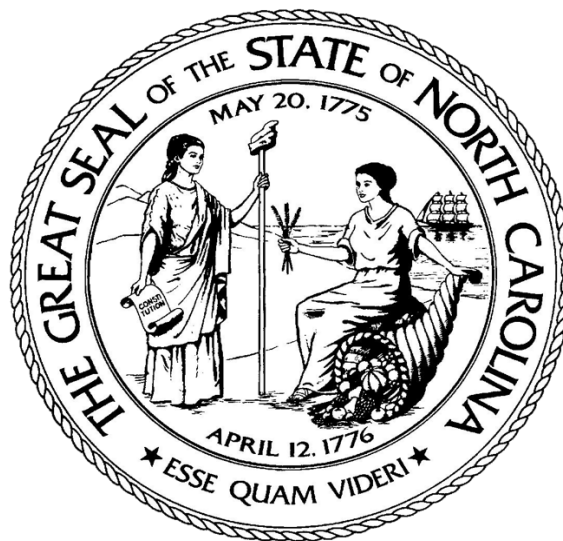


**Plan to Produce Up to 150 New Behavioral Health Inpatient
Beds in Rural Areas of North Carolina and Increase
Community-Based, Behavioral Health Treatment and Services**

Session Law 2015-241, Section 12F.7.(d) and (e)



Report to the

**Joint Legislative Oversight Committee on
Health and Human Services**

by

North Carolina Department of Health and Human Services

April 1, 2016

Plan to Produce Up to 150 New Behavioral Health Inpatient Beds in Rural Areas of North Carolina and Increase Community-Based, Behavioral Health Treatment and Services

April 1, 2016

Executive Summary

Session Law 2015-241, Section 12F.7.(d) and (e) requires the North Carolina Department of Health and Human Services (DHHS) to develop a “plan to use a portion of the funds deposited in the Dorothea Dix Hospital Property Fund not to exceed twenty-five million dollars (\$25,000,000) to produce 150 new behavioral health inpatient beds,” and to “submit recommendations to increase the availability of community-based, behavioral health treatment and services that will reduce the need for costly emergency department and inpatient services” to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2016.

This Plan proposes a strategy for expanding the number of beds that provides crisis stabilization and inpatient care twenty-four hours per day, seven days per week for psychiatric and substance use services. The proposed plans could be improved upon through partnerships with both LME/MCOs as payers and with hospitals that are eligible for and interested in expanding acute inpatient psychiatric beds. Highlights of the plan include the following:

Regional Eligibility for Inpatient Psychiatric/Substance Use and Facility-Based Crisis (FBC)

Beds: Funds from the Dorothea Dix Property Fund will be offered for projects developed by hospitals and other providers serving the counties listed in Tables 1 and 2. Rural hospitals within 75 miles of the population centers of the counties listed in the tables that can serve individuals from those counties will also be invited to apply. At least one project will be selected for each of the East, West, and Central regions of the State. Existing rural hospitals meeting a service gap will be given priority. All facility projects funded through this initiative will be required to develop relationships between the referring regional hospital and the Dix-funded facility with respect to transportation, referrals, and clinical/operational expertise.

Plan for Converting Unused Medical Beds: Hospitals in the established areas will be encouraged to convert unused medical beds to behavioral health (psychiatric and substance use) beds.

Therefore, DHHS plans on identifying a percentage of the overall funds that would be set aside for conversions by willing hospitals that need start-up funding or funding to support renovation. In return, the receiving hospitals would be expected to keep the Dix-funded beds operational and available for multiple payers, including Medicaid and any 3-Way Contract funding, for a minimum period of time.

Plan for Determining Funding Needs: Given the difficulty predicting cost per bed for renovations and new construction, for the first year, we recommend allowing up to \$12,000,000 to be dedicated to this project. This amount reflects 64 new beds at roughly \$190,000 per bed (a middle-point of the various estimates for new construction and renovations across past requests). If more hospitals request less costly renovations, the money will go further, for up to 150 new beds. If mostly new and expensive construction projects are requested, it will allow for fewer. DHHS will develop and

disseminate an Invitation to Apply to community hospitals and crisis stabilization providers through the LME/MCOs. Given the high cost of these beds and the need to integrate them into the local system, priority will be given to proposals that include contributions or support from partner agencies, organizations, and facilities such as the referring hospital. It will be expected that the addition of inpatient capacity in a given area will not result in decommissioning or otherwise decreasing access to existing inpatient behavioral health beds in the region.

Plan for Financial Sustainability: The Invitation to Apply will require that applicants submit a sustainability plan for the on-going, long-term operation of behavioral health beds and expressly commit to providing behavioral health care to persons with no insurance, with insufficient insurance, with Medicaid, Medicare, or Tricare coverage, and other third-party insurance, to the extent to which they are accepted into the insurance networks. Once beds are operational, additional funding may be required for three-way contract psychiatric inpatient care to off-set some of the inpatient and other crisis stabilization care provided to persons without insurance, depending on the populations served. Expanding the availability of 3-Way funds for less expensive FBC beds could help with FBC sustainability and provide more beds for the same level of investment.

Naming of Beds in Honor of Dorothea Dix: DHHS proposes that significant consumer and family involvement be garnered in order to develop a plan for the dedication of the projects funded through the Dorothea Dix Hospital Property Fund. DHHS also recommends that decisions regarding additional proceeds are allocated with a great deal of input from consumers and families.

Community Services: DHHS continues to thoughtfully pilot, evaluate, and plan for sustainability of services that meet the needs of North Carolinians. In recent years, we have been following our plans from the Crisis Solutions Initiative and the Transitions to Community Living Initiative, and have therefore improved and expanded the supports and services available in the community for the targeted populations. The DHHS does not, in this document, offer plans for which services to expand using the Dorothea Dix Hospital Property Fund because these pilot programs are underway, and we are awaiting the final recommendations from the Governor's Task Force on Mental Health and Substance Use (TFMHSU). The existing pilots and the TFMHSU recommendations must be considered together in order to determine which activities merit investment, either through pilots or phased implementation. DHHS looks forward to working closely with the North Carolina General Assembly and stakeholders to determine the best community investments to be made using this historically important resource.

Plan to Produce 150 New Behavioral Health Inpatient Beds in Rural Areas of North Carolina and Increase Community-Based, Behavioral Health Treatment and Services

April 1, 2016

Introduction

Session Law 2015-241, Section 12F.7.(d) requires the following:

The Department of Health and Human Services (Department) shall develop a plan to use a portion of the funds deposited in the Dorothea Dix Hospital Property Fund not to exceed twenty-five million dollars (\$25,000,000) to produce 150 new behavioral health inpatient beds. The plan shall include the following components:

- (1) Conversion of existing unused physical health hospital beds in addition to the construction of new Inpatient behavioral health facilities.*
- (2) The plan shall allow hospitals in rural areas to convert unused acute care beds into licensed, inpatient psychiatric or substance abuse beds without undergoing certificate of need review by the Division of Health Service Regulation, notwithstanding the State Medical Facilities Plan, Article 9 of Chapter 131E of the General Statutes, or any other provision of law to the contrary. All converted beds shall be subject to existing licensure laws and requirements.*
- (3) An estimate of the amount from Dorothea Dix Hospital Property Fund needed to pay for the construction of new beds and the renovation or building costs associated with converting existing acute care beds into licensed, short-term inpatient behavioral health beds designated for voluntarily and involuntarily committed patients.*
- (4) A method for ensuring that the 150 inpatient beds are distributed equitably around the State and that the distribution of beds addresses the projected unmet bed need in each LME/MCO catchment area as determined in the 2015 State Medical Facilities Plan produced by the Department of Health and Human Services, Division of Health Services Regulations.*
- (5) A proposal for funding the recurring operating cost of the new behavioral health inpatient beds, including the identification of potential new funding sources.*
- (6) The newly created behavioral health inpatient beds and facilities shall be named in honor of Dorothea Dix.*

Section 12F.7.(e)The Department shall submit recommendations to increase the availability of community-based, behavioral health treatment and services that will reduce the need for costly emergency department and inpatient services.

This report begins by establishing the basis for regional eligibility for Dorothea Dix Hospital Property Funded expansion of inpatient psychiatric beds in acute care hospitals such that beds will be equitably distributed across the State. Next, the plan for funding the conversion of unused beds and issues related to both conversion and construction of facilities offering new behavioral health capacity, including considerations to be made for licensure and Involuntary Commitment (IVC) designation, is presented. The amount of funding estimated to be needed for new and renovated /converted beds is estimated per bed, based on Division of Health Service Regulation (DHSR) information. Given that operating costs of the new beds are likely to vary depending on the payer mix available to each hospital, issues related to ongoing sustainability through public and private funding sources are briefly described. The report concludes with broad recommendations for a comprehensive mental health and substance use treatment and recovery support system that we believe will provide stability in the community in order to decrease the need for inpatient stays. These recommendations come from the DHHS vision for a comprehensive service array which we have been working toward in recent years, starting with bolstering crisis services and increasing housing and employment for individuals with disabilities. The plan for increasing acute inpatient psychiatric beds, as the primary subject of this report, is an important part of the continuum that we are developing. The Division of Mental Health Developmental Disabilities and Substance Abuse Services (DMHDDAS) brought together a number of stakeholders, including DHHS Divisions (Division of Health Service Regulation, Division of Medical Assistance, Office of Rural Health and Community Care and Division of State Operated Health Facilities), LME/MCO representatives, the North Carolina Hospital Association, and North Carolina General Assembly (NCGA) staff to develop this plan. DHHS held an informational session with Critical Access Hospitals (CAHs) where six offered comments and questions to consider in the planning process.

REGIONAL NEED FOR ACUTE PSYCHIATRIC BEDS AND FACILITY-BASED CRISIS BEDS

Results of an analysis of the current psychiatric inpatient capacity and need support the identification of particular counties of focus for eligibility for the 150-bed plan. The analysis includes distance traveled from an individual's home to inpatient units, recommendations from the State Medical Facilities Plan, and an analysis of the regional availability of current and developing facility-based crisis beds.

Distance Traveled for Inpatient Services

According to the North Carolina Hospital Utilization Database,¹ from 2011 through 2013 there were a total of 151,643 discharges of adults from psychiatric/substance use disorder inpatient treatment beds in community hospitals, across all payer sources. Of those, 6,337 (4%) occurred in hospitals that were 100 or more miles from the patients' home county. This means that a substantial number of patients who find themselves waiting in an Emergency Department (ED) for a psychiatric/substance use inpatient bed have to travel far away from their home to get the inpatient care they need. This is problematic because discharges are more difficult when the hospital is far

¹ Data includes all inpatient admissions for persons with a primary diagnosis between ICD-9 codes 290.00 and 314.99, regardless of whether the hospital has a licensed Psychiatric or SA unit. Thus, treatment may have occurred in a general hospital bed. The discharge data does not contain patient address which is important for determining travel time/distance. However, Patient County of Residence is included. Distance calculations were approximated by determining the number of miles between the patient county of residence county seat, and the hospital city. Also, it reflects direct line mileage, not travel distance. Thus, it is an approximation and only large differences in distances should be considered potentially meaningful.

removed from the community resources to which they are discharging individuals. Additionally, persons who have been admitted to community hospitals with primary behavioral health crises have greater lengths of stay (LOS) in those distant hospitals. From 2009 through 2013, the average LOS when the hospital is located within 50 miles of the patients' county seat was 6.6 days, compared with an average range of 8.1 to 9.3 days for patients who stayed at hospitals that are 50 to 150 or more miles from home (North Carolina Hospital Utilization Database). These longer LOSs translate to higher costs for all payers, including Medicaid, State-funded 3-way contracts, and potentially private insurers.

In order to identify counties that may have the most significant need for local acute inpatient beds, DHHS identified the top 15 counties with the highest number of individuals discharged from inpatient units more than 100 miles away (Table 1 for adults, Table 2 for children/adolescents). Note that these are not discharges from behavioral health units, but discharges from all hospital beds where the individual has a primary mental health or substance use disorder; the discharge numbers do not reflect the number of patients involved. From 2011 through 2013, there were a total of 25,679 discharges of children/adolescents from psychiatric/substance use inpatient treatment beds in community hospitals, across all payer sources, according to the North Carolina Hospital Utilization Database. Of those, 3,121 (12%) occurred in hospitals that were 100 or more miles from the patients' home county. A substantial number of individuals who find themselves waiting in an ED for a psychiatric/substance use inpatient bed have to travel far away from their home to get the inpatient care they need.

Table 1

Top 15 Counties with Highest Number of Discharges 100+ Miles from County of Residence – Adult Inpatient (CY2011-2013)

Patient County of Residence	% <100 Miles	% >100 Miles	# <100 Miles	# >100 Miles	Total Discharges
Beaufort	33%	67%	290	600	890
Cherokee	48%	52%	166	179	345
Dare	60%	40%	212	142	354
Macon	60%	40%	222	148	370
Carteret	67%	33%	545	274	819
Pasquotank	67%	33%	244	118	362
Vance	73%	27%	382	141	523
Brunswick	82%	18%	981	217	1198
Columbus	85%	15%	680	117	797
Onslow	89%	11%	1884	231	2115
Cabarras	90%	10%	1678	186	1864
Randolph	92%	8%	2201	199	2400
Wake	95%	5%	10125	509	10634
New Hanover	95%	5%	4161	201	4362
Mecklenburg	98%	2%	10566	200	10766

Table 2**Top 15 Counties with Highest Number of Discharges 100+ Miles from County of Residence – Child/Adolescent Inpatient (CY2011-2013)**

Patient County of Residence	% <100 Miles	% >100 Miles	# <100 Miles	# >100 Miles	Total Discharges
Brunswick	52%	48%	126	116	242
Rowan	60%	40%	180	121	301
New Hanover	65%	35%	407	222	629
Cleveland	71%	29%	191	77	268
Cabarrus	72%	28%	334	127	461
Iredell	75%	25%	299	98	397
Craven	76%	24%	278	89	367
Union	80%	20%	445	112	557
Randolph	80%	20%	301	74	375
Catawba	82%	18%	261	56	317
Durham	85%	15%	444	76	520
Gaston	88%	12%	687	90	777
Onslow	91%	9%	749	77	826
Wake	93%	7%	2963	237	3200
Mecklenburg	96%	4%	3052	134	3186

State Medical Facilities Plan

Annually, DHSR publishes the State Medical Facilities Plan (SMFP) which, in part, provides need determinations for inpatient psychiatric beds and inpatient substance use/chemical dependency treatment beds. Need determinations are calculated separately for child/adolescent (age 17 and under) and adult beds. Psychiatric bed needs are calculated according to LME/MCO catchment areas. Substance use treatment bed need determinations are calculated by three set geographical regions. A certificate of need (CON) is required and need determinations are calculated only for the following licensure categories: Rule 10A NCAC 27G Section .6000, *Inpatient Hospital Treatment for Individuals who have Mental Illness or Substance Use Disorders* and Rule 10A NCAC 27G Section .3400, *Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders*. Session Law 2015-241, Section 12F.7.(d)(2) provides an exemption to the CON process for participating hospitals funded through the Dorothea Dix Fund.

The need determination methodologies have a primary goal of identifying the need for services in the catchment area (LME/MCO or region) corresponding to the patients' county of residence. The days of care (DOC) are calculated for residents of the counties that make up each of the eight LME/MCOs or three regions. The methodology converts the DOC to the total beds needed, which are then subtracted from the planning inventory (total of licensed beds, adjusted for CON-approved/license pending beds, and beds available in prior SMFPs that have not been CON-approved). This final calculation results in the bed need determinations. Note that these calculations do not take into account the number of people waiting for beds in emergency departments or other, softer indicators of need such as waiting lists or distance traveled for services.

Need determinations are recalculated annually and do not carry over from one year to the next. When the SMFP shows a need determination in an LME/MCO or region, the beds immediately are incorporated into the planning inventory. Need determinations in one year may be similar to the need in the subsequent year if no CON applications are submitted and approved for the prior year. Need determinations are projected two years in advance. This two-year projection timeframe corresponds to the average time required for a new bed to be licensed after approval of the CON.

While need determinations and bed inventories (licensed beds and planning inventory) distinguish between child/adolescent and adult beds, they do not identify or consider beds proposed or developed to serve special populations or conditions (e.g., geriatric populations, individuals with eating disorders, individuals with intellectual and other developmental disabilities who also have psychiatric or substance use disorders).

Session Law 2015-241, Section 12F.7.(d), specifies the use of the 2015 SMFP for equitable distribution of the 150 beds. However, these need determinations have “expired” and are no longer active. The current/active need determinations are those published in the 2016 SMFP. Tables 3 and 4, respectively, present the 2015 and 2016 SMFP need determinations for Psychiatric and Substance Use treatment beds.

Table 3

**2015 and 2016 State Medical Facilities Plan Need Determinations
for Psychiatric Beds**

LME/MCO	2015 Need Determination		2016 Need Determination	
	Adult	Child/ Adolescent	Adult	Child/ Adolescent
Alliance Behavioral Healthcare	43		32	
CoastalCare*	26			
East Carolina Behavioral Health*		18		
Eastpointe		25		29
Sandhills Center			4	1
Smoky Mountain Center		3		5
Totals	69	46	36	35

*Merged into Trillium for 2016 SMFP

Note: If an LME/MCO is not listed, there was no need determination in that area for either year.

Table 4

**2015 and 2016 State Medical Facilities Plan Need Determinations
for Substance Use Beds**

Region	2015 Need Determination		2016 Need Determination	
	Adult	Child / Adolescent	Adult	Child / Adolescent
Eastern	25	10	23	9
Central	12	18	22	19
Totals	37	28	45	28

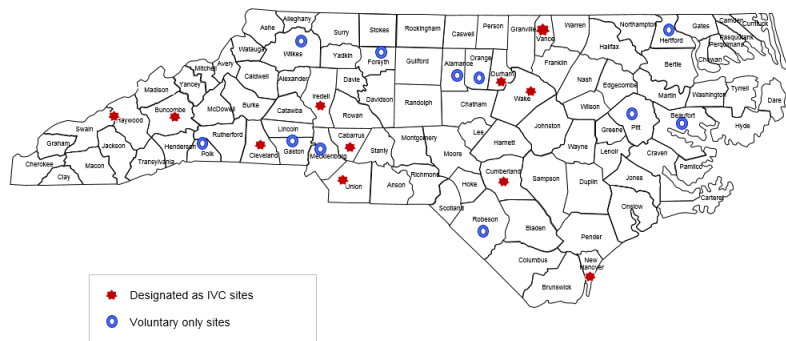
Note: There was no need determination in the Western region for either year.

It should be noted that not all need determinations result in a submitted application for a CON. A substantial proportion of these available beds are not applied for, especially those designated for the child/adolescent population. The issue of availability of CONs versus application and, relatedly sustainability of such beds, will be discussed in a later section. Since the regions specified in SMFPs overlap significantly with the counties identified in Tables 1 and 2, Tables 1 and 2 will be used to determine eligible geographic regions for new acute inpatient psychiatric bed projects.

Facility-Based Crisis Beds

In addition to inpatient beds for adults and youth with mental health and substance use disorder treatment needs, the option to expand FBC Services exists. FBC Services are 24-hour residential facilities licensed under Rule 10A NCAC 27G Section .5000, *Facility Based Crisis Service for Individuals of All Disability Groups*, to provide facility-based crisis service as described in Rule 10A NCAC 27G .5001, *Scope*. The FBC functions as a viable alternative to behavioral health inpatient when it achieves designation as an IVC facility. IVC designation is important because without IVC, individuals under IVC would otherwise likely have to go to the ED or other inpatient unit, which may not be the appropriate level of care. The State has 22 adult FBC Service unit or programs, half of which are IVC designated (See Figure 1). New 16-bed sites are currently in development at Smoky Mountain Center, CenterPoint Human Services, and Cardinal Innovations, with Eastpointe renovating an existing FBC to be able to accommodate IVCs.

Figure 1. Map of Current Facility-Based Crisis Centers



The CON process does not apply to FBC beds. NC DHSR Mental Health Licensure and Construction Sections do review and approve the licensure of FBC beds in a process very similar to that outlined above for inpatient beds. However, no CON process prohibits a hospital or healthcare system from operating an FBC unit as an alternative to a fully regulated hospital inpatient unit. The possibility of contracting the FBC operations to a community-based mental health provider also provides an alternative option for consideration.

Plan for Regional Eligibility for Inpatient Psychiatric/Substance Use and FBC Beds: Funds from the Dorothea Dix Property Fund will be eligible for projects developed by hospitals and other providers serving the counties listed in Tables 1 and 2. Rural hospitals within 75 miles of the population centers of the counties listed in the tables that can serve individuals from those counties will also be invited to apply. At least one project will be selected for each of the East, West, and Central regions of the State. The types of projects eligible for funding in these regions include up-fitting or renovating current hospital facilities or FBCs to offer psychiatric/substance use inpatient services or IVC capable FBCs and new construction where required. Existing rural hospitals meeting a significant service gap will be given priority. Where available, the FBC facilities must be co-located or operationally linked with Behavioral Health Urgent Care Centers with 23-hour crisis observation/stabilization, which will provide quick access to the crisis stabilization beds in the FBCs. All facility projects funded through this initiative will be required to develop strong, demonstrated relationships between the referring hospital and the Dix-funded hospital with respect to transportation, referrals, and clinical/operational expertise.

CONVERSION OF EXISTING PHYSICAL HEALTH BEDS

The NC DHSR receives bed count information (number of licensed beds and operational beds) from medical facilities with their licensure renewal applications. However, psychiatric hospitals and substance use residential facilities are only required to report licensed beds to DHSR without identifying how many of the licensed beds are operational. Acute care hospitals report the number of both licensed and operational beds on the annual license renewal application. The number of operational beds can fluctuate throughout the year and from one year to the next based on a number of factors specific to each hospital. There is the potential for inaccuracy if data on operational beds

is used to assume overall availability of beds for possible conversion. In listening sessions with a subset of Critical Access Hospitals, two out of six hospitals each expressed interest in converting 10 or fewer unused medical beds.

Plan for Converting Unused Medical Beds: Hospitals in high-need areas will be encouraged to convert unused medical beds to behavioral health (psychiatric and substance use) beds. Medical facilities that elect to pursue funding to convert medical beds into behavioral health beds will provide data to demonstrate the number of beds available to be converted. It is difficult to estimate the funding required for general medical facilities to convert beds in a unit to meet behavioral health needs and accept individuals under IVC. In fact, some may not require any funding, but instead will need a guarantee of funding for sustainability. Therefore, DHHS plans on identifying a percentage of the overall funds that would be available for a limited number of these conversions by willing hospitals that need start-up funding or funding to support renovation. In return, the receiving hospitals would be expected to keep the Dix-funded beds operational and available for multiple payers, including Medicaid and any 3-Way Contract funding, for a minimum period of time.

ESTIMATES OF FUNDS NEEDED FOR RENOVATION AND CONSTRUCTION

The expansion of services or the increase in beds for the provision of behavioral health is divided into two categories. The first involves conversion of medical beds in existing space that are not currently being used. The majority of these spaces will not be equipped for use as a behavioral health bed—of either the hospital or FBC type. This type of conversion will likely be different at every location. This up-fit would also be dependent on the services provided and the necessary safety requirements. The second category of increasing beds is to house new behavioral health beds in newly constructed space. Once the type of service and requirements are described, then the review of the plans and inspection of the completed work would be required to meet the Hospital Licensure Rules or FBC Licensure Rules, Mental Health Rules and National Fire Protection Association Life Safety Code 101, 2000 edition.

DHSR has very limited data on the cost of renovations or new construction of psychiatric or substance use beds. During the calendar years 2012-2015, only three substance use applications were received and all involved new construction. The average capital cost per bed ranged from \$25,000 to \$166,400. During the same time period, seven inpatient psychiatric applications were received which involved new construction. The average capital cost per bed ranged from \$82,125 to \$379,783. There were 12 inpatient psychiatric applications that involved renovations. The average capital cost per bed ranged from \$0 to \$167,609. This limited data shows that the capital cost per bed varies tremendously and is based on the circumstances at each facility.

There is also very limited data on the costs for renovation or construction of FBC beds. DMHDDSAS has partially funded four FBC projects in the past two fiscal years. Each project is unique. Three projects involve new construction and the FBC beds are just one component of a multi-service facility. One is a renovation project with total capital construction/renovation costs—which improves an 11 bed facility to a 16 bed IVC capable facility – of approximately \$95,000/bed.

Plan for Determining Funding Needs: *Given the difficulty predicting cost per bed for renovations and new construction, for the first year, we recommend allowing up to \$12,000,000 to be dedicated to this project. This amount reflects 64 new beds at roughly \$190,000 per bed (a middle-point of the various estimates for new construction and renovations across past requests). If more hospitals request less costly renovations, the money will go further, for up to 150 new beds. If mostly new and expensive construction projects are requested, it will allow for fewer. After this first round of applications, the level of interest in new psychiatric acute beds will be more evident, and future funding can be based on prior applications. DHHS will develop and disseminate an Invitation to Apply to community hospitals and crisis stabilization providers through the LME/MCOs. Given the high cost of these beds and the need to integrate them into the local system, priority will be given to proposals that include contributions or support from partner agencies, organizations, and facilities such as the referring hospital. It will be expected that the addition of inpatient capacity in a given area will not result in decommissioning or otherwise decreasing access to existing inpatient behavioral health beds in the region.*

OPERATING COSTS OF NEW BEDS

As indicated in Session Law 2015-241, Section 12F.7.(d), the funds will be available to pay for the costs of converting/constructing behavioral health beds. Other funding sources will have to be identified to pay for the on-going operating costs of providing services to persons who occupy those crisis beds. Around the State, inpatient facilities utilize receipts from public and private payers to fund daily operations, except for uninsured individuals not funded through 3-Way Contracts with the State and the LME/MCO. However, funding for treatment in FBCs is often unavailable through private insurance and for individuals without insurance.

Payer mix is specific to both populations served (Medicaid is more common for children and adolescents, Medicare for older adults) and to the region where the facility is situated. During a Critical Access Hospitals (CAHs) interest meeting conducted by the DHHS, there were two CAHs that provided ideas for payment sources. One CAH stated that it has a high percentage of Medicare and Medicaid patients in its payer mix, so it saw these two payers as the primary payment sources to make operating costs sustainable. Another CAH has experienced a high number of adolescent patients with behavioral health issues, so it saw Medicaid as its primary payment source for sustainability.

N.C.G.S. § 131E-183, *Review Criteria*, sets forth the criteria which must be reviewed prior to the issuance of a CON. One of the criteria reviewed by DHHS to determine that an application satisfies the criteria before a CON for the proposed project shall be issued is the assurance of financial sustainability of the proposed project. Specifically, N.C.G.S. § 131E-183 (a)(5) states that “financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.”

Plan for Financial Sustainability: *The Invitation to Apply will require that applicants submit a sustainability plan for the on-going, long-term operation of behavioral health beds. All applicants for funding from the Dorothea Dix Hospital Property Fund will be required to expressly commit to providing behavioral health care to persons with no insurance, with insufficient insurance, with*

Medicaid, Medicare, or Tricare coverage, and other third-party insurance, to the extent to which they are accepted into the insurance networks. They will be required to partner with the LME/MCOs to ensure that individuals with Medicaid will be funded and to ensure there is need in the area for the proposed services. Additional funding for three-way contract psychiatric inpatient care to off-set some of the inpatient and other crisis stabilization care provided to persons without insurance may be required, depending on the populations served. Currently, 3-Way Contract funds for uninsured adults can only be provided to community psychiatric hospitals, but expanding the availability to fund less expensive FBC beds could help with FBC sustainability and provide more beds for the same level of investment.

ADDITIONAL REQUIREMENTS FOR PARTICIPATING HOSPITALS

Licensure

NC DHSR conducts a review and approval process of applications for licensure of inpatient beds in North Carolina hospitals. The State licensure process to expand the scope of services or increase beds for the provision of behavioral health includes a review of the hospital's operational policies and procedures for the proposed scope of services, a review of staff files to validate competencies, qualifications, schedules to ensure staffing to meet the acuity levels of patients, and adequate supplies and equipment to meet the needs of patients. Prior to issuance of the amended license for the bed conversion or addition of behavioral health beds, the designated space must be approved by the DHSR Construction Section for patient occupancy.

Before expansion of services or increase in beds for the provision of behavioral health a construction plan review must be conducted along with an on-site inspection of the facility by the DHSR Construction Section. This review shall be composed of compliance with the Hospital licensure rules, Mental Health rules and National Fire Protection Association Life Safety Code 101, 2000 edition for the Center for Medicare/Medicaid Services. Upon completion a recommendation for licensure shall be sent to the Acute and Home Care Licensure and Certification Section.

IVC Designation

Per S.L. 2015-241, Section 12F.7.(d), hospitals that request Dorothea Dix Property fund dollars to convert unused medical inpatient beds to behavioral health inpatient beds will have to serve persons who are voluntary admitted as well as involuntarily admitted for psychiatric and/or substance use treatment. In order to be eligible to admit and treat persons, under involuntary commitment, the hospitals will have to apply to DMHDDSAS and be approved as a facility designated to serve persons who are involuntarily committed.

NAMING OF BEDS IN HONOR OF DOROTHEA DIX

Consumers and families around the State are very passionate regarding the legacy of Dorothea Dix and the use of funds resulting from the sale of the Dorothea Dix Hospital property. DHHS proposes that significant consumer and family involvement be garnered in order to develop a plan for the dedication of the projects funded through the Dorothea Dix Hospital Property Fund. It is important to note that at present, there is community concern about the level of consumer and family input

into the use of these funds, so DHHS recommends that decisions regarding additional proceeds are allocated with a great deal of input from consumers and families.

COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES

The plan for producing new crisis stabilization beds is focused on one of the most important, intensive, restrictive, and costly levels of care in the publicly-funded mental health and substance use service system. In all of our endeavors, we seek to provide all North Carolinians the behavioral health services (inclusive of mental health and substance use disorder services) that offer the best quality in the least restrictive environment and at a fair cost. We also work closely with the State's three most important stakeholders – consumers and families, providers who serve them, and LME/MCOs entrusted to manage the services – to ensure our solutions are grounded in what will work for our State.

As requested, the DHHS plan for increasing the availability of community-based behavioral health treatment and services that will reduce the need for costly emergency department and inpatient services is summarized below. As with any policy and system change, it is most prudent to take a Plan, Do, Study, and Act approach. Since 2013, we have been intentional in our identification of problem areas across the system through data and stakeholder input, in piloting potential solutions and measuring outcomes, and in finding ways to implement successful or promising solutions across the State. We also acknowledge that change takes time. Moving from a system reliant significantly on inpatient care to one that wraps a variety of services around individuals in the community, in different settings and with different needs, takes time. It takes time to develop new community resources through workforce development, time to train providers in evidence-based practices, time and energy to change cultures so that providers and families can be supportive of new ways of serving people, and time to allow individuals to adjust to changes and begin to demonstrate improved outcomes. We must also acknowledge that we have limited power to influence the care of some individuals in our State because of their payer source (e.g., private insurers, Medicare, Tricare and the uninsured).

In identifying solutions to long ED wait times, we must approach each link in the system analytically, from the least restrictive or intensive interventions through the most intensive and restrictive services and finally to supports for people transitioning out of those settings. Our analysis and our piloting of programs described below stem from our Crisis Solutions Initiative, which continues to involve a great deal of stakeholder input from across the State, and our Department of Justice Settlement Agreement/Transitions to Community Living Initiative (TCLI). TCLI has required a great deal of work to wrap services around individuals in the community and promote integration and purposeful, meaningful community life.

The Problem

Entrance into Emergency Departments

The first place to identify the problem of long ED wait times is in the EDs themselves in an attempt to determine who is going to the ED and who is experiencing long waits. We have some data to suggest that with respect to payer source, 1/3 of individuals in EDs for behavioral health issues have Medicaid, 1/3 are uninsured or “self-pay”, and 1/3 are privately insured (including Medicare).

While we have an alternative crisis system for the uninsured and for Medicaid, our resources for the privately insured are very limited.

There are a number of issues that result in limited movement through EDs and therefore high volumes for individuals with behavioral health difficulties. One problem in the ED is that individuals come to the ED whose care could be more appropriately addressed in outpatient or other community settings, such as a via local provider, facility-based crisis centers, behavioral health urgent care (BHUC) centers (i.e., walk-in clinics and 24/7 walk-in clinics), or peer respite resources. Unnecessary visits result in a larger volume of individuals with behavioral health needs in EDs than is necessary.

Waiting in Emergency Departments

Our stakeholders have also identified special needs as a barrier to moving people through the ED and into appropriate care. Specifically, some individuals have intellectual and other developmental disabilities, are deaf or hard of hearing, have significant medical complications, or other special needs as well as behavioral health disorders. These other needs sometimes require specialized inpatient or community services that can be difficult to find or are very limited in quantity due to the specialized and therefore limited demand for those services. Difficulty finding inpatient or outpatient placement can delay movement through the ED and result in longer wait times for those needing inpatient care. Inpatient units are often reported as being at capacity, which also results in longer ED wait times.

Another situation that causes delays is when an individual in a behavioral health crisis becomes agitated and damages property or injures staff. A behavioral health crisis can be incredibly frightening for people, and in a stressful environment such as an emergency department, they can become defensive because of the nature of their mental illness. For example, someone experiencing delusions or hallucinations may perceive that those who are trying to help them are actually trying to harm them and respond defensively as a result. Once these defensive behaviors occur, it can be more difficult to find an inpatient unit willing or able to admit the individual, leading to longer ED waits.

Discharging from ED, Inpatient, and Other Crisis Services

Finally, for individuals not in need of inpatient care following an ED visit for behavioral health, as well as for individuals transitioning out of other crisis services and inpatient units, hospitals have reported difficulty finding adequate community supports, including housing and treatment, depending on the person's personal resources and insurance. In some cases, group homes are not equipped to handle behavioral health crises and send individuals to the ED, then deny their readmission to the group home once the crisis subsides. Inpatient units, EDs and other crisis services do not prefer to discharge individuals to the community without services or housing, but quickly finding such resources is a significant challenge for both the providers and LME/MCOs, and especially for people without Medicaid.

Plan for Crisis Services Related to ED Utilization and Inpatient Capacity: *The Crisis Services Continuum, as utilized in the Crisis Solutions Initiative, outlines a variety of services available to match the level of care to the individual's need. Services range from prevention, to early*

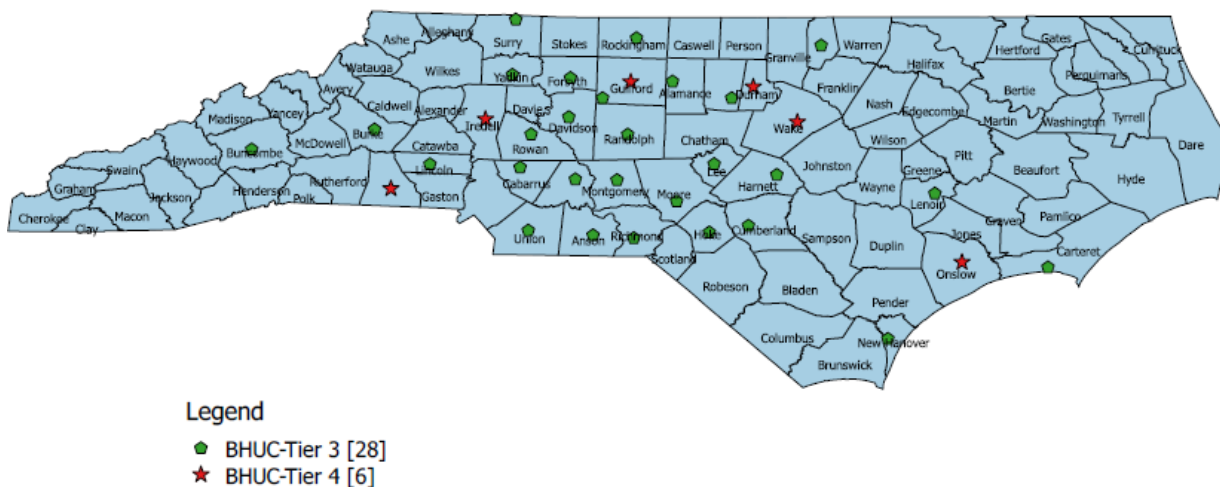
intervention, responsive services, and stabilization. The Transitions to Community Living Initiative is focused on increasing the quality and accessibility of community supports that can keep individuals living independently, with support, in the community. The following is a listing of recent programs and pilots, along with the current and/or planned financial sustainability.

1. **Mental Health First Aid (MHFA):** North Carolina has trained more than 360 instructors and almost 18,000 individuals in MHFA, an evidence-based eight-hour curriculum that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. People trained in MHFA have greater confidence in providing help to others and are more likely to advise them to seek professional help prior to a crisis developing. In terms of funding, DHHS has identified mental health block grants as one funding resource, and we hope to develop more support in local communities and educational institutions to spread this training.
2. **De-Escalation Training:** In addition to the existing Crisis Intervention Training for law enforcement, the State is investigating potential training opportunities for ED, inpatient and group home staff that could reduce the escalation of crisis and agitation in EDs and group homes (e.g., Project BETA: Best Practices in Evaluation and Treatment of Agitation and Group Home Employee Skills Training). Potential funding has been identified through federal block grants.
3. **Psychiatric Advanced Directive Statements:** Psychiatric Advanced Directive Statements (PADS) have been employed in North Carolina to document an individual's instructions/preferences for behavioral health treatment, in the event that in a future crisis, the individual does not have the capacity to provide or withhold informed consent about recommended psychiatric treatment. DHHS is working with stakeholders to improve the availability of education and training for providers and consumers to ensure that PADS are developed, when desired, and accessible to crisis responders when needed. The link to the website for PADS is provided at <http://www.nrc-pad.org/states/north-carolina>.
4. **Peer-Operated Crisis Respite/Hospital Diversion:** Peer-Operated Crisis Respite is an important resource for individuals in our community experiencing crisis but not necessarily needing inpatient care. Some individuals need some time away from a stressful situation, in a supportive environment with individuals who can support their continuing recovery. DHHS had planned to contract with consumer-operated businesses to pilot these programs this year. However, it was determined that the consumer-operated businesses need more support for business and program development prior to such an undertaking. We expect to begin a request for applications for these programs next summer, and we recommend a blending of federal block grant funds and one-time state appropriation for start-up. We are working on sustainability plans for these valued alternatives to hospitalization and ED visits.
5. **EMS Community Paramedicine:** This program provides start-up costs and on-going support for 12 pilot programs around the State to utilize trained paramedics to divert individuals in Behavioral Health crisis from unnecessary ED visits. Counties covered include Wake, Durham, Franklin, Halifax, Orange, Forsyth, Rockingham, Stokes, Lincoln, Guilford, McDowell, Brunswick, and Onslow. Current funding is provided through one-time

state appropriation and federal block grant; future options include potential Medicaid funding and/or recurring appropriations.

6. **Outpatient Crisis Intervention:** We currently have State-funded and Medicaid-funded Mobile Crisis Management Services which we will soon begin to revise in order to ensure better response and coordination with after-crisis treatment. Other payers (Medicare, private insurance) do not pay for this service. LME/MCOs are working with providers to ensure that individuals in crisis have access to their providers rather than being sent to an ED for crisis interventions.
7. **Behavioral Health Urgent Care (BHUC) Centers:** BHUC centers are growing in number as an effective alternative to hospital EDs for individuals in crisis who are not experiencing significant medical distress. In State Fiscal Year 2015 (SFY15), there were 152,000 ED visits for individuals with a primary mental health or substance use diagnosis, across all payer sources. The six counties with BHUCs open 24 hours a day had an average of 25% fewer ED admissions per capita in SFY15 for individuals with these primary diagnoses. If similar BHUC centers could be made available statewide as an alternative to EDs, NC could see up to 30,000 fewer ED visits for this population per year. Estimates of potential cost savings and population density required to support these 24/7 facilities are being developed. Medicaid members with a primary Mental Health, Intellectual or Developmental Disability, or Substance Use Disorder diagnosis had a 30-day readmission rate to EDs of 13.4% in SFY15.

Figure 2. Map of Behavioral Health Urgent Care (24/7 and extended hours)



The cost modeling on these centers is not yet sophisticated. Those few sites that have existed for a number of years were largely funded at a local level and outside of state regulated dollars. With a state level focus on the development of requirements and policy that is relatively new, DHHS will be better able to quantify the financial return on investment. Anecdotaly, the per client operational costs in a fully functioning center appear to about 50 – 75% of an ED visit costs. Additionally, the individuals seen in BHUCs are less likely to be

hospitalized – BHUCs do not face the same barriers as EDs in making referrals to FBC beds and other levels of outpatient care.

Additionally, there are another 28 sites that operate less than 24 hours a day but still have physician oversight, medical staff on-site, and some form of security arrangement that allows them to accept custody of IVC clients.

Four more sites are in development, by the LME/MCOs listed below, using the state appropriation contributions as well as local investments.

- 1. Smoky Mountain Center in Buncombe County is moving an existing adult FBC, creating a co-located BHUC, and creating a child/adolescent FBC. Of particular interest here is that the local hospital system is another funder and major partner in this project due to the expectation that ED and inpatient diversion will be successful.*
- 2. Eastpointe in Robeson County is renovating an existing adult FBC to add beds and make it IVC capable and adding a co-located BHUC component.*
- 3. CenterPoint Human Services in Forsyth County is constructing new co-located BHUC and FBC units. Again, notably, the local hospital systems are partnering with the LME-MCO.*
- 4. Cardinal Innovations Healthcare Solutions in Mecklenburg County is constructing a new child/adolescent FBC.*

Funding Sources: as noted above, state appropriations and federal block grants have helped to establish BHUC linked with Facility-Based Crisis centers. As we develop better cost models, the LME/MCOs may be able to incorporate and support more 24/7 BHUCs into their networks. However, insufficient reimbursement from other sources (Medicare, Tricare, private insurers, uninsured) could affect the sustainability of these clinics. Parity laws and closer partnerships with other payers in our State could help our efforts.

- 8. **Critical Time Intervention:** Critical Time Intervention (CTI) is an intensive short-term evidence-based case management model for adults with serious mental illness. Post discharge from an ED or inpatient stay is a critical time for individuals to be well connected to ongoing services and supports which will reduce recidivism. CTI is a strategy currently being piloted in four sites with federal block grant dollars (Alamance, Person, New Hanover, Onslow, Cumberland, and Gaston counties). At a cost of about \$7,000 per a nine month course of care, the national evidence for CTI is impressive. Studies reflect reductions in homelessness, law enforcement involvement, and re-hospitalizations. DHHS is working to create policies that will allow Medicaid reimbursement for CTI. We are also expanding to two to four more teams across the State for the TCLI population (individuals with severe mental illness who are in or at risk for entry into adult care homes). Ongoing State funding for indigent care could increase the number of individuals served. This service is not currently funded by private insurers or Medicare.*
- 9. **Other Outpatient/Enhanced Adult Community Services:** Under the Transitions to Community Living Initiative (TCLI), North Carolina has invested in a more intensive system of supports and high quality treatment in the community. In addition to CTI, TCLI has resulted in the transformation of Assertive Community Treatment (ACT) from a local service*

definition to an evidence-based practice that is closely monitored to ensure quality, the development of statewide, evidence-based supported employment services (Individual Placement Supports) to help people to gain and keep employment as part of their recovery, Peer Support Services, and housing supports to help people maintain independent living with the supports they need. The culture change and lessons we are learning around maintaining people successfully in the community are informing our efforts to provide stable community living for individuals transitioning out of inpatient and out of EDs into the community. Funding is provided by state appropriation and Medicaid; few, if any, of these services are covered by private insurers or Medicare; for State funds, only individuals meeting criteria for TCLI are prioritized for these services.

10. **Behavioral Health Services for Individuals with Intellectual and Other Developmental Disabilities (I/DD):** DHHS has been working with Disability Rights North Carolina and all eight of the LME/MCOs to identify better treatment resources for individuals with both Intellectual or Developmental Disability (I/DD) and behavioral health needs. As noted earlier, limited community and outpatient resources trained to adapt behavioral health treatments to this population contribute to long waits in EDs for specialty inpatient treatment and difficulty finding appropriate community treatment to facilitate discharge. In 2015, North Carolina increased funding for NC Systemic, Therapeutic Assessment, Respite and Treatment (NC START) to increase their capacity to provide services to children. NC START is intended to offer respite and to build the capacity of local behavioral health providers to serve individuals with I/DD. Additionally, LME/MCOs are supporting NC START and other initiatives to better serve these individuals.
11. **Children's Services:** With respect to children's services, DHHS has an array of community services and a number of pilots to test new models. We have also developed a draft waiver for children with severe emotional disorders, which could have a beneficial effect on ED wait times for children, especially since a large number of children are covered by Medicaid. Additionally, a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) provides family-driven service planning and intensive care coordination paired with family peer support for children and youth with complex mental health needs. This program is being piloted in Wayne, Sampson, Mecklenburg, Orange, Chatham, Alamance, Davie, Forsyth, Stokes, Rockingham, Buncombe, and Henderson Counties. If successful, it could be the basis for another evidence-based service available to Medicaid and uninsured children, but not likely funded by private insurers.

Ten percent of the Mental Health Block Grant funds are set aside by SAMHSA to help individuals experiencing their first episode of psychosis. This evidence-based program is being piloted in Wilmington and Raleigh, with an existing model program at UNC-Chapel Hill.

It is well recognized that trauma is common among the children and youth we serve and, if left untreated, the impact can be lifelong and devastating. In 2013, North Carolina funded the NC Child Treatment Program to train our workforce in evidence-based, trauma-informed treatment. To date they have trained 350 clinicians across the State in one of four evidence-based models, and a registry is available online to help anyone in need of

treatment find a trained and qualified provider. LME/MCOs are working with the NC CTP to ensure payment for specially trained providers results in sustainable services.

Governor's Task Force on Mental Health and Substance Use Recommendations: *The Governor's TFMHSU is currently finalizing its recommendations. As presented at a recent Health and Human Services Joint Legislative Oversight Subcommittee meeting, there are a number of themes that are consistent with the solutions we are currently piloting. Additionally, we note that recommendations around treatment and recovery for individuals with opioid use disorders, case management, and housing/housing supports in the community are areas that we have not yet approached. These are very important elements that have great potential for decreasing ED and inpatient admissions and re-admissions.*

General System Recommendation: *DHHS continues to thoughtfully pilot, evaluate, and plan for sustainability of services that meet the needs of North Carolinians. In recent years, we have been following our plans from the Crisis Solutions Initiative and the Transitions to Community Living Initiative, and have therefore improved and expanded the supports and services available in the community for the targeted populations. The DHHS does not, in this document, offer plans for which services to expand using the Dorothea Dix Hospital Property Fund because these pilot programs are underway, and we are awaiting the final recommendations from the TFMHSU. The existing pilots and the TFMHSU recommendations must be considered together in order to determine which activities merit investment, either through pilots or phased implementation. DHHS looks forward to working closely with the North Carolina General Assembly and stakeholders to determine the best community investments to be made using this historically important resource.*