LT-BH COMMITTEE

Material Related To

Psychiatric Inpatient Services

For the Final 2009 SMFP

For the
N.C. State Health Coordinating Council Meeting

On

October 8, 2008

LT/BH COMMITTEE

Revised Tables for Chapter 15

Petition:
Crossroads Behavioral Health

Summary of Agency and Staff Recommendations to the Long-Term and Behavioral Health Committee for the September 26, 2008 Meeting related to Chapter 15 of the Final 2009 SMFP

Recommendations Related to Chapter 15, Psychiatric Inpatient Services:

- Revised Tables for Chapter 15:
  - Beginning with the Proposed 2009 SMFP, at the request of the NC Department of Health and Human Services (DHHS) and approved by the SHCC, Table 15B was organized by Local Management Entities (LME) instead of by Mental Health Planning Areas and Regions. Revised Table 15B includes totals for the state, instead of summing by the previously used four mental health planning regions.
  - In July 2008, Foothills LME merged with Smoky Mountain Center LME, which resulted in revised Tables 15A, 15B and 15C. Please see attached LME map for more information

Revised Table 15B demonstrates need determinations in the following LME areas for child adolescent psychiatric inpatient beds:

- Smoky Mountain: Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, McDowell, Macon, Swain, Watauga, Wilkes
- Piedmont: Cabarrus, Davidson, Rowan, Stanly, Union
- Crossroads: Surry, Iredell, Yadkin
- Five County: Vance, Granville, Franklin, Warren, Halifax
- Sandhills: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond
- Southeastern Regional: Robeson, Bladen, Columbus, Scotland
- Johnston
- Southeastern Center: New Hanover, Brunswick, Pender
- Albemarle: Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington

Revised Table 15B demonstrates need in the following LME areas for adult psychiatric inpatient beds:

- Smoky Mountain: Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, McDowell, Macon, Swain, Watauga, Wilkes
- Five County: Vance, Granville, Franklin, Warren, Halifax
- Cumberland
- Johnston
- Wake
- Onslow -Carteret
- Albemarle: Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington

It is recommended that the revised Tables 15A, 15B and 15C be adopted.

- There was one petition from Crossroads Behavioral Healthcare, Elkin, NC. We received two comments regarding the petition by the deadline of 9/9/2008 at 5:30 pm, one in favor of the petition, and one opposing the petition.

  The Agency recommends denial of the petition for the following reasons:
  1. The development of a policy that requires new psychiatric beds to be designated for involuntary admissions through a letter of agreement with the LME is a proposed new policy that would have a statewide effect. Therefore, in accordance with procedures set forth in Chapter 2 of the SMFP, it has not been timely filed for inclusion in the 2009 SMFP. Consequently, the Agency recommends the petitioner's request regarding involuntary admissions be considered in the spring of 2009 for inclusion in the next proposed SMFP.

  2. Policy Psy-2 in the 2008 SMFP requires new psychiatric beds be developed only if excess acute care beds are converted. The SHCC approved to delete this policy from inclusion in the Proposed 2009 SMFP. The Agency recommends that this Policy should not be reinstated in the 2009 SMFP because it limits the options that can be used to develop need determinations for inpatient psychiatric beds.

Table 15A: Inventory Of Psychiatric Beds, Excluding State Hospitals

LOCAL MANAGEMENT ENTITY	HOSPITAL	COUNTY	LICENSED BEDS	CON-APPR BEDS (NOT LICENSED)	TOTAL BEDS	LICENSED BEDS FOR ADULTS	LICENSED BEDS FOR CHILD/ADOL	CON-APPR ADULT BEDS	CON-APPR CHILD/ADOL BEDS
Smoky Mountain	Charles A. Cannon Memorial	Avery	0	0	0	0	0	0	0
	Total for Smoky Mountain		**0**	**0**	**0**	**0**	**0**	**0**	**0**
Western Highlands	Mission-St. Joseph's Health System	Buncombe	57	0	57	48	9	0	0
	Pardee Memorial Hospital	Henderson	21	0	21	21	0	0	0
	Park Ridge Hospital	Henderson	41	0	41	41	0	0	0
	Rutherford Hospital	Rutherford	14	0	14	14	0	0	0
	St. Luke's Hospital	Polk	10	0	10	10	0	0	0
	Total for Western Highlands		**143**	**0**	**143**	**134**	**9**	**0**	**0**
Pathways	King's Mtn. Hospital	Cleveland	14	0	14	14	0	0	0
	Gaston Memorial Hospital	Gaston	63	0	63	43	20	0	0
	Total for Pathways		**77**	**0**	**77**	**57**	**20**	**0**	**0**
Mental Health Partners	Grace Hospital	Burke	22	0	22	22	0	0	0
	Frye Regional Medical Center	Catawba	84	0	84	56	28	0	0
	Catawba Memorial	Catawba	38	0	38	28	10	0	0
	Total for Mental Health Partners		**144**	**0**	**144**	**106**	**38**	**0**	**0**
Mecklenburg	Presbyterian Hospital	Mecklenburg	60	0	60	40	20	0	0
	Carolinas Medical Center	Mecklenburg	66	0	66	44	22	0	0
	Total for Mecklenburg		**126**	**0**	**126**	**84**	**42**	**0**	**0**
Piedmont	Stanly Memorial Hospital	Stanly	12	0	12	12	0	0	0
	Northeast Medical Center	Cabarrus	10	0	10	10	0	0	0
	Rowan Memorial Hospital	Rowan	20	0	20	15	5	0	0
	Thomasville Medical Center	Davidson	26	0	26	26	0	0	0
	Total for Piedmont		**68**	**0**	**68**	**63**	**5**	**0**	**0**
Crossroads	Davis Regional Medical Ctr.	Iredell	16	0	16	16	0	0	0
	Total for Crossroads		**16**	**0**	**16**	**16**	**0**	**0**	**0**
CenterPoint	N.C. Baptist Hospitals	Forsyth	44	0	44	24	20	0	0
	Forsyth Memorial Hospital	Forsyth	80	0	80	80	0	0	0
	Old Vineyard Youth Services	Forsyth	46	0	46	0	46	0	0
	Total for CenterPoint		**170**	**0**	**170**	**104**	**66**	**0**	**0**
A - C - R	Alamance Regional Medical Ctr.	Alamance	44	0	44	36	8	0	0
	Total for A - C - R		**44**	**0**	**44**	**36**	**8**	**0**	**0**
Guilford	High Point Regional	Guilford	24	0	24	24	0	0	0
	Moses Cone Health System	Guilford	80	0	80	48	32	0	0
	Total for Guilford		**104**	**0**	**104**	**72**	**32**	**0**	**0**

Table 15A: Inventory Of Psychiatric Beds, Excluding State Hospitals

LOCAL MANAGEMENT ENTITY	HOSPITAL	COUNTY	LICENSED BEDS	CON-APPR BEDS (NOT LICENSED)	TOTAL BEDS	LICENSED BEDS FOR ADULTS	LICENSED BEDS FOR CHILD/ADOL	CON-APPR ADULT BEDS	CON-APPR CHILD/ADOL BEDS
OPC	UNC Hospitals	Orange	76	0	76	48	28	0	0
	Total for OPC		**76**	**0**	**76**	**48**	**28**	**0**	**0**
Durham	Durham Regional Hospital	Durham	23	0	23	23	0	0	0
	Duke University Medical Center	Durham	19	0	19	19	0	0	0
	Total for Durham		**42**	**0**	**42**	**42**	**0**	**0**	**0**
Five County	Franklin Regional Medical Center	Franklin	0	0	0	0	0	0	0
	Halifax Memorial Hospital	Halifax	20	0	20	20	0	0	0
	Total for Five County		**20**	**0**	**20**	**20**	**0**	**0**	**0**
Sandhills	Sandhills Regional Medical Center	Richmond	10	0	10	10	0	0	0
	Hospital	Moore	36	0	36	36	0	0	0
	Good Hope Hospital	Harnett	0	12	12	0	0	12	0
	Central Carolina Hospital	Lee	0	0	0	0	0	0	0
	Total for Sandhills		**46**	**12**	**58**	**46**	**0**	**12**	**0**
Southeastern Regional	Southeastern Regional Medical Center	Robeson	33	0	33	33	0	0	0
	Total for Southeastern Regional		**33**	**0**	**33**	**33**	**0**	**0**	**0**
Cumberland	Cape Fear Valley Medical Center	Cumberland	28	0	28	12	16	0	0
	Total for Cumberland		**28**	**0**	**28**	**12**	**16**	**0**	**0**
Johnston	Johnston Memorial Hospital	Johnston	20	0	20	20	0	0	0
	Total for Johnston		**20**	**0**	**20**	**20**	**0**	**0**	**0**
Wake	Holly Hill Hospital (1)	Wake	80	44	124	28	52	24	20
	Total for Wake		**80**	**44**	**124**	**28**	**52**	**24**	**20**
Southeastern Center	New Hanover Regional Medical Center	New Hanover	62	0	62	62	0	0	0
	Total for Southeastern Center		**62**	**0**	**62**	**62**	**0**	**0**	**0**
Onslow-Carteret	Brynn Marr Behavorial Health System	Onslow	30	0	30	10	20	0	0
	Total for Onslow-Carteret		**30**	**0**	**30**	**10**	**20**	**0**	**0**
Beacon Center	Wilson Memorial Hospital	Wilson	23	0	23	23	0	0	0
	Nash General Hospital	Nash	44	0	44	34	10	0	0
	Total for Beacon Center		**67**	**0**	**67**	**57**	**10**	**0**	**0**

Table 15A: Inventory Of Psychiatric Beds, Excluding State Hospitals

LOCAL MANAGEMENT ENTITY	HOSPITAL	COUNTY	LICENSED BEDS	CON-APPR BEDS (NOT LICENSED)	TOTAL BEDS	LICENSED BEDS FOR ADULTS	LICENSED BEDS FOR CHILD/ADOL	CON-APPR ADULT BEDS	CON-APPR CHILD/ADOL BEDS
East Carolina Behavioral Health	Craven Regional Medical Center	Craven	23	0	**23**	23	0	0	0
	Roanoke-Chowan Hospital	Hertford	28	0	**28**	28	0	0	0
	Pitt County Memorial Hospital	Pitt	52	0	**52**	42	10	0	0
	Beaufort County Hospital	Beaufort	22	0	**22**	22	0	0	0
	Total for East Carolina Beh.		**125**	0	**125**	**115**	**10**	**0**	**0**
Albemarle	No Facility		0	0	**0**	0	0	0	0
	Total for Albemarle		**0**	**0**	**0**	**0**	**0**	**0**	**0**
Eastpointe	Duplin General Hospital	Duplin	20	0	**20**	20	0	0	0
	Wayne Memorial Hospital	Wayne	61	0	**61**	41	20	0	0
	Total for Eastpointe		**81**	**0**	**81**	**61**	**20**	**0**	**0**
STATE TOTALS			**1,602**	**56**	**1,658**	**1,226**	**376**	**36**	**20**

(1) Holly Hill Hospital received a CON for relocating 44 existing psychiatric beds from Dorothea Dix Hospital effective on 8/14/2007. To be operational on January 1, 2009.

TABLE 15B: 2011 Projection of Psychiatric Bed Need By Local Management Entity

PART 1. PROJECTION OF CHILD/ADOLESCENT PSYCHIATRIC BED NEED FOR YEAR 2011

A LOCAL MANAGEMENT ENTITY (LME)	B 2007 <18 Days of Care	C 2007 <18 Population	D 2011 <18 Population Projected	E 2011:<18 Projected Days of Care (B x D)÷C	F 2011 Adjusted Days of Care E-20%E	G <18 Number of Beds (F ÷ 365)	H <18 Total Beds Needed (G ÷ 75%)	I Pyschiatric Bed Inventory Child/ Adolescent	Child/Adolescent Bed Need (Surplus/Deficit) (I - H) (Deficits are Shown as Minuses)
Smoky Mountain: Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, McDowell, Macon, Swain, Watauga, Wilkes	1,274	105,854	107,888	1,298	1,039	3	4	0	-4
Western Highlands: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey	904	104,247	107,548	933	746	2	3	9	6
Pathways: Cleveland, Gaston, Lincoln	2,365	88,991	89,637	2,382	1,906	5	7	20	13
Mental Health Partners: Catawba, Burke	802	57,944	58,683	812	650	2	2	38	36
Mecklenburg	7,992	222,663	250,110	8,977	7,182	20	26	42	16
Piedmont: Cabarrus, Davidson, Rowan, Stanly, Union	3,000	179,799	196,519	3,279	2,623	7	10	5	-5
Crossroads: Surry, Iredell, Yadkin	1,124	64,718	68,783	1,195	956	3	3	0	-3
CenterPoint: Forsyth, Stokes, Davie	2,037	103,919	108,209	2,121	1,697	5	6	66	60
A - C - R: Alamance, Caswell, Rockingham	1,316	60,399	61,376	1,337	1,070	3	4	8	4
Guilford	2,112	110,625	114,935	2,194	1,755	5	6	32	26
OPC: Orange, Person, Chatham	1,625	47,264	49,464	1,701	1,361	4	5	28	23
Durham	1,314	61,422	66,134	1,415	1,132	3	4	12	8
Five County: Vance, Granville, Franklin, Warren, Halifax	1,201	56,547	56,548	1,201	961	3	4	0	-4
Sandhills: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	2,522	131,740	137,069	2,624	2,099	6	8	0	-8
Southeastern Regional: Robeson, Bladen, Columbus, Scotland	1,152	67,562	66,869	1,140	912	2	3	0	-3
Cumberland	1,309	83,599	81,454	1,275	1,020	3	4	16	12
Johnston	990	42,078	47,625	1,121	896	2	3	0	-3
Wake	6,488	215,630	246,838	7,427	5,942	16	22	72	50
Southeastern Center: New Hanover, Brunswick, Pender	1,854	69,760	76,265	2,027	1,622	4	6	0	-6
Onslow - Carteret	1,731	53,210	53,254	1,732	1,386	4	5	20	15
Beacon Center: Edgecombe, Nash, Wilson, Greene	1,386	60,773	60,240	1,374	1,099	3	4	10	6
East Carolina Behavioral Health: Beaufort, Bertie, Craven, Gates, Hertford, Jones, Pamlico, Pitt, Northampton	1,892	91,136	92,543	1,921	1,537	4	6	10	4
Albemarle: Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington	686	40,718	42,330	713	571	2	2	0	-2
Eastpointe: Duplin, Lenoir, Sampson, Wayne	1,587	74,178	75,099	1,607	1,285	4	5	20	15
CHILD/ADOLESCENT STATE TOTALS	48,663	2,194,776	2,315,420	51,807	41,445	114	151	408	

TABLE 15B: 2011 Projection of Psychiatric Bed Need By Local Management Entity (LME)

PART 2. PROJECTION OF ADULT PSYCHIATRIC BED NEED FOR YEAR 2011

LOCAL MANAGEMENT ENTITY	K 2007 18+ Days of Care	L 2007 18+ Population	M 2011 18+ Population Projected	N 2011:18+ Projected Days of Care (K x M)÷L	O Number of Beds Adults (N÷365)	P Total Adult Beds Needed (O ÷ 75%)	Q Adult Bed Inventory	Adult Bed (Surplus/ Deficit) (Q-P) (Deficits are Shown as Minuses)
Smoky Mountain: Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, McDowell, Macon, Swain, Watauga, Wilkes	11,937	408,502	421,946	12,330	34	45	0	
2008 SMFP Need Determination for 10 Adult Beds							10	-35
Western Highlands: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey	14,963	391,492	410,756	15,699	43	57	134	77
Pathways: Cleveland, Gaston, Lincoln	14,858	282,014	295,593	15,573	43	57	57	0
Mental Health Partners: Catawba, Burke	9,751	184,003	190,144	10,076	28	37	106	69
Mecklenburg	20,305	640,172	717,791	22,767	62	83	84	1
Piedmont: Cabarrus, Davidson, Rowan, Stanly, Union	14,499	518,875	569,109	15,903	44	58	63	5
Crossroads: Surry, Iredell, Yadkin	7,172	196,701	211,903	7,726	21	28	16	
2007 SMFP Need Determination for 12 Adult Beds							12	0
CenterPoint: Forsyth, Stokes, Davie	13,158	321,285	341,253	13,976	38	51	104	53
A - C - R: Alamance, Caswell, Rockingham	7,005	197,858	204,012	7,223	20	26	36	10
Guilford	13,463	350,159	372,392	14,318	39	52	72	20
OPC: Orange, Person, Chatham	6,675	176,921	187,363	7,069	19	26	48	22
Durham	5,792	193,166	206,217	6,183	17	23	42	19
Five County: Vance, Granville, Franklin, Warren, Halifax	9,009	174,462	181,449	9,370	26	34	20	-14
Sandhills: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	13,742	396,875	421,267	14,587	40	53	60	7
Southeastern Regional: Robeson, Bladen, Columbus, Scotland	7,531	185,468	189,756	7,705	21	28	33	5
Cumberland	5,293	230,001	237,712	5,470	15	20	12	-8
Johnston	5,084	115,189	130,469	5,758	16	21	20	-1
Wake	16,082	617,245	711,516	18,538	51	68	52	-16
Southeastern Center: New Hanover, Brunswick, Pender	11,152	269,812	303,142	12,530	34	46	62	16
Onslow - Carteret	5,653	179,560	187,994	5,919	16	22	10	-12
Beacon Center: Edgecombe, Nash, Wilson, Greene	8,503	183,068	187,944	8,729	24	32	57	25
East Carolina Behavioral Health: Beaufort, Bertie, Craven, Gates, Hertford, Jones, Pamlico, Pitt, Northampton	20,051	303,383	317,529	20,986	57	77	115	38
Albemarle: Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington	4,376	141,997	149,912	4,620	13	17	0	-17
Eastpointe: Duplin, Lenoir, Sampson, Wayne	10,261	216,386	221,227	10,491	29	38	61	23
ADULT STATE TOTALS	**256,315**	**6,874,594**	**7,368,396**	**273,546**	**749**	**999**	**1,286**	

Table 15C (1): 2011 Need Determination For Adult Psychiatric Inpatient Beds

HSA	Local Management Entity (LME) and Counties	Adult Psychiatric Bed Need Determination*	CON Application Due Date	CON Beginning Review Date
I	Smoky Mountain: Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, McDowell, Macon, Swain, Watauga, Wilkes	35	To be determined	To be determined
IV,VI	Five County: Vance, Granville, Franklin, Warren, Halifax	14	To be determined	To be determined
V	Cumberland	8	To be determined	To be determined
IV	Johnston	1	To be determined	To be determined
IV	Wake	16	To be determined	To be determined
VI	Onslow -Carteret	12	To be determined	To be determined
VI	Albemarle: Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington	17	To be determined	To be determined
It is determined that there is no need for additional Adult Psychiatric Inpatient Beds anywhere else in the State.				

Need determinations as shown in this document may be increased or decreased during the year pursuant to Policy GEN-2 (See Chapter 4).

Application Due Dates are absolute deadlines. The filing deadline is 5:30 p.m. on the Application Due Date. The filing deadline is absolute (See Chapter 3).

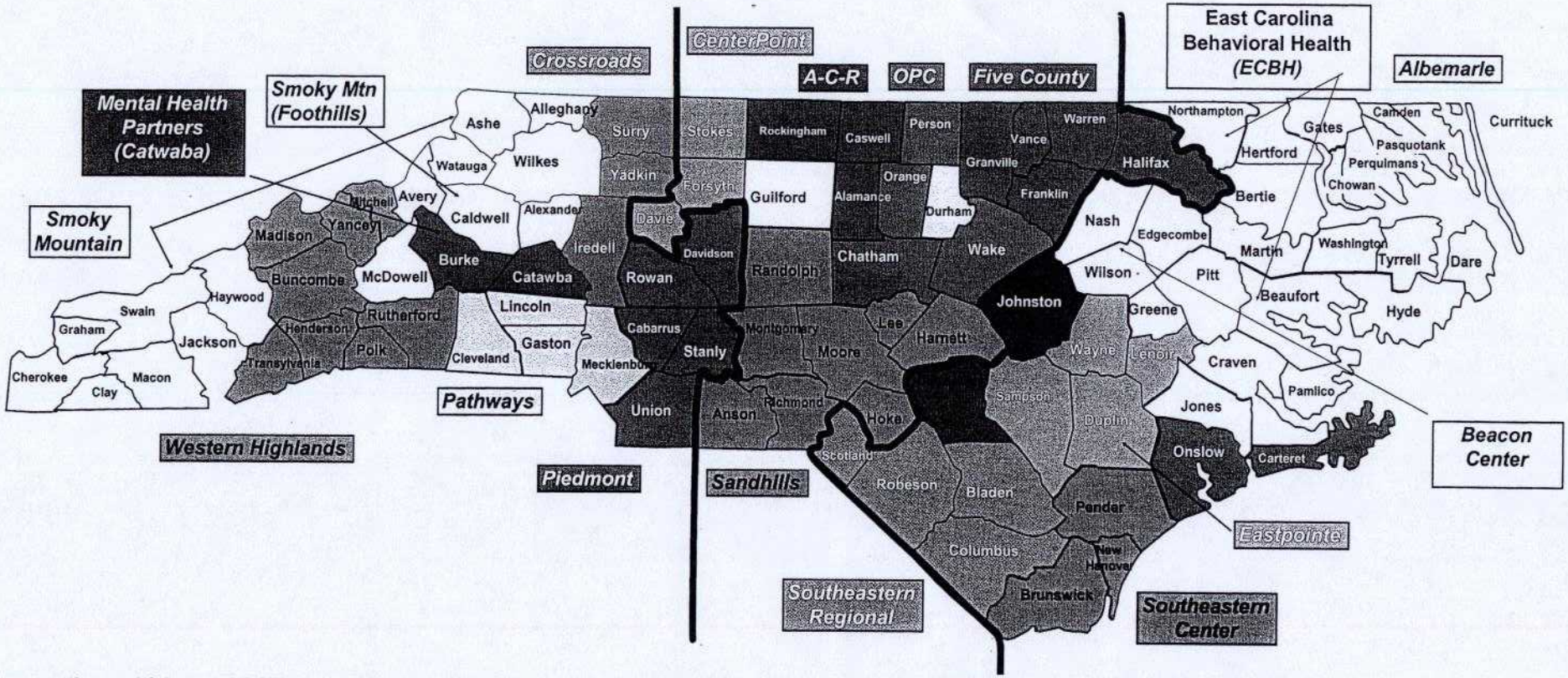
Table 15C (2): 2011 Need Determination For Child/Adolescent Psychiatric Inpatient Beds

HSA	Local Management Entity (LME) and Counties	Child/Adolescent Psychiatric Bed Need Determination*	CON Application Due Date	CON Beginning Review Date
I	Smoky Mountain: Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, McDowell, Macon, Swain, Watauga, Wilkes	4	To be determined	To be determined
II, III	Piedmont: Cabarrus, Davidson, Rowan, Stanly, Union	5	To be determined	To be determined
II, III	Crossroads: Surry, Iredell, Yadkin	3	To be determined	To be determined
IV, VI	Five County: Vance, Granville, Franklin, Warren, Halifax	4	To be determined	To be determined
II, IV, V	Sandhills: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	8	To be determined	To be determined
V	Southeastern Regional: Robeson, Bladen, Columbus, Scotland	3	To be determined	To be determined
IV	Johnston	3	To be determined	To be determined
V	Southeastern Center: New Hanover, Brunswick, Pender	6	To be determined	To be determined
VI	Albemarle: Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington	2	To be determined	To be determined
It is determined that there is no need for additional Child/Adolescent Psychiatric Inpatient Beds anywhere else in the State.				

Need determinations as shown in this document may be increased or decreased during the year pursuant to Policy GEN-2 (See Chapter 4).

Application Due Dates are absolute deadlines. The filing deadline is 5:30 p.m. on the Application Due Date. The filing deadline is absolute (See Chapter 3).

Local Management Entities (LMEs)
Regions by Counties --- July 2008



The counties within an LME share the same color. Unless otherwise indicated, the LME name is the county name(s).

Dick Oliver, LME Team Leader 919-715-1294

LME TEAM MEMBERS: Lisa Jackson - Raleigh Office based.

Wester Region Team Members:

Bill Bullington	Julia Sinclair	**PBH assigned
(828) 226-3632	(919) 715-1294	to Ken Marsh
Catawba Western Highlands	Crossroad - Mecklenburg Foothills - Smoky Pathways - Guilford	PBH

Central Region Team Members:

Mark O'Donnell	Ken Marsh	Yvonne French
(919) 218-7832	(252) 492-6971	919-218-6892
Five County Centerpoint	Sandhills Wake PBH	ACR OPC Durham

Eastern Region Team Members:

Rose Burnette	Marie Kelley	Mabel McGlothlen	Beverly Bell
(252) 355-9032	(919) 218-5950	(919) 218-1953	(919) 218-4820
Albemarle ECBH	Beacon Ctr Eastpointe SE Center	Johnston Onslow-Carteret SER	Cumberland

Long-Term Care and Behavioral Health Committee
Policy PSY-2 Petition
Regarding the Proposed 2009 SMFP
For the Final 2009 SMFP

Agency Analysis:

Petitioner:
Crossroads Behavioral Healthcare
Elkin, NC 28621

Request

The petitioner requests that the State Health Coordinating Council:

1) Modify the proposed language in the 2009 State Medical Facilities Plan to require new psychiatric beds to be designated involuntary if the Local Management Entity (LME) needs beds for involuntary admissions; and,
2) Prohibit the conversion of skilled care beds to psychiatric beds, and retain the provision requiring the conversion of excess licensed acute care beds to inpatient psychiatric beds.

The petitioner further requests that Chapter 4, Statement of Policies, Mental Health, Developmental Disabilities, and Substance Abuse (General), 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."*

Background Information

Request #1:

The petitioner requests that instead of deleting Policy Psy-2 from the 2009 SMFP the Policy should be revised to include provisions for designation of beds for involuntary admissions when the LME determines a need for beds for this purpose. However, this revision constitutes the development of a new policy not a reinstatement of the policy that is proposed to be deleted. The Policy proposed to be deleted reads as follows:

"POLICY PSY-2: ALLOCATION OF PSYCHIATRIC BEDS

A hospital submitting a Certificate of Need application to add inpatient psychiatric beds shall convert excess licensed acute care beds to psychiatric beds. In determining excess licensed acute care beds, the hospital shall subtract the average occupancy rate for its licensed acute care beds (adjusted for any CON-approved deletions) over the previous 12-month period from the appropriate target occupancy rate of acute care beds listed in Policy AC-4 and multiply the

percentage difference by the number of its existing licensed acute care beds, then subtract from the result the number of approved new acute care beds which are pending development."

Request #2:
The petitioner, in the discussion about prohibiting conversion of skilled care beds to psychiatric beds, states *" 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."* However, the Agency notes that the appeal referenced by the petitioner has not been "dropped" and litigation for the 12 psychiatric beds is still pending. Thus, the SMFP cannot be adjusted at this time. As background regarding the application referenced by the petitioner, on May 15, 2007, Davis Regional Medical Center filed a CON application for 12 psychiatric beds identified as needed in the 2007 SMFP. [Note: The need determination was based on approval of a petition for a special need determination.] On September 13, 2007, the application was denied by the CON Section for a multitude of reasons. One of the reasons for denial was failure of the project to conform to Criterion (1) because it did not conform to Policy PSY-2 for the reason that the hospital proposed to convert nursing facility beds instead of acute care beds. Additionally, the application did not conform to Criterion (3a) because the hospital did not demonstrate that the needs of the persons served in the skilled nursing facility beds would be adequately met if the skilled nursing beds were eliminated. There were also numerous other reasons for the denial.

Davis Regional Medical Center appealed the denial of its application and Iredell Memorial Hospital intervened in the appeal. To date, the appeal has not been dropped but is still pending a resolution. Depending on how Davis Regional Medical Center decides to resolve the appeal, the psychiatric beds may or may not be reallocated. If Davis Regional Medical Center chooses to completely dismiss its appeal, the psychiatric beds would be reallocated in accordance with Policy Gen-1: Reallocations. In that case, a person submitting a CON application for the reallocated beds would be required to comply with the policies in the SMFP that is in effect on the date the new review begins for the reallocated beds.

Analysis/Implications

Request #1:
The petitioner, Crossroads Behavioral Health, is a Local Managing Entity (LME) 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. The petitioner explains that patients with significant mental illness depend upon Crossroads to assemble a complex network of inpatient and outpatient care to meet their needs. Many patients and their families 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.

The petitioner reports that 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. Because no hospital in Service Area 8 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. The petitioner summarizes by stating that the petition should be granted in response to their analysis of the number of patients presenting at local emergency rooms for acute mental health services, and referred for involuntary commitment, and the absence of local involuntary beds to meet those needs in the Service Area 8.

However, the petitioner requests the development of a policy concerning an issue that is not currently addressed in policies in the 2008 or Proposed 2009 SMFP and that if approved would have a statewide effect. Although the Agency recognizes involuntary admissions is a pressing issue in Iredell County and potentially an issue in other counties in the State, the process for submitting petitions for policy changes is set forth in Chapter 2 of the 2008 SMFP and states:

"People who wish to recommend changes that may have a statewide effect are asked to contact the Medical Facilities Planning staff as early in the year as possible, and to submit petitions no later than March 5, 2008. Changes with the potential for a statewide effect are the addition, deletion, and revision of policies and revision of the projection methodologies. These types of changes will need to be considered in the first four months of the calendar year as the "Proposed SMFP" ... is being developed."

Thus, the deadline for submittal of recommendations regarding policy changes for inclusion in the Proposed 2009 SMFP was March 5, 2008 in order that persons across the State would have an opportunity to review and comment on the proposed policy changes that could affect them. Consequently, the petitioner's request would be appropriate for consideration in the spring of 2009 for possible inclusion in the Proposed 2010 SMFP. At that time, other options to address the issue of involuntary admissions could be considered and evaluated in the review of the petitioner's recommendation, such as developing a definition of a qualified applicant for psychiatric beds or revising Policy MH-1.

Request #2:

With regard to the petitioner's request to prohibit the conversion of skilled care beds to psychiatric beds, the Agency believes retaining the requirement that only excess acute care beds shall be converted to psychiatric beds unnecessarily limits options for development of needed psychiatric beds. The situation in Iredell County may support such a request; however, this may not be the same situation in all other areas of the State. In other words, there may be skilled nursing beds in hospitals in other counties that are underutilized and no longer needed that a hospital may wish to convert to psychiatric beds. Also, it may be more feasible in some counties to convert underutilized substance abuse or rehabilitation beds, as opposed to underutilized acute care beds. Because service needs and the types of underutilized beds may vary from county to county, prescribing that an application for a psychiatric bed need determination may only be approved if excess acute care beds are converted may prevent the development of needed psychiatric beds when a hospital wants to retain its acute care beds and convert other beds instead. Therefore, the Agency supports deleting Policy PSY-2, as it is written in the 2008 SMFP, in order to reduce restrictions on the types of beds that must be converted to develop psychiatric beds identified as needed in the SMFP. This change will increase opportunities for development of the need determinations for inpatient psychiatric beds.

[Note: If a hospital wants to convert acute care beds to psychiatric beds, the project could be exempt from certificate of need review if it contracts with the LME in accordance with NCGS 131E-184(d). Thus, a hospital does not need to apply for a certificate of need to develop the psychiatric beds identified as needed in the SMFP if it decides to convert acute care beds pursuant to the exemption in the CON Law.]

As for the petitioner's concern that allowing hospitals to convert skilled nursing beds would eliminate another source of care for mental health patients, the petitioner does not appear to be aware of the other criteria in the Certificate of Need Law that are applied to the review of a project. In particular, Criterion (3a) states:

"In the case of a reduction or elimination of a service, including the relocation of a facility or services, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care."

Therefore, when a hospital proposes to convert skilled nursing beds to psychiatric beds, it is required to document that the needs of the patients currently receiving skilled nursing care will continue to be adequately met after the elimination the skilled nursing beds. If the hospital cannot demonstrate that persons will continue to be able to receive needed health services, then the application will not be conforming to Criterion (3a) and will be denied. Thus, the petitioner's concern related to taking into consideration the loss of a source of care for patients is already an issue evaluated in the review of a project, because it is addressed in another review criterion contained in the CON Law.

Agency Recommendation

The Agency recommends denial of the petition for the following reasons:
1. The development of a policy that requires new psychiatric beds to be designated for involuntary admissions through a letter of agreement with the LME is a proposed new policy that would have a statewide effect. Therefore, in accordance with procedures set forth in Chapter 2 of the SMFP, it has not been timely filed for inclusion in the 2009 SMFP. Consequently, the Agency recommends the petitioner's request regarding involuntary admissions be considered in the spring of 2009 for inclusion in the next proposed SMFP.

2. Policy Psy-2 in the 2008 SMFP requires new psychiatric beds be developed only if excess acute care beds are converted. The SHCC approved to delete this policy from inclusion in the Proposed 2009 SMFP. The Agency recommends that this Policy should not be reinstated in the 2009 SMFP because it limits the options that can be used to develop need determinations for inpatient psychiatric beds.

CROSS ROADS BEHAVIORAL HEALTHCARE
200 Elkin Business Park Drive Elkin, NC 28621 (336) 835-1000

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:

Name	Crossroads Behavioral Healthcare
Address	200 Elkin Business Park Drive Elkin, North Carolina 28621
Phone	(336) 835-1001, extension 1104

DFS Health Planning
RECEIVED
JUL 30 2008
Medical Facilities
Planning Section

Contact:

Name	David R. Swann, Chief Executive Officer
Phone	336.835.1001, extension 1104
Email	dswann@crossroadsbhc.org

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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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

Subject: Petition from Crossroads Behavioral Healthcare regarding Changes to Criteria for Licensing of New Psychiatric Beds in Community Hospitals
From: "Nancy M. Lane" <nlane@pda-inc.net>
Date: Tue, 9 Sep 2008 16:17:34 -0400
To: "'Carol G. Potter'" <Carol.Potter@ncmail.net>
CC: "'Laura Easton'" <leaston@caldwell-mem.org>

DFS Health Planning
RECEIVED
SEP 09 2008
Medical Facilities
Planning Section

Dear Ms. Potter

On behalf of Laura Easton, President, Caldwell Memorial Hospital, Lenoir, North Carolina, please accept the following comments on the petition from Crossroads Behavioral Healthcare for a policy favoring psychiatric beds licensed to accept involuntary admissions.

Caldwell Memorial too faces long delays finding beds for psychiatric inpatients who require involuntary admission. It is not unusual for a person to stay in the emergency room for two or three days, while we search for beds across the state. During this time, the person requires continuous direct staff attention . Caring for high-need patients in this way is very costly for the community hospital, and does not provide the individual in question with the best possible care.

Caldwell joins with others in urging the State Health Coordinating Council to take advantage of this one-time opportunity to increase access to psychiatric beds that are designed and licensed to accept involuntary admissions. A policy like the one proposed gives Local Management Entities in areas that are adequately served the flexibility to waive the requirement, and it encourages providers who are willing to provide this important service.

Thank you for your time and serious consideration.

Regards,
Nancy M. Lane

PDA, Inc.
2016 Cameron Street
PO Box 12844
Raleigh, North Carolina 27605
919-754-0303
919-754-0328 FAX
For
Laura Easton, President
Caldwell Memorial Hospital
321 Mulberry Street, SW | Lenoir, NC 28645
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DAVIS REGIONAL MEDICAL CENTER

DFS Health Planning
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SEP 09 2008
Medical Facilities
Planning Section

August 13, 2008

Ms. Carol Potter, Medical Facilities Planning Section
Long-Term and Behavioral Health Committee
701 Barbour Drive
Raleigh, NC 27626

Re: Petition on the *Proposed 2009 SMFP* requesting the addition of Policy PSY-2

Dear Ms. Potter:

This letter is in response to a petition filed by Crossroads Behavioral Healthcare (Crossroads) requesting the addition of a new policy, PSY-2, which would require applicants for a certificate of need to develop inpatient psychiatric beds to "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." Davis Regional Medical Center (DRMC), the only provider of inpatient psychiatric care in Area 8, opposes this petition for several reasons, which are presented in this letter.

Background

Davis Regional Medical Center (DRMC) is the only provider of inpatient psychiatric care in Area 8 (which includes Surry, Yadkin and Iredell counties). As shown in Table 15B in the *Proposed 2009 SMFP*, this area is projected to need a total of 28 adult inpatient psychiatric beds by 2011; however, DRMC only operates 16 beds, resulting in a deficit of 12 beds. This bed need determination is being suppressed, however, based on the *2007 SMFP* need determination for 12 beds. In 2006, Davis Regional Medical Center (DRMC), in discussions with its psychiatrists and other medical staff members, foresaw the need for these beds, and petitioned the SHCC for 12 additional adult inpatient psychiatric beds. The SHCC approved DRMC's petition, resulting in the allocation of 12 beds in the *2007 SMFP*.

DRMC proposed to develop the 12 additional beds to support the increasing utilization of its existing 16 beds (CON Project ID# F-7869-07). The new beds would be located in space currently occupied by skilled nursing beds, which would be taken out of service.

Although DRMC's CON application was denied, the primary reason for its denial was the existence of Policy PSY-2, which required DRMC to convert "excess" acute care beds in order to be approved. While DRMC did not propose to convert acute care beds (particularly given that it has an approved CON, Project ID# F-7392-05, to transfer 18 acute care beds to its sister hospital in the county), it believes that proposing to develop the 12 additional psychiatric beds in existing skilled nursing space is a more effective use of resources, rather than constructing new space for the beds. However, because of the strict language of Policy PSY-2 in the *2007 SMFP*, the CON Section was unable to consider the approved transfer of the 18 beds in calculating "excess" beds. Please note that for the *2008 SMFP*, Policy PSY-2 was revised to allow the CON Section to consider approved transfers in its calculation and the *Proposed 2009 SMFP* reflects the deletion of the policy in its entirety.

DRMC's Concern with the Petition

Based on a review of the language of the Petitioner's proposed policy, it is clear that the language is narrowly tailored in such a way as to essentially control the manner in which additional inpatient psychiatric beds may be proposed to be added at DRMC and be approvable by the CON Section. This reading of the proposed policy is further strengthened when viewed in conjunction with the comments given at the public hearing on the *Proposed 2009 SMFP* in Charlotte by Iredell Memorial Hospital, which also opposed the approval of DRMC's CON application for more psychiatric beds, in part on the basis that DRMC did not propose expanding its service to admit involuntary patients and that DRMC proposed to delicense skilled nursing beds. It is clear from the petition that its proposed changes are identical to the comments it raised regarding DRMC's CON application.

If the petition is approved as proposed, it will be unfairly prejudicial to DRMC and other facilities with similar situations. In order to be approved for more beds, DRMC would be required to begin admitting involuntary patients and propose a different space for the new beds, possibly even newly-constructed space. DRMC maintains that its project as proposed was consistent with the three Basic Principles governing the *State Medical Facilities Plan*. The proposed project promoted cost effective approaches by limiting the amount of construction dollars spent, expanded health care services to the medically

underserved by developing new psychiatric beds[1] with a new inpatient geriatric psychiatry component, and it encouraged quality health care services by providing the level of services appropriate for a hospital of its size and nature. DRMC believes Crossroads' petition unfairly singles out its proposal.

Further, DRMC believes that requiring LME approval of each inpatient psychiatric proposal across the state will limit the autonomy of private providers and undermine the CON process. Although Crossroads has done a fine job working in the new LME system, the extension LME oversight into the CON process seems to be outside of their jurisdiction. Further, Policy MH-1 currently requires an applicant to contact the affected LME and invite the organization to comment on the proposed project. The proposed policy would be duplicative.

In particular, DRMC disagrees with the statements made by the Petitioner regarding the need for hospital-based skilled nursing units in the psychiatric care continuum. DRMC does not care for Alzheimer's or dementia patients in its skilled nursing beds, and it does not believe that this is the most appropriate location for these patients. Hospital-based skilled nursing units represent less than five percent of skilled nursing capacity in North Carolina (1,998 hospital-based beds versus 42,236 beds in freestanding facilities).[2] This is down from approximately seven percent of North Carolina's skilled nursing capacity in the *1999 SMFP*. In 2005, Academy Health examined the effects of hospital-based skilled nursing unit closures on health care utilization, spending and outcomes for Medicare fee-for-service beneficiaries. Although closures obviously changed utilization patterns, it did not adversely impact patient outcomes.[3]

Since the Balanced Budget Act of 1997 significantly curtailed reimbursement to hospital-based skilled nursing units, the number of these units has declined nationally. In order to be admitted to a hospital-based skilled nursing unit, patients must have been discharged from an acute care hospital, then admitted to a hospital-based skilled nursing unit. Thus, unless the patient with a behavioral health issue, such as Alzheimer's or dementia, first needed acute care services, he or she would not be eligible for hospital-based skilled nursing. Moreover, hospital-based units are appropriate for short-term patients, not the longer stays associated with Alzheimer's and dementia patients. In fact, according to IMH's website regarding its hospital-based skilled nursing unit, "[o]ur 48-bed unit is specially staffed to provide transitional short-term care for elderly patients who

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1 Crossroads' petition demonstrates that psychiatric patients in the service area are underserved and DRMC proposed to expand bed capacity for these patients.

2 *Proposed 2009 SMFP*

3 What Happens When Hospital-based Skilled Nursing Facilities Close?: A Propensity Score Analysis, *Available at* http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=103623268.html.

are not ill enough to require acute care, yet who are too sick to be placed in a freestanding skilled nursing home or to return home."[4] Clearly, this type of care is not appropriate for patients with long-term issues such as Alzheimer's or dementia.

In addition, DRMC agrees with Crossroads that a great need for additional mental health services exists in the region and further agrees that there is a need for involuntary services. However, DRMC does not believe that this is the appropriate venue, nor the appropriate manner, to pursue the addition of involuntary services to the region. DRMC does not believe that requiring facilities to begin taking involuntary admissions through the CON process is reasonable, practical or realistic, for the following reasons:

1. The *SMFP* has **never** distinguished between inpatient beds for voluntary versus involuntary admissions. To develop a policy requiring applicants to admit involuntary patients would be a significant departure from the current methodology for additional inpatient psychiatric beds, which does not address the need based on voluntary versus involuntary patients. Currently, the methodology is based on all inpatient psychiatric admissions, however the proposed petition would base need primarily on a *disease-based* methodology rather than a *utilization-based* methodology.
2. Placing policy restrictions on the inpatient psychiatric beds need determination creates a slippery slope which may have severe implications on other reviewable services. For example, the proposed policy sets a precedence for the approval of policy changes that would require that acute care beds could only be awarded to facilities which provide obstetrics services or that operating rooms could only be awarded to facilities which provided neurosurgery. In both cases, the provision of services is largely based on the availability of physician resources.
3. The proposed policy limits providers who are able to provide necessary entry level services from doing so without providing more intensive crisis services. DRMC and its psychiatrists believe that voluntary services are necessary to the community and prevent patients from needing involuntary services in later stages of disease progression. Further, there is an immediate need for voluntary services in the service area. The proposed policy would limit providers from providing necessary basic services unless they had physician and facility support to serve "tertiary" patients as well. The logical extension of Crossroads' requirement applied to other services, such as cardiac catheterization would be to require all hospitals with cardiac catheterization equipment to provide open heart services. The SHCC and DHSR know that this is not the most appropriate

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4 http://www.iredellmemorial.org/centers.aspx?id=53

way to create a cost-effective health system. In addition, it is better to provide basic services close to home, when the alternative is providing no services at all.

4. Although the petition and comments imply that DRMC simply refuses to begin admitting involuntary patients, this implication is untrue. As the only provider of inpatient psychiatric care in the service area, DRMC is well-aware of the need for involuntary care and supports the Petitioner's arguments about the need for services in the area. Contrary to the Petitioner's insinuation, DRMC's choice to admit only voluntary patients (and likely the choice of the other providers in North Carolina who do not admit involuntary patients) is not motivated by financial pressures. In many cases, involuntary patients have a payor source and are able to pay for services; thus, the decision not to admit involuntary patients is not driven by financial concerns. Conversely, some voluntary patients may not have a payor source. As such, no facility would have a reason to provide voluntary services over involuntary services since both patient types have similar payor mixes. Rather, DRMC did not propose to begin admitting involuntary patients for the following reasons:
    a. Neither its existing unit nor the proposed unit would have been configured appropriately to care for involuntary patients. Historically, DRMC has not accepted involuntary admissions due to the size and configuration of its unit. DRMC's psychiatric unit was not designed to be a freestanding unit at the facility, but was developed in existing space three years after the original facility was constructed. As such, the existing unit at DRMC consists of a single hallway with four private and six semi-private rooms. This leaves no method of separating high acuity involuntary patients from low acuity voluntary patients. In the medical center's 2007 CON application DRMC proposed to renovate an existing skilled nursing unit to develop 12 additional inpatient psychiatric beds. The proposed unit had a similar hallway configuration to the original unit with eight private and two semi-private rooms. DRMC's primary concern on its psychiatric unit is providing an environment that is safe and conducive to healing. When high-acuity patients, who are often violent, verbally aggressive and high flight risks enter DRMC's small unit they pose a threat to other patients' abilities to benefit from DRMC's psychiatric program. The convergence of voluntary and involuntary patients in such a confined space often detracts from the healing environment.
    b. DRMC based the need for additional beds in its CON application on the growth of its existing service, which does not admit involuntary patients. Thus, it believes the volume of voluntary admissions can support the additional 12 beds that were proposed.

As stated previously, DRMC and its psychiatrists believe that voluntary services are essential to the prevention of involuntary admissions.

c. Perhaps most importantly, ***DRMC cannot and will not in the future admit involuntary patients because its psychiatrists will not admit involuntary patients***. This point is essential to understand. Without physician support, DRMC could propose to admit only involuntary patients, but no physicians would be available to treat them. Surely the DHSR and the SHCC are well-aware that psychiatrists are one of the most difficult specialists to recruit. DRMC believes that it can more effectively recruit additional psychiatrists if they are not required to admit involuntary patients. Even if DRMC were to propose to develop a unit which supported the admission of involuntary patients, those patients would continue to be transferred elsewhere due to the unavailability of physicians to admit those patients.

During settlement discussions following the appeal of Project ID # F-7869-07, DRMC offered to work with Iredell Memorial Hospital (IMH), one of the commenters and another hospital in Service Area 8, to jointly recruit a psychiatrist to admit and care for involuntary admissions; however, that offer was rejected. DRMC believes this demonstrates the medical center's commitment to serving involuntary patients and its attempt to work with community leaders to do so. It is not proper for IMH and Crossroads to use the petition process to their advantage to strong-arm DRMC into taking involuntary patients, even though DRMC does not have the physician or facility resources to care for these patients. As DRMC said in its response to comments, the 2001 legislation which created the local management entity system was intended to enhance collaboration between providers, not to force single providers into providing services they are incapable of providing for an entire market of providers unwilling to provide the services themselves.

In summary, DRMC believes that the proposed petition should be disapproved for the following reasons:

1. The need for skilled nursing beds should not be intertwined with the need for inpatient psychiatric services.
2. The proposed policy has long term implications on the *SMFP* methodology for inpatient psychiatric services.
3. The proposed policy has negative implications for need determinations for other services.
4. The proposed policy undermines facilities that are able to provide basic primary care services and results in no inpatient services.

Thank you for the opportunity to comment on this petition, and please feel free to contact me if you have questions.

Sincerely,

Karen Metz

Karen Metz
Chief Executive Officer