

- MENTAL HEALTH
- DEVELOPMENTAL DISABILITIES &
- SUBSTANCE ABUSE

NORTH CAROLINA COUNCIL OF COMMUNITY PROGRAMS

Status of Council Action:

*Developed by Management Systems Workgroup
3/9/07: Endorsed by Area Directors Forum
3/16/07: Adopted by Council Board of Directors*

NC COUNCIL POLICY POSITION STATE PSYCHIATRIC HOSPITAL DOWNSIZING & BED DAYS

Introduction

The Secretary of the North Carolina Department of Health and Human Services (DHHS) has indicated that the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Division) is continuing to pursue a plan for decreasing the use of State-operated hospitals. This plan would increase the development of local services as alternatives to hospitalization in partnership with Local Management Entities (LME's) through a bed reduction plan. To be successful, such an endeavor must correct for past difficulties and implement the recommendations of previous evaluations of the system that have been largely ignored or marginalized.

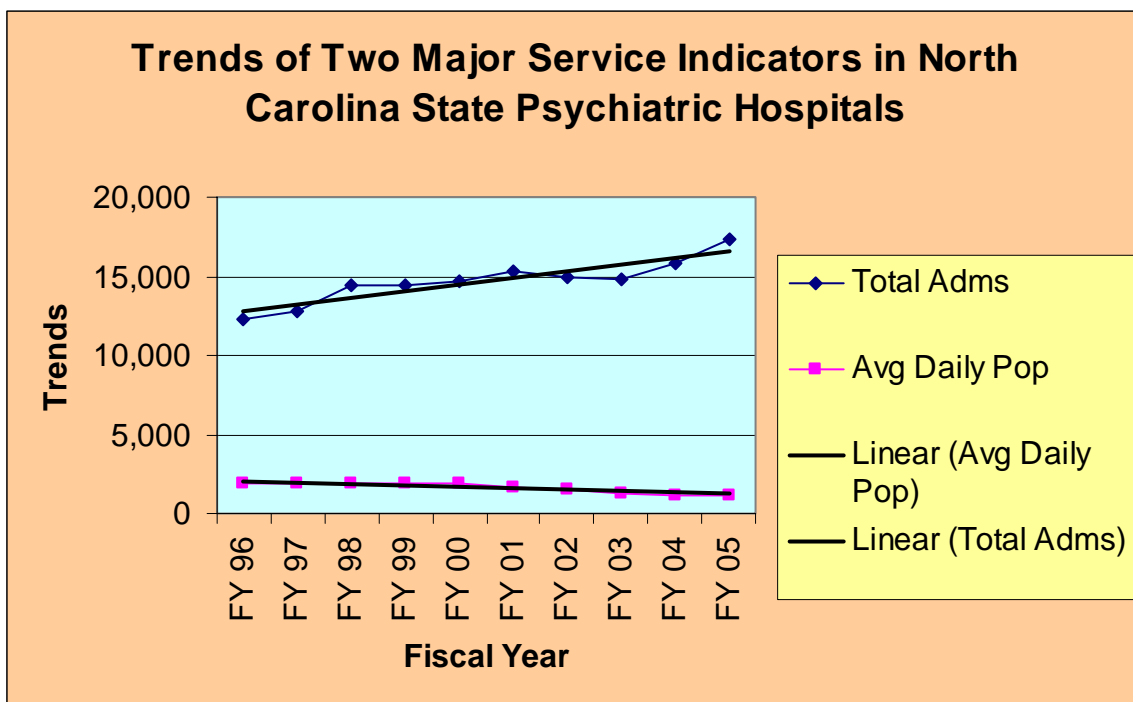
Background

One of the primary objectives in each of North Carolina's public mental health, developmental disabilities and substance abuse services system State Plans for reform and transformation has been to reverse the heavy reliance on State-operated institutions for inpatient care. Currently however, funding and policy positions do not adequately support these efforts. North Carolina currently spends less on a per-consumer basis for mental health and substance abuse services than the majority of other States and the general fund contribution for Medicaid ranks it 43rd in the nation. At the same time, North Carolina is spending more than most States on State facility-based services. 1.26 per 1000 North Carolinians will receive State psychiatric hospital treatment compared to the national average of 0.62 per 1000. The absence of continuity of care and Community Detoxification are two factors that contribute to these increases in State Hospital use.¹ If North Carolina truly wants a community based system, it must make difficult funding and policy decisions to prevent unnecessary State facility use.

¹ Heart of the Matter Consulting, Inc. (December 2006); *Long-Range Plan for Meeting Mental Health, Developmental Disabilities & Substance Abuse Services Needs for the Sate of North Carolina.*

Federal law (the Olmstead decision) and nationally recognized best practices support the provision of services to people with disabilities in least restrictive community settings. During Fiscal Year 2002 (and pursuant to system reform), the Division developed and began implementing a plan to expand community services and thereby reduce the number of beds in State-operated psychiatric hospitals. Although progress has been made in enhancing North Carolina’s system of “mental health” service delivery, the utilization of State hospitals has remained unacceptably high. The costs of State Hospitals have actually increased.

Table 1



As indicated in Table 1, from Fiscal Year 1996 through Fiscal Year 2005, the average combined daily population of North Carolina’s State-operated psychiatric hospitals declined by 36% but the combined total admissions for each year increased by 40%.

Funding of local programs is not sufficient either for an appropriate array of service or the intensity and consistency of services needed to enable people to live successfully in local communities.² Consequently, our State’s mental health system continues to experience numerous systemic problems and only fundamental changes in the structure and funding of the system will improve treatment outcomes for persons served..

² Heart of the Matter Consulting, Inc. (December 2006); *Long-Range Plan for Meeting Mental Health, Developmental Disabilities & Substance Abuse Services Needs for the Sate of North Carolina.*

It has become very clear that additional steps must be taken to shift reliance from State institutional care to community based alternatives.

Position Statement

It is the position of the North Carolina Council of Community Programs that the following 12 steps be enacted prior to re-introduction of bed day allocations. Without these actions, the bed day allocation process is certain to fail and as it stands, offers few positive incentives for LMEs, community providers, community stakeholders (e.g., local hospitals, police agencies, etc.) and the consumers served by the system.

1. The State must move institutional funding to the LME budget and make the LME responsible for purchasing needed State-operated facility care. Only the LME may make payment authorizations for a State Facility admission. This will require a shift in funding to the LME side of the budget and redirection of savings when downsizing occurs. Savings related to hospital bed day reductions would then be used by the LME to increase community alternatives to institutional care (e.g., peer-operated drop-in centers, mobile crisis units, etc.).
2. A single point of entry through the LME into State psychiatric hospitals is necessary to ensure implementation of alternative care, uniform screening and care management. This single point of entry prevents decision-making on State facility admissions by those who have real or perceived conflicts of interest.
3. The LME will offer an alternative plan to each individual for whom inpatient admission is being considered. Rules should be established and the LME contract must require alternative plans and/or discharge plans of care for each person prior to admission to a State facility. Each LME should include in its Local Business Plan (LBP) or Crisis Plan (CP) a summary of the community treatment needs of individuals in State facilities and indicate if the capacity to provide those services exists and if not, the cost to provide them.
4. The Division must summarize the State-wide LBP and CP needs data and recommend downsizing and funding on that basis. Each LME should have a plan for State psychiatric hospital reduction that incorporates a summary of treatment needs for area residents who will be exiting State hospitals. It is only through this mechanism that planning and implementation of programming can occur to reduce recidivism.
5. People with substance abuse problems constitute the primary reason for increased numbers of admissions to the State hospitals. Persons who are intoxicated should not be admitted to State facilities but to appropriate local detoxification and treatment programs that are developed State-wide.
6. The State should commission a legal review of EMTALA and its application to community hospitals and LME's and consider what would be required (e.g., changes in State law) to divert persons from State hospital referrals once they are in hospital emergency rooms. Currently, local hospitals do not refer to local facility-based crisis programs as hospitals perceive these local programs as inadequate to provide the needed level of care. A review and changes in (or re-interpretation of EMTALA requirements) may be useful in changing this perception.

7. The State must fund crisis options to divert unnecessary State facility or community inpatient admissions. The system cannot coordinate care effectively, establish and manage waiting lists, nor appropriately prioritize available resources for those most in need without a centralized Crisis/Screening-Triage-Referral (C/STR) system in each catchment area that is the single entry for inpatient care or its alternatives. The C/STR functions must meet enforceable standards for timely determination of eligibility and access to care and services, taking into account the urgency of need for those services.
8. The State should make available resources for each LME to have a hospital discharge planner. This individual(s) should develop with each consumer an alternative treatment plan to prevent inpatient care or when inpatient care is indicated, a discharge plan with alternative community-based care at the appropriate time. These positions help individuals return to the community sooner and with better results. Care Coordination should assure that authorizations for persons admitted to inpatient or alternative acute care crisis services are reviewed at least every three (3) days. Authorizations should also be reviewed prior to discharge to assure the following: the consumer is connected with a responsible clinician prior to discharge; the consumer has sufficient supports, medication etc. until the first appointment; and a contact with the primary clinician must occur within seven (7) days following discharge.
9. We support the legislative proposal to expand the first level commitment pilot project Statewide. These pilots have proven to be a cost-effective strategy to decrease waiting time for people to receive the exam and finalize the recommendation for commitment.
10. Because law enforcement officers are the first responders in crisis situations, we recommend that “mental health” training for all law enforcement officers be increased from four (4) to 40 hours as required by CIT curriculum.
11. The State cannot meet its objectives for least restrictive care without community inpatient options. We suggest the following:
 - a. The State should standardize the Medicaid rate for inpatient psychiatric services at a level that will make sense for hospitals (currently hospitals all have different rates).
 - b. The State should amend the State Medical Facilities plan to identify a need for additional inpatient beds for psychiatry.
 - c. Incentives must be funded by the State to make it more attractive for receptive local hospitals to provide acute psychiatric care. The climate is different in each market and LME’s also pay a different rate for each market.
 - d. The crisis plan developed by each LME needs to be funded with incentives from the State for local hospitals to provide acute care.
 - e. Absent the development of acute psychiatric inpatient beds through local hospitals, the State should consider funding 16 beds, or less, units for psychiatric inpatient care through the LME’s.
12. The State must exercise the political will that is necessary to increase capacity through adequate rates that are necessary to promote the ability of LME’s to develop local programs such as intensive in-home services, Acute Community Treatment Teams, peer-operated drop-in centers, etc.

Rather than conducting additional studies, endless debates and unnecessary delays, our State policymakers must take immediate action to fulfill the vision for a community-based, market-driven mental health system that was originally envisioned in the State Plans. Accomplishing these recommendations would bring about great benefits for those with “mental health” issues as well as for taxpayers. While we applaud the intentions of the Secretary to continue pursuing efforts to increase community capacity, the inescapable conclusion is a need for immediate policy and system changes. These changes are vital in order to reverse the continued dependency on State hospitals and to transfer responsibility for acute inpatient care to local authority. The LME’s in North Carolina stand ready and willing to partner with the State to bring this goal to fruition and welcome the opportunity for continued discussion with the Division toward this end.

Previous Evaluations

Numerous evaluations of our system have been completed with some excellent recommendations for change. Some of the more noteworthy studies include: the *Study of North Carolina State Psychiatric Hospitals and Area Mental Health Programs* (completed by the Public Consulting Group, Inc. in April 2000); the *Study of Mental Health/Substance Abuse Facilities and Their role in North Carolina’s System of Care* (completed by MGT of America in October 2001); and, most recently, the *Long-Range Plan for Meeting Mental Health, Developmental Disabilities & Substance Abuse Services Needs for the State of North Carolina* (completed by Heart of the Matter Consulting, Inc. in December 2006). Rather than continuing to study and debate, we believe it is now time to take immediate action to implement many of the changes presented in the above referenced reports. The following are some key conclusions from those studies (note: many recommendations were overlapping and these have not been repeated).

Study of North Carolina State Psychiatric Hospitals and Area Mental Health Programs (2000)

- Immediately begin the reduction of 667 beds from State-operated psychiatric hospitals to create opportunities for transferring funds to community-based services.
- Adopt a three-hospital model to create additional funding for community services.
- Create a special transfer account that would account for all of the savings and revenue operations accrued from hospital downsizing.
- Implement a standardized, affordable benefit for assessment and acute care services State-wide.
- Utilize the savings achieved under the three-hospital model to support the cost of a Basic Benefit Package to fund capital investments, bridge funding and State hospital replacement funding.
- Conduct a more thorough investigation into the existing service delivery system to determine the utilization and cost of these services and to identify the levels of services that already exist in the system.

Study of Mental Health/Substance Abuse Facilities and Their Role in North Carolina’s System of Care (2001)

- The current financial incentive structure between area/county programs and State operated facilities is wrongly aligned, encourages over-utilization of State services and contributes to unclear accountability.

- State hospital bed day plans should emphasize a process to place the management, financing and responsibility for consumer care solely under the LME. This process would give the LME's full financial and clinical responsibility and total accountability for the consumer.
- Make all State institutions receipt-supported and substantially increase their ability to function in a more competitive environment.
- In addition, implement the recommendations suggested in a previous 1998 MGT report including:
 - Decrease the number of substance abuse consumers treated in State psychiatric hospitals by expanding the types of consumers accepted by Alcohol and Drug Abuse Treatment Centers (ADATC).
 - Move the geriatric patients to community-based facilities and close the geriatric long-term and nursing facility units at the hospitals.
 - Close the Youth Units and develop community resources to treat these young mental health consumers.
 - More closely align the use of bed-days to the LME's population.
 - Create a single stream of funding for "mental health" services.
- The Division should develop an implementation plan for downsizing State hospitals while new facilities are being built.
- The Division should produce an annual report to the Legislative Oversight Committee regarding the progress of downsizing the hospitals and building new facilities.

Long-Range Plan for Meeting Mental Health, Developmental Disabilities & Substance Abuse Services Needs for the State of North Carolina (2006)

- Funds realized from the reduction of State-operated hospital beds should be transferred to the community to develop local alternatives to hospitalization.
- LME's should evaluate each referral to a State-operated hospital, regardless of the referral source, for alternative treatment options.
- If a hospital admits or does not discharge a consumer when the LME has developed a clinically appropriate and adequate alternative to hospitalization, the LME should not be charged for those days.
- The State should strongly consider funding Acute Crisis Treatment Teams and crisis capacity programs (or expansions in counties with State hospital rates in excess of the State average) and provide technical assistance to assure that models are adhered to and the culture is established.
- The Division should continue to monitor monthly performance indicators for hospital days, readmission rates within 30 days, availability of appropriate care at discharge, etc.
- A single point of entry into State facilities is necessary; and decision-making on State facility admissions should not be made by those with real or perceived conflicts of interest.
- The State should enact legislation that provides for alternative treatment and involuntary outpatient orders
- People with substance abuse problems constitute the primary reason for increased numbers of admissions to the State hospitals and need local detoxification and treatment.
- LMEs must provide services to divert persons with MH/DD/SA conditions from possible jail/prison incarceration or juvenile justice detainment when they are accused of a non-violent or misdemeanor crime.
- Spending less and serving more equates to not providing an adequate intensity and continuity of care, which has a significant correlation with State Facility use.

In addition to these formal studies, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) recommended some excellent changes in their draft report of 2007 that included the following:

- Build community capacity and financing reform within the mental health system.
- Appropriate additional resources to expand facility-based and non-facility based crisis services.
- Review all previous State Plans and produce a new document that meets the requirements of G.S 122C-102 and contains a cumulative Statement of all still-applicable provisions of those plans.
- Amend Article 4 of Chapter 122C to clearly articulate those administrative and managerial functions that are the responsibility of an LME. Clarify that LME functions may not be removed by the Secretary absent an individualized finding that a particular program is not providing minimally adequate services or is in imminent danger of failing financially.
- The LOC shall study mechanisms to allow LME's to purchase bed days from the State psychiatric hospitals. The LOC shall consider options for holding LMEs accountable for their use of State psychiatric institutions, and provide incentives to increase community capacity.

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