our newsletter and volunteers for their valuable support throughout the year to the ongoing mission of NC TIDE.

We wish all of you a safe and happy holiday season.

A Message from the President

Jill Queen, 2013 NC TIDE President

Greetings,

Only a month ago, many of you convened with NC TIDE at the Fall 2013 Conference in Asheville, NC. I hope those of you in attendance found the Fall Conference to be informative and beneficial. NC TIDE expresses our gratitude to all the members, participants, vendors and speakers that helped NC TIDE make the Fall Conference a success! During the conference, the membership voted to approve changes to the NC TIDE By-laws. These changes enabled your current officers to continue their terms of office through 2014. The revised By-Laws are located on the NC TIDE website.

At the Fall Conference, many of you turned in your conference evaluation forms and provided the Planning Committee with valuable feedback. As a result, the NC TIDE planning Committee is underway with their planning activities for the Spring conference. We would like to have your input on how NC TIDE can best meet your needs and serve as your resource for providing "***Excellence in Training and Promoting Professionalism***". Please feel free to contact any of your NC TIDE Committee Members or Officers to share your thoughts and ideas. More information about the upcoming Spring Conference will be forthcoming in the next few months. NC TIDE is confident you will not want to miss the Spring Conference in Wilmington.

Now, the Holiday Season is upon us and NC TIDE looks forward to continuing to serve as your training organization in 2014. As 2014 approaches, NC TIDE faces the New Year with excitement and anticipation, as our organization continues to strive to be the best training organization for our members, face new challenges and achieve new goals in meeting the needs of the managed care environment and integration of behavioral and physical care.

As 2013 draws to a close, we end the year with gratitude to the NC TIDE membership and the continued support from Managed Care Organizations, consumers and families, provider agencies, advocates, state offices such as the Division of Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services, Division of Medical Assistance, and UNC School of Government. NC TIDE is not a success without each of you.

Thank you again for all your support and helping NC TIDE achieve success over the past year. I look forward to continuing to serve the organization and membership as president. Happy Holidays and all my best to each of you for a prosperous New Year!

Jill Queen, President
NC TIDE

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Volunteer to be a part of the 2014 NC TIDE Committee.

Contact Jill Queen at
Jill.Queen@cardinalinnovations.org

NC Tide Mission Statement: ***"A Tradition of Excellence in Providing Training and Promoting Professionalism".***

2014 Goals:

NC TIDE strives to be the best training organization for our members by meeting the needs of the managed care environment and integration of behavioral and physical care.

- Promoting and increasing our strengths as a strong organization committed to quality training and education with a focus on consumers, families, stakeholders, providers and MCOs,
- Serving the state of North Carolina and the NC TIDE Membership with great leaders and members who are highly motivated, knowledgeable and experienced,
- Increasing membership by tailoring conferences to meet the needs of our members, providers, clinicians, MCOs and consumers by offering quality conferences and continued education units,
- Increasing exhibitors at NC TIDE conferences to offer the best resources, networking and connections to the latest technology and products available for the specialized market of behavioral health care.
- Pursuing and engaging in partnerships with key stakeholders and State Agencies in order to meet the needs of the managed care environment and integration of behavioral and physical care.

NC Tide 2013 Fall Conference Highlights

Laura Hamilton motivated conference attendees with her wit and real life experiences about choices and changes including how to create a plan for successful change.

Comedy Hypnotist Tim Triplet entertained and wowed the audience by hypnotizing a selected group of NC TIDE Conference attendees that volunteered to be in the show. The show provided many laughs and some very unforgettable moments. NC TIDE's own President, Jill Queen was a participant in the show along with several other committee members including Sherry Phillips, Beth Brown and Mike O'Connor. Thanks go out also to our wonderful conference attendees and exhibitors who provided entertainment with their willing participation.

Dave Richard officiated the closing session for NC TIDE. During the session, Mr. Richard gave conference attendees new prospective on behavioral health, discussed new initiatives and goals. Mr. Richard encouraged all conference attendees to partner together, provide input and feedback to key leaders regarding behavioral health and ensure accountability for quality care focused on outcomes.

NC TIDE Members voted to approve the proposed by-law changes which changed the term of office for officers to two year terms. As a result, your current NC TIDE officers will continue serving in their offices throughout 2014.

Mindful Communication

By Karen S. Holst, MSW, LCSW, EdD and Jude Johnson, MA, LMFT
Monarch

Are you looking for ways to reduce stress, improve wellness, increase productivity and focus? Maybe you're searching for better communication with co-workers, family members or friends. Mindfulness may be part of the solution since it is about cultivating moment to moment awareness that's friendly and forgiving in nature. Nationwide organizations like Apple, Google and General Mills have invested in mindfulness. These successful companies recognize mindfulness as a cost-effective approach in reducing stress, increasing productivity and creativity in the workplace. A growing body of research continues to validate the practice of mindfulness citing a plethora benefits. Mindfulness is diverse as it has expanded to the military, universities, hospitals, pain clinics, public schools and many other settings. Mindfulness is growing exponentially because of its profound and lasting results.

While primary care doctors are attempting to help us reduce stress and illness, their health is at risk too according to an article published by the American Medical Association. Approximately 60% of primary care physicians report burnout, emotional exhaustion and depersonalization (treating their patients like objects). This study showed that an 8-week course in mindfulness-meditation decreased burnout, improved well-being and caused doctors to show more empathy to their patients. Imagine what it would be like if our healthcare system was more attentive and compassionate.

When we're facing stress over time, money, work or relationships it is especially challenging to have a friendly non-judgmental attitude towards ourselves and others. Many of us are experiencing chronic stress over our projections of the future or replays of the past, all while we miss the most important moment, this one. The present moment is the only time we ever have an opportunity to learn and take action towards our hopes and dreams. Mindfulness helps us see that we have a choice on how to pay attention and where we focus our attention. It is not about forcing our attention or practicing self-blame as a way to improve ourselves. Mindfulness is rather about being conscious of what is present here and now. Present moment awareness empowers us to see deeper into the reality of the moment. Since mindfulness allows us to see things more clearly and accurately we can more easily respond with intelligent action, rather than being tossed about by waves of stress.

Meditation is a formal mindfulness practice which is the process of non-doing while cultivating moment to moment non-judgmentally awareness. Being with yourself in this way grows an understanding for the nature of your mind. Observing sensations, thoughts, and feelings as an impartial witness helps us respond from a more centered and conscious place. People often assume they are not cut out for meditation because their mind wanders or it seems to generate too many thoughts. If you are one of these folks, welcome to the club, you are not alone. It has been estimated that our minds create approximately 50 to 60 thousand thoughts every day. It is natural for our minds to generate thoughts and to look for solutions to our problems. Thinking is not a problem on its own, it is when we self identify with our thoughts that is problematic. For instance, do you believe every thought you have? Are many of your thoughts a story about what is wrong with you or others? People, who practice meditation regularly, generally discover they are not their thoughts or emotions. They see that thoughts are real but not always true.

While thoughts are not always true, our bodies are unaware of this fact. How many of us have been engaged in imaginary arguments, either rehearsing the conflict with someone we are planning to meet or with someone we have already spoken with? When someone disagrees with your strongly held beliefs, how does your body feel? Most of us have strong reactions when our beliefs are challenged because we identify who we are with

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what we think, otherwise known as self-identification. When we are caught self-identified stress, we are often tensing our muscles and have difficulty accessing clear communication. Our ability to communicate effectively may be hampered when someone disagrees with us because we are caught in the stress response otherwise known as fight/flight/freeze. When under stress many of us have the tendency to become passive or aggressive to varying degrees. Consider interchanging the word passive for flight/freeze and aggressive for fight when thinking about our biological response to conflict. This may help you see how conditioned we are to responding this way under stress. When in conflict we are often out of sync with how we are feeling or we are too engaged in the hot surface emotions to really be listening.

Let's look at a few practical ways to cultivate effective communication. First start practicing listening more closely to yourself. This means paying close attention to your body's sensations while you are communicating with others or when you are caught up in rehearsing past or future communications. See if you can notice where you experience emotions in your body. You may notice increased heart rate or body temperature among other changes. Notice the story or the stream of thoughts you are having about these emotions without judging them as good or bad. See if while listening to others you can see them with fresh eyes, instead of framing them with your regular predictions and judgments. Having a beginner's attitude opens you up to new possibilities and may allow you to see and hear more when you are communicating with others. When you practice stopping you will begin to notice more about yourself and others.

Another practical way to cultivate mindful communication is to remember the acronym STOP. The S stands for Stop and do nothing. T stands for Take a conscious breath. Breathe and know that you are breathing. Feel the sensations of the breath coming in and out. The O is to Observe you inner and outer experiences without judging them or trying to change them. The P stands for Proceed with present moment awareness that is friendly and non-judgmental. Feel free test out these practical exercises in your daily life. You may modify or add to them in order to meet your communication needs. Consider applying these practical skills first in areas of your life that are not too challenging and then work your way up to larger challenges as your practice strengthens.

MARK YOUR CALENDARS NOW!

Our 2014 conference schedule is as follows:

- **2014 Spring Conference:**

  April 27 – April 30, 2014

- **2014 Fall Conference:**

  November 2 – November 5, 2014

7 Ways to Sustain North Carolina's Telemedicine Momentum

A Response to Gov. McCroy's Progressive Telepsychiatry Plan

By: Jim Varrell, M.D.

I applaud Gov. Pat McCrory and North Carolina for recognizing the impact telepsychiatry can have on mental health care and the operations of hospital emergency departments.

As North Carolina has acknowledged, telepsychiatry in emergency departments has a value far beyond fee for service. Telepsychiatry is advantageous for hospitals where psychiatrists are not readily available and can shorten the time patients spend in emergency departments awaiting evaluations and assessments. This has a significant impact on patient care, the patient experience, and the operations and financial management of our entire healthcare system.

North Carolina's Department of Health and Human Services (DHHS) is developing a plan for implementing an integrated, statewide telepsychiatry program to serve patients referred from emergency departments. Legislation appropriates $4 million over 2 years to establish and administer the program, pay assessment fees, purchase equipment, and contract with outside vendors for day-to-day program management.

North Carolina has made history with this attempt to address the state's shortage of psychiatrists via a progressive, statewide telepsychiatry program.

This announcement has received well-deserved national attention, however, as implementation advances and conversations continue, I would like to see North Carolina progress its stance on telemedicine in other realms as well.

What else can be done?

These seven changes would continue to improve behavioral health care for North Carolina citizens and further cement North Carolina's position as a telemedicine innovator.

1. Fund Around-the-Clock ED Psychiatric Care - The presented telepsychiatry plan is modeled off of the Albemarle Hospital Foundation (AHF) telepsychiatry program that was launched in 2011 and funded by the Duke Endowment. This successful program offers psychiatric care via telemedicine from 8am to 6pm. While this schedule significantly shortens length of stay for psychiatric and other patients, this still leaves 14 hours a day without an easily accessible psychiatric provider. Psychiatric and substance abuse emergencies happen at all hours of the day and night and are particularly prevalent in after-hours periods. North Carolina's plan could be improved by incorporating a 24-hour telepsychiatry service that provides psychiatric care on-demand regardless of the time of day.

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A national study of 300 Emergency Department directors found that 41% of facilities have patients waiting 2 days or more for care.[1] At the model Albemarle Hospital Foundation (AHF) program, lengths of stays reduced from an average of 48 hours pre-telepsychiatry to 22.5 hours as a result of 8am to 6pm telepsychiatry.[2] What if North Carolina could take this a step further and offer psychiatric evaluation within just a few hours at any time of day? The benefits and outcomes would multiply as length of stay reduced.

The Joint Commission recently released new standards to improve ED patient flow and reduce patient boarding time frames to a recommended 4-hour period. I applaud the work of the North Carolina Telepsychiatry Network and its Project Director Shelia Davies on their unprecedented statewide efforts to meet these Joint Commission standards, and I now challenge North Carolina to further expand their innovative program with around-the-clock telepsychiatry services.

2. Use Telemedicine for Psychiatric Care -Throughout the Participating Hospitals: House Bill 580, which outlines the program, specifies the use of telepsychiatry services for emergency department patients only. What about other psychiatric needs within the hospital? The Albemarle Hospital Foundation program successfully used telepsychiatry in inpatient units, and other hospitals throughout the nation have effectively used telepsychiatry for consultation and liaison services on med/surg floors. Telepsychiatry can be effective in all hospital settings and I encourage North Carolina to consider additional hospital-based psychiatric services in inpatient units, on med/surg floors and beyond in order to improve access to care once a patient is admitted to a hospital as well.

3. Encourage Hospitals not Funded by this New Program to also Consider Telepsychiatry: Fifty-eight communities are projected to receive state funds for telepsychiatry in the ED over the course of 2 years. This number corresponds with the 58 counties in North Carolina that qualify as “Health Professional Shortage Areas” due to a lack of mental health providers. While the statewide telepsychiatry program will make a significant dent in the number of North Carolina hospitals using telepsychiatry, it will not touch EDs in every community. ED telepsychiatry provides significant cost reduction for hospitals far beyond the fee-for-service.

For example, according to a 2012 study by Dr. Bret Nicks and Dr. David Manthy at Wake Forest University, "Psychiatric boarding in the ED prevents 2.2 bed turnovers and costs an average of $2264 per patient."[3] The indirect cost savings of ED telepsychiatry make it a financially viable decision for all counties. Thus, I encourage all hospitals not involved in the new program to consider adopting telepsychiatry independently.

1 Schumacher Group. (2010) Emergency department challenges and trends. 2010 survey of hospital emergency department administrators.

[2] Using Technology to Take on NC’s Toughest Mental Challenges. (2013). North Carolina Department of Health and Human Services Fact Sheet.

[3] Nicks and Manthey. “The Impact of Psychiatric Patient Boarding in Emergency Departments.” *Emergency Medical International.* 2012.

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There are multiple organizations including the Office for Advancement of Telehealth and the National Telecommunications Administration that are willing to fund equipment purchases and develop new telepsychiatry programs. With that in mind, there is little reason for hospitals throughout North Carolina not to consider telepsychiatry. When all hospitals and communities invest in telepsychiatry, North Carolina will be able to holistically address statewide behavioral health needs.

4. Further the Use of Telepsychiatry in Other Settings: Telepsychiatry is not only for use in hospitals. A variety of other settings can benefit from improved access to psychiatrist specialists. Telepsychiatry can be used in correctional facilities, outpatient facilities, residential programs, schools, nursing homes, military bases, primary care offices, urgent care centers, crisis centers, FQHCs and more. Dr. Robin Cummings, the Director of the Office of Rural Health and Community Care in North Carolina led the charge on one such program at the Community Care of Sandhills (CCS). Last year, under the local guidance of Dr. Cummings and the state guidance of Dr. Mike Lancaster from North Carolina Community Care, Inc., CCS launched one of the first successful primary care telepsychiatry programs in the country. As the state embraces telepsychiatry in hospitals, I challenge stakeholders to imagine and test further innovative telepsychiatry applications in new settings like this.

5. Leverage Equipment Investments to Develop Other Telemedicine Applications: The projected $1.2 million statewide equipment investment should be leveraged to open the door to other telemedicine applications and improved care across multiple disciplines. Neurology, radiology, dermatology, cardiology, and more are all successful telemedicine disciplines that could continue increasing care options in North Carolina hospitals. These additional applications could be established in an affordable, time-saving way by piggybacking off of the telemedicine infrastructure setup as part of the new statewide telepsychiatry program. I ask that North Carolina get the most out of its telemedicine equipment and program establishment by taking advantage of multiple healthcare improvement opportunities and disciplines.

6. Mandate Private Payer Reimbursement for Telemedicine: North Carolina needs to further facilitate telepsychiatry and telemedicine by mandating private payer reimbursement for telehealth. Nineteen states, including the recent additions of Virginia and Missouri, currently require private insurance companies to reimburse for telemedicine. If North Carolina were to join this list it would become one of the more advanced telemedicine policy states in the country.

7. Share Outcomes and Expertise: The shortage of psychiatrists is national concern; 96% of the United States has unmet needs for psychiatric prescribers.[4] Emergency departments in all states struggle with overcrowded EDs and rising incidents of behavioral health crises. According to a large-scale outcome study of almost 100,000 users of the VA telepsychiatry program, patients' hospitalization utilization decreased by an average of 25% with the implementation of telepsychiatry. [5]

[4] Konrad, T. Ph.D., Ellis, A., M.S.W., Thomas, K., M.P.H., Ph.D., Holzer, C., Ph.D., Morrissey, J. Ph.D. (2009, Oct). County-Level Estimates of Need for Mental Health Professionals in the United States. Psychiatric Services, 60(10):1307-1314.

[5] Linda Godleski, M.D.; Adam Darkins, M.D., M.P.H.; John Peters, M.S. (2012) *Outcomes of 98,609 U.S. Department of Veterans Affairs Patients Enrolled in Telemental Health Services study from 2006–2010.*

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Additionally, in North Carolina the model Albemarle Hospital Foundation program saw a reduction of involuntary commitments by 33%, which resulted in cost savings for hospital and state inpatient treatment facilities. [6]

North Carolina lawmakers have recognized that emergency department telepsychiatry is a proven tool for alleviating psychiatric costs and concerns. I challenge North Carolina to share their knowledge, particularly outcome data and policy best practices with other states. Other states should follow North Carolina's lead in acknowledging that the value and benefit of emergency department telepsychiatry extends far beyond fee-for-service.

With this new program, North Carolina is already poised as a leader for other states in adapting new technologies to augment its existing healthcare system. Considering the implementation of any of these new steps would make it more clear to other state governments that the value and benefit of telepsychiatry is worth the investment and that it provides a clear way to increase access to care and support healthcare staff in an affordable, time-conscious manner.

***About the Author**: Dr. Jim Varrell is a North Carolina licensed psychiatrist. He is American Board certified in Psychiatry and Neurology and certified by the American Academy of Child and Adolescent Psychiatry. Dr. Varrell is an active advocate for the appropriate use of telepsychiatry and telemedicine and has been involved in the development of telepsychiatry policies in New Jersey, Florida, and Delaware. He regularly preforms psychiatric evaluations via telepsychiatry and manages a staff of telepsychiatrists who serve behavioral health consumers in North Carolina and beyond. Dr. Varrell has presented on telepsychiatry to the American Psychiatric Association, the National Rural Health Association, the American Telemedicine Association, and multiple Grand Rounds presentations.*

[6] Using Technology to Take on NC's Toughest Mental Challenges. (2013). North Carolina Department of Health and Human Services Fact Sheet.

The Good Lives Model as Best Practice for the Treatment of Sexually Aggressive Youth

By: Sam Phifer, LCSW, Executive Director
New Hope Treatment Centers

The Good Lives Model (GLM) of offender rehabilitation, initially developed by Tony Ward and his colleagues in 2003, is now emerging as a best practice model for the treatment of sexual offenders. This model, which is now integrated with Ward and Hudson's Self-Regulation Model (SRM), offers a unique and comprehensive approach to the rehabilitation of sexual offenders. Since its introduction, the GLM has quickly gained international attention as a useful theory and practice model for general offender rehabilitation. New Hope Treatment Centers began incorporating both models into practice in 2006, and now views this integrated, strength- based approach as the cornerstone of treatment for adolescents with sexually offensive behavior problems.

Over the past 25 years or so, the predominate practice approaches used with juvenile sexual offenders consisted of traditional risk-based approaches, primarily Relapse Prevention (RP) and the Risk Needs Responsivity (RNR) models. While the GLM acknowledges the value of traditional risk-based approaches, it also recognizes that a risk-focused approach is insufficient to address all of the treatment needs commonly seen in this population. For decades, RP and RNR approaches to treatment were seen as best practice and few providers questioned their efficacy or bothered to venture beyond their limitations. The GLM outlines a patient-centered, holistic approach to rehabilitation, which emphasizes the qualities of life that are important to the client. Ward defines these qualities as" Primary Goods". The model also examines the concrete activities one uses to obtain these Primary Goods. These activities are defined as "Secondary Goods". The goal(s) of therapy when utilizing the GLM include; determining the Primary Goods that are important to the client and reinforcing their importance, helping the client see and overcome barriers to obtaining these goods, helping the client understand the relationship of primary goods to their offending behavior, and ultimately building each client's capacity to attain the goods they want in socially acceptable, non-offensive ways.

This client-centered process draws upon the strengths of the client, which is counter to the traditional problem focused, or diagnosis-driven approach to care and treatment. In our experience at New Hope, clients appreciate this radical shift in how they are approached in treatment, and as a result are more motivated to engage and participate in treatment. From a research and common sense approach, we know that the level of internal motivation or engagement in the treatment process is directly related to positive outcomes, so in that regard alone, the GLM starts out light years ahead of the traditional risk-based models. This model also promotes a Rogerian style by promoting autonomy, focusing on strengths, and maintaining unconditional positive regard for the client. The style and underpinnings for the Good Lives model are not only a very comfortable fit for most clinicians, but we know from research and practice that clients respond better to this type of approach. In addition, the GLM allows practitioners to move beyond the traditional,

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stigmatized risk-based approach, which focuses solely on preventing the problematic behavior of sexual offending. The Good Lives Model challenges clients to look at core schemas and the ways in which clients go about getting their needs met in general. By shifting away from constant attention in therapy being paid to the highly stigmatized deviant sexual behaviors, and instead looking at more general beliefs and problem- solving techniques, practitioners at New Hope report being better able to keep clients engaged in and motivated for treatment. This a critical leap forward in ensuring clients complete treatment and benefit from the experience. Adolescents in treatment at New Hope demonstrate excitement when discussing their life ambitions, and enjoy working with their families to develop better "Good Lives Plans". The improved motivation and comfort with therapy is a fresh change for those of us who struggled for years in helping adolescents get comfortable discussing relapse prevention strategies, particularly when we require them to discuss their sexual deviance with parents and caregivers. The Good Lives Model gives us a positive window into therapy, and offers a therapeutic route to help our clients explore their lives in great detail, without needing to pay constant attention to the problem behavior which typically brought them to treatment.

Best practice is typically defined as "the methods or techniques which are widely accepted by the experts in the field of study". It's easy to see how the basic underpinnings of the GLM fit this definition of best practice. Nowadays, therapists almost universally embrace a Rogerian style and strength-based approach. For example, Motivational Interviewing is gaining widespread attention as a best- practice technique, by emphasizing the value of getting and keeping clients engaged in treatment by simply focusing on the ambivalence they are experiencing regarding change. Using a holistic model that helps clients change core beliefs and build better coping strategies intuitively makes sense as best practice. The Good Lives Model incorporates all of these well- accepted philosophies and strategies. It provides a comprehensive theory, guides clinical practice, embraces client's strengths, and works to help each person develop a comprehensive plan for improving his/her life.

Sam E. Phifer, LCSW

Sam is the Executive Director at New Hope Carolinas, a 150-bed Psychiatric Residential Treatment Facility located in Rock Hill SC. New Hope Carolinas is accredited by the Joint Commission, and specializes in behavioral healthcare for adolescents. Sam is an LPC and a Certified Sex Offender Treatment Specialist. For more information on New Hope Treatment Centers, visit our website at www.newhopetreatment.com .

Mindfulness Corner

One of the skills to begin to communicate mindfully is to be aware of all the communication that is occurring. We communicate constantly. We communicate with our eyes, body stance, physical gestures, facial expressions, and other slight movements. If we are not careful we may be communicating something we did not intend to. It is important to remember that communication is one thing that cannot be erased or "undone." So when we are communicating, especially when faced with challenging situations, one of the first things we can do is simply be aware of what is occurring in our bodies. By focusing inward on the physical sensations that are present we are less likely to engage in gestures or actions or use words we may later regret. The act of focusing inward is the pause between the stimulus and the reaction. Through the pause we can realize our choices and chose to respond rather than react. In that pause we can identify what is occurring from an impartial observer. Instead of "I'm angry," another choice is to identify, "I'm experiencing sensations of anger." After the encounter we can then investigate the origin behind the reaction. Investigating "what was it about that situation that evoked anger?" Perhaps it's a desire to be heard, to be respected, a fear of being embarrassed. This will lead us into our next topic for the Mindfulness Corner, intention.

OF NOTE……..

NC TIDE is committed to providing our readers with relevant training, information and education that assist in improving performance at all agency levels via our conferences and newsletters.

We welcome you to become a part of our quarterly newsletters (March, June, September, and December). If you or know someone in your agency or a community partner/group associated with you that has information (no selling or advertisements please) to share with other agencies, you may submit those articles to Alice Matthews at abmcms@aol.com for review.

CFAC CONNECTIONS

Submitted By: Suzanne Thompson, MBA/MHA, Division of MH/DD/SAS

Dave Richard Likes to Listen and Learn

The new director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), Dave Richard, has been touring North Carolina listening and learning from the agency's consumers and families about their concerns, hopes and ideas for the future.

"I wanted to hear directly from people what their concerns are," said Richard. "That is why I travelled the state listening and collecting stories, complaints and suggestions of how to make improvements."

Throughout July and August, Richard attended 10 local Consumer and Family Advisory Committee (CFAC) meetings across the state. The main goal of the tour was to introduce himself to consumers and families throughout the state, listen to their concerns, and ask for input on solutions that would improve the way the state provides care.

"All of my experiences listening and learning will help inform the process of improving a system that works to create better outcomes for people while also stopping the ever expanding costs of providing care to our citizens," Richard added. "The Partnership for a Healthy North Carolina will improve Medicaid into a system that looks at the whole person and builds upon the best of what we are doing now."

Local CFACs welcomed Richard for often lively discussions. Most began with a short introduction after which CFAC members and those in attendance asked questions directly to Richard. He often answered questions for several hours and ensured that everyone had an opportunity to have their voice heard.

"Our CFAC was honored that he is taking the time to hear from groups across the state that have been struggling to find their identity and worth," said Sandra Buckman, CFAC Chair for ECBH. "We also appreciated his candor and open door policy in fielding questions."

Richard was very direct in his answers and acknowledged that there is work to be done in some areas. He championed the Partnership for a Healthy North Carolina and asked those in attendance to share ideas and solutions with him.

"We look forward to the options that will be offered beyond the present system," added Buckman. "Hopefully these meetings will be the beginning of effective dialogue that will help heal and end much of the confusion arising out of a system transformed too many times without ever having reached the finish line."

Local CFACs are required by NC General Statute 122C-170 to advise the governing board of each Local Management Entity on the planning and management of the local public mental health, developmental disabilities and substance abuse services system. Membership consists of family members and adult consumers of mental health, developmental and intellectual disabilities, and substance abuse services.

Highlight: The State CFAC had Representative Justin Burr co-chair of the Legislative Oversight Committee on Health and Human Services at their meeting in November and they had a very positive dialogue.

EXHIBITOR INFORMATION

Take advantage of the opportunity to highlight new products and services and gain beneficial marketing exposure as you speak to 325+ behavioral healthcare professionals from all over the State of North Carolina. Sponsorship opportunities for the NC TIDE 2014 Spring and Fall Conferences are available. Make sure your company responds quickly to the sponsorship opportunities because exhibitor slots are available on a first-come, first-served basis. NC TIDE Conferences will be held on ***April 27 – 30, 2014 and November 2-5, 2014***. Make your plans now to join us.

Learn more about the various exhibitor opportunities contact: Brenda Pittman
bpittman@eastpointe.net, 910-298-7158

Thank You *to all NC TIDE Exhibitors! The NC TIDE Conference would not be a success without the resources and financial support of our exhibitors.*