Atrium Health

May 6, 2020

Ms. Valerie Jarvis, RN/BSN, Chair
Long-Term and Behavioral Health Committee
North Carolina State Health Coordinating Council
DHSR.SMFP.Petitions-Comments@dhhs.nc.gov

Re: **Atrium Health Comments/Inpatient Psychiatric Bed Need Methodologies**

Dear Ms. Jarvis and members of the Committee:

Atrium Health appreciates the opportunity to provide comments on the inpatient psychiatric bed need methodologies for adults and children/adolescents. These methodologies were established around 35 years ago and have not been updated to reflect changes in the medical, behavioral health and reimbursement environments. We think the current methodology does not accurately reflect the need for additional inpatient psychiatric beds in the state, specifically in the urban areas of the state. We offer these observations and suggestions for consideration by the members of the Long-Term and Behavioral Health committee of the State Health Coordinating Council.

The current bed need methodology assumes all licensed beds are operational. There are many beds across the state not currently operational for a variety of reasons. Even in locations with all beds operational there is wide variation in the utilization rates of the beds. The utilization numbers for the existing licensed inpatient psychiatric beds appears surprisingly low given the high rate of ED boarding experienced across the state. At Atrium Health our inpatient psychiatry beds in the Charlotte region are utilized at a rate of 95-97% occupancy.

Factors contributing to low bed availability and lower utilization include:

- Provider shortages – there is a significant national shortage of psychiatrists and the areas most impacted by this shortage are rural communities. The ability of hospitals to open and utilize beds is directly linked to availability of a psychiatrist.

- Environment of Care – extensive changes to ligature risk requirements were issued by the Centers for Medicare and Medicaid Services (CMS) and embraced by The Joint Commission in 2019. These new guidelines required significant investments in the physical plant and environment of care to comply. In many instances the required investment was more than some community hospitals could invest considering the low

rate of reimbursement for inpatient psychiatric care. Beds may be closed across the state due to not being able to meet the new CMS guidelines for ligature risk reduction.

- Population and acuity of patients waiting for placement – the patients with typically long stays in our emergency departments are typically in one of the following groups:
  - Geriatric – there is no geriatric psych bed designation in the bed licensing methodology. Geriatric patients are at high risk when placed into a population of highly aggressive patients with psychosis and therefore hospitals defer those placements.
  - Child and Adolescent – While the SMFP does recognize this population with its own methodology, the provider shortage is uniquely impactful for Child and Adolescent Psychiatry and the ability to recruit a Child and Adolescent Psychiatrist outside urban markets is negligible.
  - High Acuity patients with psychosis related illnesses – when the state hospital system abruptly stopped admitting patients for short term stabilization the remaining providers in the state were left with a population in our acute care emergency rooms that inpatient psychiatric units were unprepared to manage. Very few inpatient psychiatric units in the state are willing to accept patients who with violent or sexual aggression tendencies. Many units do not have adequate staff or an adequate environment of care to manage these patients safely.
  - Intellectual and Developmental Disability – this patient population is showing up in acute care emergency rooms at an increasing rate due to lack of community services for these patients. The community infrastructure was stripped away with the LME/MCO implementation and has left this population adversely impacted. These patients rarely meet criteria for inpatient care and do not require hospitalization, yet they are sitting in emergency rooms across the state.

- Network Adequacy-Hospitals who are willing to accept some of the higher acuity patients or patients without a payer source are impacted by lack of adequate community resources to ensure a safe discharge. On the campus of Atrium Health Behavioral Health Charlotte, a facility of Carolinas Medical Center, we care for the highest acuity population of inpatients. The length of stay on that campus is averaging 18 days for adults, when the remainder of the country averages 8-10 days for inpatient psychiatry length of stay. A significant driver of length of stay is inadequacy of the local networks of community providers and social services. If we were to address network adequacy and supports for youth and family services, the need for additional beds in this state may be negligible.

It is likely that some communities will still experience a shortage of available inpatient psychiatric beds no matter what changes are made in the methodology. These problems will persist and continue to impact the rate at which new beds are opened.

On April 21, 2020, the DHSR Planning Section released a slide deck of issues and ideas to consider related to the inpatient psychiatric bed need methodology and requesting feedback

from the provider community. Atrium Health offers the following comments in response to the questions raised in the slide deck.

Need for More Beds

On slide 8 of the deck the question is asked if North Carolina needs additional inpatient psychiatric beds. Atrium Health absolutely believes there is a need for additional inpatient psychiatric beds in the state. The biggest problem is in the location of the existing beds. Some counties and service areas are very highly utilized while others are chronically underutilized.

Options to Change the Need Methodology

The slide deck proposed several options for changing the inpatient psychiatric bed need methodology. These proposed options included:

1. changing the service area,
2. changing the basis for calculating need,
3. eliminate the mathematical need methodology,
4. keep everything status quo

Atrium Health supports Option 3, the elimination of a mathematical need methodology, as proposed on slide 20 of the slide deck. This option will still maintain DHSR oversight of the service through the requirement to file CON applications to add beds, but it will give providers who see a need for more beds the opportunity to add beds.

If the SHCC believes a mathematical methodology should be maintained the only option Atrium Health is completely opposed to is the status quo. We propose the SHCC could consider the methodology changes detailed below.

Option 1: Change the Service Area

Atrium Health would recommend using HSAs as the service area for inpatient psychiatric bed need methodology. The current LME-MCO service areas were set up as a result of reimbursement mechanisms and infrastructure. The LME-MCO areas are not always geographically connected and they do not match normal patient referral and travel patterns.

Option 2: Change the Basis for Calculating Utilization

The current methodology also focuses on the county of residence for the patients within the LME-MCO service areas. Atrium Health would propose the SHCC consider changing to a methodology based on the location of the facility rather than the patient.

Other Ideas to Consider

Atrium Health would also recommend the SHCC assess the variation in utilization of existing beds and consider adjustments to the inventory. There are providers who currently have extremely low levels of utilization. Under the current methodology the need for new beds is restricted by facilities with low utilization. While this might be reasonable in small service areas,

in the current large LME-MCO service areas the underutilized beds may be nearly 200 miles away. The SHCC should consider a measure to deal with chronically underutilized facilities. One option would be to consider eliminating chronically underutilized beds from the inventory as was done in the prior version of the operating room methodology.

It is also important that we try to assess the true need for beds by working to capture all patients in need of inpatient psychiatric care. Many patients are held in EDs while waiting for placement in an inpatient psychiatric facility. Even when patients are moved to a bed in a general acute care hospital they are often classified as observation patients. Many times, these patients are never converted to inpatients. These patients can remain in observation status for long periods of time, even to the point where payment may be denied, due to a lack of available psychiatric beds. It is our understanding these patients would not be counted in the current reporting method.

Atrium Health appreciates the opportunity to provide these comments.

Sincerely,

Greg Bass
Director, Strategic Services Group
Atrium Health