CROSS ROADS BEHAVIORAL HEALTHCARE
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# Petition to the State Health Coordinating Council Regarding Changes to Criteria for Licensing of New Psychiatric Beds in Community Hospitals For the 2009 State Medical Facilities Plan

***Petitioner:***

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## PETITION

## STATEMENT OF REQUESTED CHANGE

Crossroads Behavioral Healthcare respectfully requests the following policy change to the 2009 State Medical Facilities Plan (SMFP).

Chapter 4 Statement of Policies, Mental Health, Developmental Disabilities, and Substance Abuse (General) should have the following additional policy.

> *PSY-2 "To support the State Mental Health initiative regarding community placement of persons who require psychiatric hospitalization, new psychiatric beds should be designated to accept involuntary admissions. Facilities proposing to develop or add psychiatric beds shall demonstrate by letter of agreement that the proposed beds will meet the needs of the Local Management Entity service area in which the proposed beds will be located, including the need for involuntary beds. Skilled nursing beds are a critical component of community mental health care; therefore, new psychiatric beds should not result in a loss of hospital-based skilled nursing beds."*

## REASONS FOR THE PROPOSED CHANGES

As a Local Managing Entity (LME), Crossroads Behavioral Health is responsible for the care and management of patients who qualify for involuntary psychiatric admission for consumers in Iredell, Surry and Yadkin counties (Service Area 8). Since the mental health reform legislation of 2001, Mental Health Authorities such as Crossroads discontinued providing direct clinical care and now manage and coordinate comprehensive care through a network of contracted providers. Patients with severe mental illness depend upon Crossroads to assemble a complex network of inpatient and outpatient care to meet their needs. We are highly dependent on private sector providers to deliver the care. Many of our patients and their families now use local emergency rooms as their first line of defense in a mental health crisis due to the lack of viable alternatives close to their home.

Between April 1, 2007 and March 31, 2008, more patients, 117 per 10,000 population, have been admitted to emergency departments with either a primary or associated mental health diagnosis. This is significantly higher than the state average of 94.9 per 10,000. However, during that same time period fewer patients have been admitted to emergency departments with either a primary or associated substance abuse diagnosis than the state average (see attached table for third quarter data from FY 2007-08).

During FY 2007-08, Crossroads Behavioral Healthcare managed care for 454 involuntary patients referred to the State Hospital and 529 patients referred to community psychiatric hospitals and detoxification facilities from LME Service Area 8. Crossroads, through a network provider, opened a six-bed non-hospital based sub-acute care residential program that began taking involuntary patients in January 2008. This program is not equipped as a hospital, and therefore can only admit certain patients on involuntary petition. Because no hospital in our service area has involuntary beds, the 454 patients and a majority of the 529 patients that were petitioned for involuntary commitment were referred outside their home county, at distances of 30 to 150 miles away. To meet legal requirements, each patient under an involuntary petition, is transported by local law enforcement officers to the receiving hospital. For their own protection, and that of the officers, some are handcuffed while in the custody of law enforcement.. Along the way, patients may encounter medical problems and the law enforcement officers were required to stop at the nearest hospital to access medical treatment for the patient before continuing on to the receiving psychiatric hospital. The law enforcement officers are away from their routine duty, reducing law enforcement capacity while they transport patients outside of their routine jurisdiction. Fuel costs and overtime have escalated budget concerns for local governments.

When patients are discharged from the hospitals farther from home, they must be referred back to treatment in their home community. This transition requires the patients to establish new professional relationships with care providers and some treatment services may not be as easy to access as it was in the hospital where they began their inpatient treatment.

The NC General Assembly, in its Short Session 2008, appropriated $8,121,264 to divide among each LME region for the purchase of local inpatient psychiatric beds or bed days. Crossroads will manage the Crossroads portion of this money to purchase involuntary psychiatric beds for our citizens. However,

without local involuntary psychiatric beds, purchase these beds will have to be outside of the Crossroads area.

Current analysis of the number of patients presenting at local emergency rooms for acute mental health services, and referred for involuntary commitment, coupled with the absence of local involuntary beds to meet those needs in the Service Area 8, compels Crossroads Behavioral Healthcare's submission of this petition to the North Carolina State Health Coordinating Council to amend its proposed plan for psychiatric hospital beds.

Crossroads serves the counties of Iredell, Surry and Yadkin (Service Area 8) with a combined 2008 population of 266,886. Crossroads is a nationally accredited and publicly-funded Local Managing Entity (LME) managing and garnering the public resources to provide behavioral health care for the citizens who have mental health, developmental disabilities and substance abuse disorders. With more than 35 years of experience in the community and knowledge of our consumers and their needs, Crossroads has established excellent patient trust and developed the knowledge base that enables us to ensure quality care management.

Crossroads' analysis of access to care data, and on-going assessment of the behavioral health needs of citizens who need treatment demonstrates that the current number of active psychiatric hospital beds in our region cannot meet the expectations and needs of our communities. A disservice is done to our citizens when patients are sent to hospitals outside of Crossroads' three-county catchment area for acute psychiatric hospital care, they are further from their home, family and local behavioral health providers.

We expect to see 12 additional acute psychiatric beds in the 2009 State Medical Facilities Plan when it is adjusted for the dropped appeal associated with a failed 2007 CON application. These beds could increase the local capacity to serve patients in need of this level of care. The addition of these beds will not appreciably help our community if the plan contains no requirement to accommodate the needs of our communities for involuntary beds.

Many of our mental health patients, particularly those with Alzheimer's and dementia, are well served in the hospital-based skilled care units. With a relatively short-stay, they can be stabilized and return to their homes. If hospitals are permitted to convert skilled nursing inventory we will lose another source of care.

In our service area, the most populous county, Iredell, has a deficit of 49 skilled care beds according to the State Health Facilities Plan. The deficit is not enough to show need for more beds in the plan, therefore capacity is not anticipated to increase in the foreseeable future. Meanwhile, critical capacity could be lost in a conversion.

**Therefore; Crossroads is requesting the State Health Coordinating Council to:**

1) **Modify the proposed language in the 2009 State Medical Facilities Plan to require new psychiatric beds to be designated involuntary if the LME needs involuntary beds; and,**

2) **Prohibit the conversion of skilled care beds to psychiatric beds and retain the provision requiring the conversion of acute care beds.**

The former PSY-2 did not require beds to be designated as involuntary, however the policy did prevent the loss of skilled care beds by requiring the conversion of acute care beds to psychiatric beds.

Although most acute care hospitals providing psychiatric inpatient services in North Carolina are designated to accept involuntary patients, a small number accept only voluntary patients. Of the six acute care hospitals in the Crossroads three-county area, only one has an inpatient psychiatric unit. This psychiatric unit meets many of the needs of voluntary patients; however does not have any beds designated as involuntary. The designation of psychiatric beds as involuntary does not limit the hospital to accepting only involuntary patients; rather it does allow the hospital to admit the full range of patients (both voluntary and involuntary). Furthermore, meeting the criteria for treating involuntary patients through the implementation of safety and security mechanisms improves the care of all psychiatric patients.

Inpatient payment to physicians is low, creating a significant challenge to recruit independent psychiatric staff to community hospitals. Crossroads has entered into partnerships with several of the local hospitals in our region to jointly recruit psychiatrists. These efforts have led to only one successful recruitment. Hospitals outside of the Crossroads area have recruited hospitalist psychiatrists to staff these units, and some pay physicians for their services in attempts to meet this challenge.

Hospitals are not being asked to offer community involuntary inpatient treatment without assistance. The General Assembly enacted in the budget for 2008-09 the recurring amount of $8,121,644 for psychiatric and detoxification beds and physician care in local community hospitals. If patients are eligible, Medicaid and Medicare also reimburse hospitals for inpatient treatment in a community hospital. Medicaid will not cover inpatient psychiatric treatment in a freestanding psychiatric hospital.

These funds will permit LMEs to purchase local inpatient psychiatric beds from local hospitals, but these beds must be designated involuntary to meet the inpatient psychiatric needs in the Crossroads area. The state Department of Health and Human Services will contract with LMEs in FY 2008-09 and community hospitals for management of beds or bed days. Local bed days, paid for with State funds, will be managed and controlled by LME including the determination of which hospital or state hospital the patient shall be admitted to. This permits the LME to secure treatment for the patient locally if beds are available to purchase. Funds are held in statewide reserve for the hospitals, and LMEs will submit claims for payment to the DHHS from the reserve fund.

The skilled care beds serve mental health patients from the communities as well. Hospital skilled care beds are used to serve patients that may be preparing for referral into community-based skilled care beds. Any reduction in skilled care beds would disrupt the balance of resources available to these fragile patients. According to the Proposed 2009 State Medical Facilities Plan, Iredell County has a deficit of 49 skilled beds. The conversion of 12 skilled beds to psychiatric inpatient beds would increase the deficit.

This is a pivotal time in psychiatric care in the State of North Carolina. The General Assembly, the Governor and the Department of Health and Human Services are working together to improve access and appropriateness of care. The 2009 plan provides for 107 new adult psychiatric beds. Adding

Service Area 8 brings the total to 119. This will be a one time event and the resource should be focused on meeting the patient needs in local communities.

## ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS OF NOT MAKING THE REQUESTED CHANGE

The absence of local inpatient psychiatric beds designated as involuntary can compromised patient care and perpetuate associated services that are costly to the patients and communities.

First, the shortage of inpatient psychiatric beds designated as involuntary creates challenges for local hospital emergency departments to get patients admitted to receiving hospitals. The wait time has grown from several hours to several days over the last few years. The staffing required to manage these patients in emergency departments is higher than for any other patients and the extended wait time limits the capacity of emergency departments to address other patients.

Second, patients who are involuntarily committed must be transported in the custody of local law enforcement officers to the receiving facility. Involuntary committed patients are in an acute crisis, may be handcuffed while in the custody of local law enforcement and often have medical complications compounding their mental condition. The potential of aggravating the patient's condition is exacerbated by length of the transportation.

Third, patients with co-morbid medical conditions may experience further decline in their health status and law enforcement officers do not have the equipment and are not qualified to provide the care these patients may need.

Fourth, the cost of transportation is a huge burden on law enforcement and the community. Each transport requires two officers to leave their community. Because the travel time takes an average of four to eight hours overtime has become a burden for rural law enforcement departments and the absence of the officers may jeopardize the safety of other citizens.

Lastly, Crossroads must provide care management to patients hospitalized to plan for the patients' discharge and return to community services. Patients are predominantly referred to involuntary inpatient treatment at hospitals located in Charlotte, Winston-Salem, Morganton, Asheville, Gastonia, Hickory, Burlington, Kings Mountain, Raleigh, and Butner – none of which are in Service Area 8. Helping these patients achieve a successful transition from one of these medical environments and back to their community is necessary. Patients often view this as a significant challenge once they begin care in a hospital located outside of their normal medical community.

## ALTERNATIVES TO THE REQUESTED CHANGE CONSIDERED AND REJECTED

**Status quo**

Crossroads has attempted to negotiate with local hospitals over the last several years requesting them to add involuntary psychiatric inpatient capacity and have not been successful. If the State Medical Facilities Plan adds beds and does not have a policy to require that some of those beds be available for involuntary admissions, the problem will not be solved.

Transportation costs, medical complications associated with transporting patients long distances and care coordination of patients away from their community all have negative local impacts.

**Permit all beds to be voluntary**

If beds are designated "voluntary" the provider cannot admit involuntary patients. The reverse is not true. Designation "involuntary" permits hospital to accept either voluntary or involuntary.

**Place new beds only in free standing psychiatric hospital**

In Crossroads' experience, most patients who have severe mental health problems also have medical complications which require acute care medical assistance as well as mental health care. A community acute care hospital can address both needs.

On the reimbursement side, Medicaid will not reimburse free standing psychiatric hospitals for care. Such a solution would effectively deprive access to an entire segment of the community, those with severe mental health problems and co-existing medical complications.

## EVIDENCE OF NON-DUPLICATION OF SERVICES

This requested change will not cause duplication of services.

This request does not add to the inventory of beds. It directly addresses a critical deficit in the behavioral health system and responds to an acute community need to complete the inpatient link in the total care system.

Not every LME Service Area has this problem. Most have some involuntary admission beds, and many will have enough beds. This petition is focused on areas like Service Area 8 that have insufficient or no options. In Service Areas where involuntary access is not a problem, the LME could indicate no preference for type of beds.

## CONCLUSION

The proposed policy is cost effective, focuses the 2009 State Medical Facilities Plan on a critical problem in mental health care in North Carolina. North Carolina needs a greater number of psychiatric inpatient beds to offset the losses in beds that occurred in the late 1990's when hundreds of psychiatric beds were lost due to hospital closures. The result has been an increase in the number of patients hospitalized at the State psychiatric hospitals and an increase in the wait time at local emergency rooms for mental health patients who are to be transferred to a higher level of care at a hospital having involuntary psychiatric beds. Involuntary psychiatric hospital beds offer the hospital and the community the flexibility to meet these needs.

**Attached: Table for third quarter data from FY 2007-2008**

**ATTACHMENT**

# PATIENTS ADMITTED TO LOCAL EMERGENCY DEPARTMENTS FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE PRESENTING PROBLEMS

Emergency Department Admissions by Local Management Entity, QTR 3, SFY 2008
January 1, 2008 through March 31, 2008 Source: NCDETECT

Mental Health Rankings

| Local Management Entity | Mental Health (n) | Rate of MH Admissions/10,000 population | Substance Abuse (n) | Rate of SA Admissions/10,000 population |
|---|---|---|---|---|
| Guilford | 2,684 | 58.8 | 1,262 | 27.6 |
| Mecklenburg | 5,570 | 65.0 | 2,609 | 30.4 |
| Onslow-Carteret | 1,577 | 69.2 | 598 | 26.2 |
| Durham | 1,821 | 72.4 | 756 | 30.0 |
| Wake | 6,008 | 73.1 | 1,704 | 20.7 |
| Southeastern Center | 2,482 | 73.2 | 1,147 | 33.8 |
| Beacon Center | 1,810 | 74.0 | 738 | 30.2 |
| Orange-Person-Chatham | 1,721 | 77.5 | 605 | 27.2 |
| Five County | 1,827 | 79.2 | 606 | 26.3 |
| Sandhills Center | 4,513 | 85.2 | 1,411 | 26.6 |
| ECBH | 3,530 | 89.8 | 1,154 | 29.3 |
| Smoky Mountain | 3,188 | 90.0 | 981 | 27.7 |
| Cumberland | 2,815 | 91.3 | 1,056 | 34.3 |
| Albemarle | 1,720 | 93.0 | 445 | 24.1 |
| **Statewide** | **85,755** | **94.9** | **26,104** | **28.9** |
| Johnston | 1,529 | 97.5 | 438 | 27.9 |
| Piedmont | 7,102 | 101.7 | 1,924 | 27.6 |
| CenterPoint | 4,828 | 113.6 | 1,317 | 31.0 |
| Eastpointe | 3,401 | 116.6 | 970 | 33.3 |
| Crossroads | 3,067 | 117.0 | 666 | 25.4 |
| Pathways | 4,357 | 117.7 | 984 | 26.6 |
| Foothills | 1,966 | 122.2 | 503 | 31.3 |
| Burke-Catawba | 3,068 | 126.4 | 730 | 30.1 |
| ACR | 3,335 | 129.8 | 783 | 30.5 |
| Southeastern Regional | 3,652 | 142.8 | 1,108 | 43.3 |
| Western Highlands | 8,184 | 164.6 | 1,609 | 32.4 |

Substance Abuse
Rankings

| Local Management Entity | Mental Health (n) | Rate of MH Admissions/10,000 population | Substance Abuse (n) | Rate of SA Admissions/10,000 population |
|---|---|---|---|---|
| Wake | 6,008 | 73.1 | 1,704 | 20.7 |
| Albemarle | 1,720 | 93.0 | 445 | 24.1 |
| Crossroads | 3,067 | 117.0 | 666 | 25.4 |
| Onslow-Carteret | 1,577 | 69.2 | 598 | 26.2 |
| Five County | 1,827 | 79.2 | 606 | 26.3 |
| Pathways | 4,357 | 117.7 | 984 | 26.6 |
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| Beacon Center | 1,810 | 74.0 | 738 | 30.2 |
| Mecklenburg | 5,570 | 65.0 | 2,609 | 30.4 |
| ACR | 3,335 | 129.8 | 783 | 30.5 |
| CenterPoint | 4,828 | 113.6 | 1,317 | 31.0 |
| Foothills | 1,966 | 122.2 | 503 | 31.3 |
| Western Highlands | 8,184 | 164.6 | 1,609 | 32.4 |
| Eastpointe | 3,401 | 116.6 | 970 | 33.3 |
| Southeastern Center | 2,482 | 73.2 | 1,147 | 33.8 |
| Cumberland | 2,815 | 91.3 | 1,056 | 34.3 |
| Southeastern Regional | 3,652 | 142.8 | 1,108 | 43.3 |

All Behavioral Health Admissions (including Developmental Disabilities)

| County | Behavioral Health (n) | Rate of BH Admissions/10,000 population |
|---|---|---|
| Iredell | 1,456 | 96.6 |
| Surry | 1,759 | 240.3 |
| Yadkin | 536 | 140.2 |
| Statewide | 112,234 | 124.1 |