North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

November 1, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on Health and Health and Human Services
North Carolina House of Representatives
Room 307A, Legislative Office Building
Raleigh, North Carolina 27603

The Honorable Mark Hollo, Co Chair
Joint Legislative Oversight Committee on Human Services
North Carolina House of Representatives
Room 639, Legislative Office Building
Raleigh, North Carolina 27603

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on Health and Human Services
North Carolina Senate
Room 1026, Legislative Building
Raleigh, North Carolina 27601

Dear Representative Burr, Representative Hollo and Senator Hise:

Session Law 2014-100, Section 12F.3.(a) requires the NC Department of Health and Human Services to submit a report on Strategies for Improving Mental Health, Developmental Disabilities and Substance Abuse Services to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2014. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

This report consists of several components and is a collaborative effort among the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of State Operated Healthcare Facilities and the Division of Health Service Regulation.

Please direct all questions regarding the report to Courtney Cantrell, Ph.D., Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Dr. Cantrell can be reached at (919) 733-7011.

Sincerely,

Adam Sholar

cc: Dave Richard
Jim Slate
Courtney Cantrell
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SENT VIA ELECTRONIC MAIL

Mark Trogdon, Director
Fiscal Research Division
North Carolina General Assembly
619 Legislative Office Building
Raleigh, NC 27603-5925

Dear Mr. Trogdon:

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Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES AND FISCAL RESEARCH DIVISION

on

STRATEGIES FOR IMPROVING MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

as required by Session Law 2014-100, Section 12F.3.(a)

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Division of State Operated Healthcare Facilities and
Division of Health Service Regulation

November 1, 2014

Executive Summary

Session Law 2014-100, *The Current Operations and Capital Improvements Appropriations Act of 2014*, required the Department of Health and Human Services (Department) to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on *Strategies for Improving Mental Health, Developmental Disabilities, and Substance Abuse Services* by November 1, 2014. The report is to address the components set forth in bold below. Recommendations provided in this Executive Summary will be more fully explained in the body of the report.

1. **A strategy for improving communications and coordination among all divisions within the Department that administer funds or programs related to the delivery of behavioral health services, especially regarding the most appropriate and efficient uses of public and private inpatient behavioral health services. The Department shall include as part of its strategy a process to address shortages and deficiencies identified in the annual state Medical Facilities Plan.**

   The Department employs several strategies operating at multiple levels in its efforts to provide a seamless approach to managing behavioral health services. These strategies are summarized below.

   A. The Department created a Deputy Secretary of Behavioral Health and Developmental Disabilities position with responsibility for providing leadership on all issues related to behavioral health and intellectual and developmental disabilities (I/DD) within the agency. This position also serves as part of the Secretary's Executive Leadership Team and has direct oversight of the Division of State Operated Healthcare Facilities (DSOHF) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) as well as programmatic oversight for the Transitions to Community LivingInitiative (i.e., DOJ agreement). Additionally the Deputy Secretary is included on all Medicaid policy decisions related to Behavioral Health and I/DD.
   B. The Department continues and improves upon Collaborative DHHS meetings on Behavioral Health (BH) and I/DD. The Department has multiple formal settings where Behavioral Health and I/DD decisions are vetted. These settings include:

      (1) Secretary's bi-monthly Local Management Entity-Managed Care Organization (LME-MCO) leadership meeting;
      (2) Division of Medical Assistance (DMA) and DMH/DD/SAS bi-monthly leadership meeting;
      (3) Monthly LME-MCO Chief Executive Officer leadership forum that includes the Deputy Secretary and leadership of DMH/DD/SAS, DMA, and DSOHF;
      (4) Quarterly Intra-Departmental Monitoring Team (IMT) meetings with LME-MCO, DMH/DD/SAS, and DMA staff;

(5) Weekly leadership meetings between DMH/DD/SAS and DSOHF and the Deputy Secretary; and
(6) Transitions to Community Living Initiative Leadership Team that includes staff of the DMH/DD/SAS, DMA, Division of Aging and Adult Services (DAAS) Division of Social Services (DSS), and DSOHF, with the Deputy Secretary and Special Advisor on the Americans with Disabilities Act.

C. The Department will continue its commitment to formal stakeholder engagement to include the following.

(1) Crisis Solutions Initiative;
(2) Formal Stakeholder Input groups such as DHHS Waiver Advisory Committee
(DWAC), External Advisory Team (EAT), the Coalition, the Consortium, the
Mental Health Coalition, and the Substance Abuse Federation; and
(3) Informal or time limited opportunities such as DD listening sessions, Home and
Community Based Services (HCBS) Stakeholder group, and Innovations Waiver Stakeholder group.

D. The Department will continue to improve through more formal communications on BH and I/DD issues with the Division of Vocational Rehabilitation Services (DVR), Division of Social Services (local Social Service agencies) and DHSR. The Department has extensive communications within these divisions as well as BH I/DD but should create a BH leadership monthly meeting to assure seamless coordination.
E. With respect to coordinating actual bed counts and assessing need, all relevant Departmental partners will meet every six months and before making recommendations in order to ensure all parts of the system are considered when determining inpatient bed need.

2. **A plan developed in collaboration with local management entities that have been approved to operate a managed care organizations (LME/MCOs) to increase access to, and availability of, community-based outpatient crisis and emergency services for the stabilization and treatment of individuals experiencing mental health, developmental disability, or substance abuse crises in settings other than local hospital emergency departments and State-operated psychiatric hospitals.**

This plan includes the following components:

A. Reduce Emergency Department (ED) overutilization through the continued development of an array of crisis prevention services. Acute crisis services must be available to all citizens.

B. Continue to develop the crisis services priorities outlined in the Block Grant Plans. Crisis services must be integrated into the whole service system and must be understood as a continuum as they are but one element of a robust system of care. The funding and provision of crisis services must be integrated into the other services and supports used by an individual in recovery. Recommended services include:

(1) *Prevention/Health Promotions/Wellness*: Developing an array of wellness planning, crisis/suicide prevention, and early intervention approaches through training staff and direct support professionals and expanding current evidence based interventions founded on these principles.
(2) *Integrated Care/Prevention*: Improving access to services within primary care and increasing the coordination between primary care and community providers
   a. *Outpatient Services:* Increase access to trainings and new best practices for psychotherapeutic modalities and supportive interventions that are trauma-informed, culturally competent and developmentally appropriate.
   b. *Community Based Services*: Emphasize services that teach individuals rehabilitation skills and that are tailored to their needs and flexible between routine and intensive levels of care. Focus on quality improvement and the latest best practices for helping individuals reduce dependency on services as appropriate.
   c. *Intensive Community Based Services*: Adults and children at-risk for institutional or residential care are given proven, effective treatment to stay safely and successfully in the community.
   d. *Transitions*: Continue to test models such as Critical Time Intervention and Peer Bridgers to assist in transition supports for individuals integrating back into the community through the linkage to resources and prevention of hospitalization.
   e. *Supportive Housing*: Housing supports maximum housing stability, community integration, inclusion, socialization, and technology to support community tenure through models such as Housing First and specialized group homes.
   f. *Acute/Crisis Services*: Improving crisis supports so children and adults are identified and connected to crisis services quickly and easily, through crisis/peer respite programs, a trained and educated workforce in de-escalation and prevention techniques, and flexible mobile services that help minimize the likelihood of immediate or lengthy emergency room visits or hospitalization.
   g. *Recovery Supports*: Empowerment, resiliency and self-determination are improved through kinship, mutual support, and mentorship from consumer-run services, self-directed services, and peer support.

C. Create diversion programs for individuals with I/DD and Traumatic Brain injury (TBI) and other complex special needs requiring longer treatment. This

should include the alteration of community-based crisis services available for people with I/DD to better meet individual needs.

D. Enhance programs designed to divert individuals from EDs, jails and prison by continuing to support the Treatment Alternative for Safe Communities program (TASC).
E. Address the impact on the system of individuals under a court order determination of Incapacity to Proceed (ITP) by working with Law enforcement, the judicial system and community partners to recommend any legislative or regulatory changes to divert these individuals from the justice system.
F. Enable, through policy and regulatory changes, efficient transfer of individuals experiencing crisis from EDs to Behavioral Health Urgent Care/Facility-Based Crisis Centers with appropriate medical clearance.
G. Provide training to Emergency Medical Service paramedics to assist with crisis situations.

3. **A plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services are available and accessible to children, adolescents and adults in every LME/MCO catchment area. The plan shall include ensure that an adequate number of crisis stabilization units are available in each LME/MCO catchment area. The plan shall include specific strategies for increasing the number of Facility-Based Crisis Programs for children and Adolescents as defined in section 4.b. (8)(k) of the current Medicaid State Plan. The plan shall further describe in detail all actions necessary to implement those strategies, including a description of how the Department's funds will be utilized.**

   This plan is set forth below.

   A. Develop performance incentives to keep individuals at the lowest level of care needed and ensure person-centered outcomes, including community-based stability and recovery.
   B. Address the lack of balance in the current system by providing more emphasis on prevention, early intervention and recovery support services through outcome expectations.
   C. Ensure the existing treatment system is recovery-based and available in local communities through LME-MCO monitoring of available services.
   D. Allow, through amendment of rules, State Plan, and policies, added flexibility for LME-MCOs and providers to implement evidence-based practices and outcomes.
   E. As new services or funds are added to the system in the future, ensure a balance of any new funding between prevention and primary care as well as enhance outpatient treatment levels including transition support providing a graduated array of services in the community, avoiding more expensive inpatient care when possible. Savings from efforts to reduce unnecessary ED

visits, inpatient hospitalizations and readmissions should be reinvested into preventive community services.

F. Encourage LME-MCOs to continue the implementation of alternative payment systems and encourage attention to the "whole person" through collaboration with medical providers.
G. Increase access and availability of services for those with substance use disorders.

Services for children will be outlined in the report due March 1, 2015 pursuant to Section 12F.3(b)(1).

4. **Findings and recommendations for increasing the inventory on inpatient psychiatric and substance abuse services within the State. In developing its finding and recommendations, the Department shall examine the advantages and disadvantages of increasing this inventory of services through (i) additional State-operated facilities, (ii) community hospital beds, (iii) United States Veterans Administration beds, and (iv) community-based services that decrease the need for inpatient treatment.**

The recommendations for accomplishing this task are as follows.

A. Collaborate with the LME-MCOs to analyze utilization trends for the purpose of targeting unmet need, acknowledging that the number of inpatient beds needed directly relates to the make-up and capacity of the community-based system.
B. Develop additional community-based inpatient bed capacity and develop inpatient services for specialty populations in the state facility system, while maintaining the current state facility inpatient capacity.
C. Require the management of inpatient bed utilization by LME-MCOs while ensuring that protections are in place to preserve an adequate safety net for consumers.
D. Review the effects of Critical Time Interventions (CTI) and other LME-MCO care coordination models in order to determine best practices for ensuring continuity of care for individuals transitioning to and from inpatient services.
E. Implement an integrated health information system, as well as a system of care coordination between hospitals (including EDs), LME-MCOs, community behavior health providers and primary care providers.

5. **A plan for offering hospitals and other entities incentives to apply for licenses to begin offering new inpatient behavioral health services, or to begin operating existing licensed beds that are currently unstaffed, or both.**

The plan is includes the following components.

A. First, work to ensure that community beds that are funded are adequately funded and have longer-term sustainability. This should be incentive enough for hospitals to open up this line of business.

B. Strategically reallocate beds based upon regional need, specialty needs and funding array.
C. If further incentives are needed, the Department will explore policy changes such as reallocating licensed beds that remain unused after a certain period of inactivity.

6. **Recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. In developing its findings and recommendations, the Department shall conduct a study that includes development of an inventory and assessment of the condition of every building located on the existing Cherry Hospital campus. The study shall include an examination of the feasibility of using the existing Cherry Hospital facility to provide community-based and facility-based behavioral health services, including additional child and adolescent inpatient beds.**

Cherry Hospital is located at the intersection of West Ash Street, Old Smithfield Road and Steven Mill Road in Goldsboro, North Carolina. This intersection forms four quadrants of the campus.
Although many of the buildings are currently in use by Cherry Hospital, there are significant repair and renovation requirements if the buildings continue to be utilized after Cherry Hospital vacates them. This is especially true if used for patient or consumer services.

A. The west quadrant will be kept by Cherry Hospital for various support functions and includes the Royster Building, the Conference Center, Warehouse #2. There are a few houses in this quadrant that will not be used.
B. The north quadrant contains the Old Water Treatment Plan, not used for many years, five residences not expected to be used by Cherry Hospital and the old Nurses Home which has not been used for many years. None of these structures are required for the new Cherry Hospital operations.
C. The east quadrant contains three old patient buildings. Richardson and the Criminally Insane Buildings have been out of use for over three decades and have not been in environmental conditioning. They will never be used again. The Linville Building houses long term patient records. It will be used until more suitable space is developed for this function. Also in the quadrant are the maintenance shops: carpentry, garage, paint, grounds and the car wash.
D. The south quadrant contains the major patient buildings including Woodard, U-1, U-2, U-3, U-4 and The Therapeutic Center. There are other buildings for support services in this quadrant.

Further details regarding the possible use of the buildings at Cherry Hospital are provided in the report.

7. **A method by which the Division of Health Service Regulation can begin tracking and separately reporting no later than January 1, 2015, on the inventory of inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.**

   The required data currently captured by the annual license renewal application process has been amended for licensed Mental Health/Developmental Disabilities/Substance Abuse Facilities, licensed Mental Health/Substance Abuse Hospitals and licensed Acute Care Hospitals. Beginning with the 2015 license renewal applications, the section of application asking for the inventory of inpatient behavioral beds for children has been further delineated by the age categories of: less than 6 years of age, 6-12 years of age and 13-17 years of age. The providers will submit data on these required categories on the renewal application for licensure by January 1, 2015. The bed inventory data received on the renewal applications will be entered into a database housed in the Medical Facilities Planning Branch.

8. **A status update on the implementation of each component of the 2008 Mental Health Commission Workforce Development Plan.**

   The workforce development plan is submitted as a separate report

The Department of Health and Human Services would like to thank the Joint Legislative Oversight Committee on Health and Human Services for the opportunity to set forth a collaborative and united vision for community-based and inpatient mental health and substance use disorder services for the state of North Carolina.

Legislative Directive

The North Carolina General Assembly directed the Department of Health and Human Services (DHHS) to report to the Joint Legislative Oversight Committee on Health and Human Services (LOC) and the Fiscal Research Division on how to improve the state's mental health, developmental disabilities, and substance abuse (MH/DD/SA) services. The legislation, Session Law (SL) 2013-100, Section 12F.3.(a), requires that DHHS address:

- communication and coordination across its Divisions;
- the need for additional inpatient beds;
- the need for community-based, crisis services;
- access to adequate crisis prevention and intervention services;
- the potential use of Cherry Hospital for future services; and
- the tracking and reporting of child/adolescent inpatient beds.

The required update on the 2008 Workforce Development Plan will be submitted in a separate report.

Please note that recommendations in this report are not necessarily for immediate funding or implementation. We are setting out a vision for the future of our services by establishing goals for our system. Any changes must be made incrementally and resulting outcomes must be closely monitored to ensure effectiveness. Thus far, we have prioritized crisis services as an initiative that will move us closer to our vision of a well-balanced, effective and efficient mental health system.

SECTION 1: Outpatient Service Array and Inpatient Bed Capacity: Recommendations

The first section of this report addresses the requirements of SL2013-100, Section 12F.3(a), elements (1), (3), (4), and (5).

Background. The public system funds two different continua: Medicaid and state-funded services. Services are delivered through the Local Management Entity-Managed Care Organization (LME-MCO) system. Examples of services provided are prevention, therapy and medication management, employment, housing, and residential. These are paid for by Medicaid and/or by state and federal block grant funds.

The managed, Medicaid-funded system is an entitlement program which funds an array of services for the treatment of behavioral health needs. Medicaid offers a good array, including outpatient services; enhanced, intensive services; crisis services; and inpatient services. However, the design of the current service array is inflexible, lacks adequate crisis services, and limits LME-MCOs in their ability to take advantage of the 1915(b)(c) waiver's potential for creativity in solving complex system problems.

State funds and federal block grant funds are used to pay for services and supports, many of which Medicaid does not cover. The availability of state funds varies and the amount

of these funds is limited. State dollars are used for community services and to support inpatient beds not funded by Medicaid (for ages 22-64) or private insurance. Federal block grant dollars are even more limited than state funds and are tied to a narrow array of services. State and federal funds are used for people whose insurance does not pay for a service that they need and cannot afford and for people without insurance who cannot afford the service.

Currently, the less flexible and more limited, state-funded mental health and substance abuse system is supporting many of the more costly services: e.g., inpatient utilization, long-term behavioral health supports, and investment in the psychiatric medication management "safety net." These funds must also cover anyone in the state who needs a service that is not covered by the insurer and who cannot pay. Most of these funds are dedicated to those with the highest needs, leaving little left to invest in the lower levels of care that could prevent over-reliance on more expensive, intensive services.

Increasingly, the interconnections between Medicaid and state-funded services have become apparent. For instance, there are services, such as group home supports and supported employment, which traditionally have been state-funded only and only available to Medicaid recipients. These are now available, on a limited basis, to non-Medicaid-funded recipients as (b)(3) services, through provisions in the Medicaid 1915(b)(c) waiver. The nexus between Medicaid and state-funded services, in this case, builds capacity. The Transitions to Community Living Initiative (TCLI) actively draws links not only across Medicaid and state funds for the same individuals, but also across social services that we have come to understand are so important to health and recovery. Moreover, the example illustrates the vision: people with diverse needs for mental health and substance use disorder services will receive recovery-based treatment in their communities, at the right time, in right place, with the right outcomes.

Communication and Coordination. The DHHS seeks to decrease the amount of time that people wait for services and to increase the effectiveness of available services. In the Spring of 2014, the DHHS presented options for optimal numbers of inpatient beds. It became clear at that time that DHHS's Divisions had different approaches to determining the number of beds needed. In response to the need for a more consistent approach, as well as a more unified system--inclusive of both community and facility services--Secretary Wos created a Deputy Secretary of Behavioral Health and Developmental Disabilities. The Secretary appointed Dave Richard to this role. Since that time, Deputy Secretary Richard has led the Division of State Operated Health Facilities (DSOHF) and the Division of Mental Health, Developmental Disability and Substance Abuse Services (DMHDDSAS) and forged a newly integrated system and vision.

Under the Secretary's leadership, collaboration across the Department and the engagement of stakeholders have combined to clarify policy and practice. Regular meetings among the DMHDDSAS, DSOHF, the Division of Medical Assistance (DMA), the Division of Health Services Regulation (DHSR), and other divisions have advanced management and monitoring of the system as a whole. Frequent meetings among diverse stakeholders and DHHS leadership have assisted in spotting needed improvements;

identifying paths for implementing change; and building consensus around a shared vision. As a result, the Department has approached the issue of inpatient beds within the context of the whole of the system. Consistent with the Americans with Disabilities Act (ADA) integration mandate, the DHHS is building the capacity of community services to assist individuals to remain in their homes, neighborhoods and workplaces. By doing so, crises are averted or managed in the community and reliance on costly inpatient beds is decreased.

It will take time to evaluate changes and achieve the results DHHS seeks. With the 1915(b)(c) Medicaid waiver, North Carolina began a journey. In the next phase, we must ensure that the consistent policies and necessary services are in place across the LME-MCOs. Given a clear vision for the future of the system and a structure within which they may manage flexibly, the LME-MCOs will achieve the outcomes desired by the State of North Carolina.

Service Gaps. DHHS and its stakeholders have identified the following issues/gaps in the State's mental health and substance use disorder service system. These point to opportunities for better quality and more cost-effective services for those who need mental health and substance use disorder services.[1]

Issues/gaps include:

- **Emergency Department overutilization**—EDs are overutilized and are too often used inappropriately, e.g., as a place for individuals experiencing MH and SA crises to receive and assessment and stabilization services.
- **ED wait times are excessive.** This is a result of too many individuals with MH and SA issues seeking treatment in EDs and inpatient beds to serve the same individuals are being at capacity.
- **Inpatient beds are not readily available**. These beds, especially in state facilities, are often used for individuals with complex needs, requiring longer treatment, e.g., some with intellectual and other developmental disabilities (I/DD) or traumatic brain injury (TBI). Another special population, individuals adjudicated incompetent to proceed to trial, remain in beds in state facilities for three times the average length of stay. Meeting complex needs, such as these, creates "back up" in the system for others.
- **Barriers to discharge.** Particularly for the uninsured and underinsured, it is often difficult to find funded treatment and supervised living options in the community once individuals are ready to leave the ED or inpatient setting
- **Available services don't match individual needs**. Many people must be fit into available services, although those services may be too intensive for their need, resulting in inefficiencies, or services that are not intensive enough, resulting in crises.

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[1] Although intellectual and other developmental disabilities (I/DD) are not the focus of this report, this population is included in discussion of the need for improved access to mental health and substance abuse services

- **General flexibility.** Under the fee-for-service system, the service array is highly structured, but fragmented. For example, when moving between levels of care, consumers must change providers, which can be very disruptive. Our current system allows for the LME-MCOs to titrate the right level of treatment and support to the individual.
- **Lack of emphasis on outcomes**. Current service policies are highly prescriptive and focus on process. In a managed care environment, by contrast, the state and LME-MCO's focus is on outcomes when LME-MCOs are allowed the flexibility within which to work.
- **The system is not optimally balanced**. There is little funding for prevention. Often, people do not enter services until in crisis. Additionally, there is a disproportionate emphasis on inpatient services for the uninsured or underinsured because they do not have access to community services that would decrease the likelihood of crisis or inpatient admission.
- **Transitions are not well-supported.** Currently, individuals struggle with transitions between levels of services and between hospitals and community services. Care coordination expectations do not include the needed functions of intensive follow-up and are primarily available to Medicaid enrollees, not enough of the uninsured.
- **Transitions out of prisons and jails are difficult**. Individuals have limited access to Treatment Alternatives for Safe Communities (TASC) and other transitional services that help people become positive members of the community. Often, the only funding available for those discharged from prison is the limited, state-funded, service array. Without treatment, individuals with MH and SA disorders are likely to return to the justice system.
- **Prevention is not prominent.** In the current system, most individuals only get (funded) help when they develop a mental health or substance use *disorder*, rather than receiving intervention/preventive services before symptoms develop into a *disorder*.
- **Integrated care is not yet sustainable.** There is little incentive for primary care and specialty mental health/substance use disorder services to coordinate care. The result is fragmented services and few completed referrals. These increase the likelihood of an escalation of symptoms.
- **Too many people in crisis**. The system lacks the appropriate pressures and incentives to assist people with services provided at the lowest level of care they need, in the community, near their families and informal supports.
- **The substance use disorder service array is fragmented and underfunded.** Most individuals receiving substance use disorder treatment are uninsured or underinsured. This means there are limited funds available for treatment. Although the Alcohol and Drug Abuse Treatment Centers (ADATCs) are an excellent resource, once individuals leave the ADATC, they need lower-level, community services that will help them continue in their recovery.

The following elements inform our recommendations for developing an adequate service array-- from community supports through inpatient bed availability.

- The entire array of services must be considered. From publicly funded services through those naturally available in the community, change in one part of the system necessarily effects change in service use across the array.
- Behavioral health services affect the entire State, from employment, school performance, and housing to rate of incarceration and recidivism.
- With availability of particular services, there must also be flexibility. The right services must be available in the right place, in the right amount for the individual. Flexible services can assist in achieving this end. Flexible services fit what a person needs, rather than fit the person to what is available. In the current system, we have discrete, prescriptive service definitions An example of this issue can be seen with Assertive Community Treatment (ACT) Team services. This is a comprehensive, expensive, and intensive service that some people clearly need. There are, however, a number of individuals receiving ACT who could be more effectively served in a less intense level of a similar service, at a fraction of the cost; but, the inflexibility of current service definitions prohibit this. Instead, too many of these individuals move to a much lower level of service that does *not* adequately address their recovery or keep them out of crisis or inpatient services. In sum, if people get "right-sized," flexible services that are tailored to their needs, resources can be extended to a larger number of individuals.
- Managed care is an excellent tool for the Medicaid population and needs to be leveraged. Local Management Entities/Managed Care Organizations (LME-MCOs) have the ability to oversee the system and identify and quickly address system gaps. They also provide enough oversight that flexibility can be allowed in service definitions while fraud, waste, and abuse can be mitigated with closer relationships between LME-MCOs and providers.
- The shifting of costs from one part of the system to another must be taken into account when planning changes in the allocation of state funds, federal block grant appropriations, or Medicaid funding. State funds are not only spent on the uninsured. These are also available across the entire system, including for Medicaid eligible adults for whom Medicaid does not cover a needed service; low-income individuals whose private insurance does not pay for needed services; and the uninsured. Further, if an insurer won't pay for a stay at a state psychiatric facility, it becomes a state cost. Note that for adult Medicaid recipients under 65, pure state funds are used to cover the cost of all state psychiatric hospitalizations.
- If a private insurer doesn't cover certain services (i.e., the person is underinsured) and the patient either cannot pay or refuses to pay, then state funds are the only funding option. When state funds are fully expended, the provider is left with the bill. This increases the provider's cost of doing business and could eventually decrease the availability of services if providers are less willing to offer services that are publicly-funded.
- A number of factors provide the "gravitational pull" that diverts people from the highest levels of care (e.g., inpatient hospitalization) to supports that are no more and no less than they need for recovery and independence in the community. These include an efficient and effective array of crisis services; good clinical assessments that accurately recommend the right level of care for the individual (vs. trial and error preceding a "failing out" to the right level); and supported transitions to ensure

people don't relapse into crisis due to a difficult transition from higher to lower levels of support.

Balancing the Community and Inpatient Continuum. In assessing the adequacy of the behavioral health system, especially inpatient services, the state must consider the full array of services and supports, from natural community supports through prevention and primary care outpatient services; enhanced services; long-term, residential supports; and inpatient psychiatric services. Funding higher level services at the expense of lower levels of services, results in higher levels of services becoming the default level of care. Changes to one component of the continuum affects other areas.

There is need for all levels of care, but the foundation of a strong system rests on an investment in local, cost-effective, sustainable services and supports. A well-balanced system is like a pyramid. The base of the pyramid is formed by approaches that support the individual's strengths and mobilize the resources of family and community to achieve outcomes consistent with health, well-being, and recovery. In this approach, the most costly, intense interventions are not the base of the system but the apex; they are available, but only for those whose needs cannot be met by the less intensive parts of the system: community services and supports. For most, health, wellness and recovery is enhanced or achieved through the use of natural community supports (e.g., friends, family, involvement with civic groups, meaningful work, volunteer opportunities, and peer supports). If the informal and generic community supports are robust, most people's needs can be met at the lowest level of local care. When this occurs, communities are strengthened. Supported by an adequate crisis services continuum that quickly addresses crises and engages individuals quickly back into community treatment and natural support, reliance on hospitals is reduced. When hospitalization is needed, individuals should have a seamless and supported discharge back to the community.

Internal and external pressures keep the system "right-sized," costing no more and no less than what is needed and offering individuals what they need when they need it. For instance, someone with schizophrenia could have adequate community support--including employment and family and peer support—such that, with routine medication management, they would not ordinarily need enhanced, residential or inpatient services. When the need for a higher level of service arises, following treatment, there is a smooth transition back to a community-centered whole-person recovery oriented system of care. Flexible service arrays allow a system to "wrap" treatment and recovery services around an individual, efficiently flexing services and supports in response to changing need.

Outpatient Service Array

Recommendations for Building a Community-Centered MH/SA System. To achieve this vision, the DHHS puts forward the following recommendations for community services:

- **Develop a Flexible Service Array.** Develop service definitions that are flexible, to accommodate individual differences, and that encourage the use of informalservices and natural supports.
- **Connect people to crisis services quickly through crisis/peer respite programs.** Leveraging a trained workforce, inclusive of peers, in de-escalation and prevention techniques, and flexible mobile services can minimize the likelihood of unnecessary or lengthy emergency room visits or preventable hospitalization.
- **Promote consumer empowerment, resiliency and recovery.** These core values and the approaches born of them—including consumer-run services and peer support- yield positive long-term outcomes using fewer resources.
- **Support Integrated Primary Care Services**. Integrated primary care is essential for prevention, early detection, and timely referral of individuals for mental health and substance use disorder services. It is one of the "bases" of the system pyramid discussed earlier. A great deal of avoidance of cost and morbidity could be obtained for the Medicaid and uninsured populations with integrated primary care.
- **Support Whole-Person Care in Behavioral Health**. We must include physical health outcome expectations in our chosen outcomes for the MH and SA system. These providers can work with primary care, using targeted population-based screening, to identify people at-risk for adverse health consequences for which they might not otherwise seek treatment.
- **Rebalance Funding.** As resources are added to the system, ensure funding for prevention, primary care, and enhanced outpatient treatment. Focus resources on transition between levels of care that helps keep people stable and in the community.
- **Encourage LME-MCOs to Continue to Implement Alternative Payment Models.** Right-sizing the system will require stability of funding, a focus on quality expectations and monitoring of closely monitored effects of the proposed changes over time. LME-MCOs need a predictability of funding for the next several years. If resources are stable, they will be able to take risks such as sub-capitation to providers. Stability of funding will allow the LME-MCOs to correct for the inefficiencies that pre-dated managed care.
- **Emphasize Quality Assessment and Person-Centered Plans.** Accurate, informed assessment of an individual is an investment that results in a quality treatment plan and the provision of services tailored to an individual's needs. In some cases, this means understanding the need for, e.g., assistive and other innovative technologies. High quality Person-Centered Plans are essential for determining what strengths an individual can leverage and what supports the individual needs to live successfully in the community. Good assessment is another driver that helps integrate people into community life with the least intrusive, most cost-effective services necessary for the outcomes desired.
- **Develop supportive housing that supports maximum longevity in housing, community integration, inclusion, and socialization.** For those who require support to live in the community, develop individualized plans that include the use of natural supports, services and consider the use of low-cost, in-home sensors

and other innovative technology. For individuals who are homeless, employ a "Housing First" approach, replacing "housing readiness" with a focus on obtaining stable housing as the foundation for intervention.

- **Consider Whole-System Return on Investment for Community Resources.** As more sophisticated data sets become available, the State should consider Return on Investment (ROI) studies. The State of Washington, as an example, developed one such a study to determine the impact of evidence-based services on the overall state system (see http://www.wsipp.wa.gov/Reports/12-04-1201). Establishing an evidence base for such North Carolina investments as, e.g., TROSA, The Healing Place, and other treatment and prevention-related services can establish the connection between investments and outcomes across multiple systems (Corrections, Commerce, etc.).
- **Advance Transitional Community-Based Services.** Those transitioning back into community benefit from models such as Critical Time Intervention and Peer Bridgers. These initiatives support adults at risk by offering supports for integration back into the community, increasing the individual's linkage to community resources and reducing the risk of re-admission.
    - **Increase Physical Health Safety Net Provider System.** The State's primary care safety net system for the uninsured includes Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Local Health Departments, School Based Health Centers and Free Clinics. In some cases they offer integrated behavioral health. The primary care safety net system serves vulnerable populations (uninsured, underinsured, Medicaid and Medicare) and as such operates on a very slim margin. For the uninsured they are already under resourced and generally uncompensated for physical health care services. To get preventive mental health services to the uninsured, behavioral health services need to be funded and integrated into the primary care safety net system before vulnerable individuals show up in the ED or at state facilities needing intensive services.
- **Integrate Crisis Services into the Whole Service System.** Crisis services must be understood as a continuum. We have historically placed emphasis on and funding in high-end crisis response services and undervalued strategies which could prevent crises or that are useful in intervening earlier. Training is key to achieve this end, especially for therapists, peers, direct support professionals, and other types of providers. The funding and provision of crisis services must be integrated, in a manner appropriate to the service, into mental health, developmental disabilities and substance use disorder services at all levels. When crisis services are fully integrated and tailored to individual needs, people develop the skills to maintain or maximize independence and community integration.
- **Develop community prevention resources**, through continuing programs such as Mental Health First Aid.

Inpatient Service Capacity

Background. The three State psychiatric hospitals and the three Alcohol and Drug Abuse Treatment Centers (ADATCs) provide specialized hospital-based treatment for individuals with needs that cannot be addressed in community settings. Both types of facilities are a safety net in the continuum of care for individuals in need of specialized treatment, regardless of ability to pay.

The State Psychiatric Hospitals. The State's hospitals provide comprehensive care to individuals who have a serious mental illness coupled with complex needs. The 1% of individuals presenting to an ED with psychiatric problems who are admitted to a State psychiatric hospital typically have chronic, severe and treatment-resistant illnesses that the community hospitals cannot address. Many also have multiple problems related to mental illness, including aggressive behaviors, housing issues, lack of family/social support, financial problems, medication problems, , co-occurring criminogenic risk factors, and co-occurring drug/alcohol abuse, chronic medical problems and/or intellectual developmental disabilities.

The Alcohol and Drug Abuse Treatment Centers (ADATC). The ADATCs provide inpatient safety net services for individuals with the most complicated substance use disorders. They employ evidence-based services that bring together medical, clinical and psychiatric expertise. The needs of individuals served by the ADATCs exceed community capacity due to co-morbid psychiatric and medical acuity, along with factors such as homelessness, unemployment, legal issues and a history of physical abuse and trauma.

Medical Care. Both the State psychiatric hospitals and ADATCs provide integrated medical care for individuals with mental illness and co-occurring addiction diagnoses served in facilities. All patients receive a complete physical health assessment including screenings, treatment for chronic, co-morbid medical conditions, and assessment and treatment for urgent and emergent medical conditions. In addition, those with a longer length of stay receive additional preventive healthcare services such as cancer screenings. Chronic and acute conditions common among individuals who have a severe mental illness or substance use disorder served in state facilities include uncontrolled diabetes, hypertension, coronary artery disease, chronic pain, seizures, Human Immunodeficiency Virus (HIV), Hepatitis C, Methicillin-Resistant Staphylococcus Aureus (MRSA), and cirrhotic liver disease (including end stage). A high proportion of individuals admitted are taking (or have previously taken) psychotropic medication which can be linked to adverse medical effects. Many need medical detoxification services, in addition to treatment for their mental illness, substance abuse disorder and chronic medical condition. These individuals need careful initiating, monitoring, and/or changes in their medications to treat complicated co-occurring diagnoses. In addition, individuals with serious underlying medical problems that manifest as severe behavioral and psychiatric disorders are served.

The capability of the med-psych units in the three state psychiatric hospitals approximates that of a general hospital without specialty services. Each of the State psychiatric hospitals and ADATCs offer specialized services for individuals with

different treatment needs. Walter B. Jones ADATC is the only hospital, inpatient, Opioid Treatment Program (OTP) in the state.

- Walter B. Jones also has a perinatal program for pregnant women and their infants.
- Julian F. Keith ADATC offers specialized screening, assessment and referral for individuals with Traumatic Brain Injury (TBI) and can tailor treatment programming for individuals with TBI.
- R.J. Blackley ADATC staff has been trained to assist with veteran-specific issues for individuals who have substance use disorder and other co-occurring mental health diagnoses. Through a continuing partnership with the Veterans Leadership Council of NC (VLCNC), Blackley can provide inpatient services and essential services for the transitional housing program for veterans.
- Broughton has a med-psych unit that provides integrated care for individuals with more acute and serious medical problems.
- Broughton Hospital offers services for persons who are deaf or hard of hearing for all 100 NC counties. Central Regional Hospital has a med-psych unit that includes cardiac monitoring capability and provides integrated care for individuals with more acute and serious medical problems.
- Central Regional Hospital offers services to children ages 12 and under from all 100 NC counties.
- Central Regional Hospitals also provides forensic services to persons sent for pre-trial evaluations, Incapacity-To-Proceed (ITP) evaluations and competency restoration.

Cherry Hospital has a med-psych unit that provides integrated care for individuals with more acute and serious medical problems. The newly built hospital will have enhanced capability.

Factors Affecting Inpatient Bed Recommendations

Recommendations for inpatient beds cannot be made in the absence of considering the whole system. Further, recommendations cannot be implemented without careful evaluation. The following were considered in developing our joint recommendations:

- Inpatient beds are most intensive, restrictive, and expensive part of the service array. These should be reserved for consumers whose situations cannot be addressed in a less restrictive environment.
- Need must be determined locally through LME-MCO gap analyses, community needs assessments, and periodic re-assessments. Analyses must include the factors that are keeping the state facilities full and factors that influence the demand for inpatient beds. These factors may differ in different regions of the state.

  Need for inpatient beds is impacted by resources in the rest of the service continuum.

Current Inpatient Bed Capacity

As of July 2014, North Carolina had a total of 2,674 inpatient beds for behavioral health in operation, including:

- 170 beds in general hospitals under 3-way contract with DMHDDSAS and the LME-MCOs
- 1,500 other staffed,* general hospital psychiatric beds
- 808 State-operated, civil, psychiatric, hospital beds
- 196 State-operated alcohol and drug treatment center (ADATCs) beds
-

Another 811 beds could be available if all community hospital beds that had SFY2013 Certificate of Need approvals were licensed and staffed and all space in State-operated facilities was funded. This would bring the total inpatient capacity to 3,485 beds. The chart below shows the details.

NC INPATIENT PSYCHIATRIC BED CAPACITY	**CURRENT BEDS IN OPERATION**	**ADDITIONAL BEDS AVAILABLE**	**TOTAL POTENTIAL BEDS**
Community-Based Psychiatric Beds under 3-Way Contract with DMH/DD/SAS and LME-MCOs	170		170
Other Staffed Community-Based Psychiatric Beds in General Hospitals Child/Adolescent Beds = 262 Adult Beds = 1,238 [NOTE: In the LOC presentation, we calculated the number of "publicly funded beds," including only 70% of all staffed beds.]	1,500	522	2,022
State-Operated Psychiatric Hospitals Child Latency Beds = 10 Adolescent Beds = 70 Adult Civil Beds = 728	808	245	1,053
State-Operated Alcohol & Drug Treatment Centers	196	44	240
TOTAL INPATIENT HOSPITAL BEDS	**2,674**	**811**	**3,485**

Based on the information above, NC currently has 26.1 operational behavioral health beds per 100,000 NC residents in State-operated and community facilities and potential space and licenses for 34.0 beds per 100,000 residents, based on the projected population for 2017. If available beds are limited to estimates of those funded by public sources, including Medicaid, Medicare, and State funds (70% of community beds), NC currently has 21.7 beds per 100,000 and available space and licenses for 28.1 beds per 100,000 NC residents.

Regardless of the method is used to measure overall inpatient capacity in the state, there are several problems that exacerbate long lengths of stay in local emergency departments; wait times for admission to inpatient care; and difficulty finding appropriate placements for individuals needing to be discharged. These include:

- Uneven geographic distribution of community psychiatric beds
- Lack of beds for persons with specialized needs, specifically:
  - Children ages 6-12 years old and adolescents 13 years and older
  - Persons with substance abuse disorders
  - Persons with co-occurring disorders
  - Sexually aggressive persons
- Inadequate funding for uninsured populations
- Need for diversion sites for persons with I/DD who have aggressive behavior or other serious, behavioral issues
- Use of state facilities for persons awaiting trial on "Incapacity To Proceed" (ITP) status
- Need for support from courts and law enforcement to reduce ITP admissions
- Need for coordination with law enforcement and crisis providers to reduce transports to emergency departments, which result in Involuntary Commitment admissions
- Ancillary issues that delay discharges and make community hospitals reluctant to admit persons they will have difficulty discharging, such as lack of housing, family or other, ongoing, daily supports
- Need for community-based step-down services
- Need for coordinated transitions between community hospitals, state facilities, and community-based treatment settings
- Need for synchronization of treatment models throughout the continuum of care
- Historical focus on treatment rather than prevention and early intervention for chronic conditions

In addition, addressing the problems facing our community hospitals and state facilities must take into consideration an aging population, an aging and shrinking workforce and overall population growth over the coming years.

Factors Impacting Bed Availability at the ADATCs

The SFY 2014, a 12% ($4.9 million) legislative reduction resulted in 44 fewer beds for the most vulnerable substance use disorder and co-occurring population in the state. The chart, below, illustrates the reduction:

ADATC	Total Beds Prior To SFY 2014 Reduction	Reduction	Current Beds
R.J. Blackley	**80**	**18**	**62**
Julian F. Keith	**80**	**12**	**68**

Walter B. Jones	**80**	**14**	**66**
Total	**240**	**44**	**196**

Although beds were reduced by 18%, admissions only decreased by 6% (4,148 admissions in SFY 13 and 3,874 admissions in SFY 14). The average length of stay decreased from 16.6 days in SFY 13 to 15.7 days in SFY 14.

Factors Impacting Bed Availability at State Hospitals

Increased Lengths of Stay. The average length of stay (ALOS) at the three State hospitals has increased over the past two State Fiscal Years (SFY). The ALOS varied monthly during that period from a low of 56.7 days during July 2012 to a high of 101.4 days in May 2014, with a definite upward trend. The State hospital data over the same period for patients with a length of stay of least 30 days also varied month to month and shows an upward trend, with 42% and 46.5% of discharged patients staying at least 30 days in May of 2012 and June of 2014, respectively.

Likely factors contributing to increased State hospital length of stay include:

- Higher cost, intensive residential step down in the community is inconsistently available throughout the state and limited when available.
- More patients admitted with more severe mental illness
- Increasing percentages of patients with Incapacity To Proceed (ITP) status, whose ALOS is significantly longer than civil patients' ALOS
- Difficulty discharging patients who need intensive, higher cost, residential outpatient services in the community
- Difficulty discharging patients who came to the hospital homeless or were living in unstable housing due to lack of adequate housing

Many factors contribute to the increasing State hospital ALOS. Some factors, as noted above, are related to the outpatient continuum of care available in the community.[2] Improving the outpatient continuum of care available in the community could, therefore, potentially reduce ALOS at the State hospitals. For example, if the ALOS on the Adult Admissions Units was reduced from the SFY 2014 ALOS of 50.14 days to 45 days, we estimate that the State hospitals could serve approximately 294 more patients per year.[3]

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[2] Specific recommendations on the outpatient continuum of care are reviewed in the community services section.

[3] This is calculated as follows:

(365 days per year/SFY 2014 ALOS of 50.14 days)*SFY 2014 average number of AAU beds of 323*SFY 2014 average occupancy of 93%=2186.7 patients

(365 days per year/reduced ALOS of 45 days)*current number of AAU beds of 329*average occupancy of 93%= 2481.8patients

2482-2187=295 additional patients per year

Boarding individuals with severe psychiatric illness in Emergency Departments (EDs) has become a nationwide focus of attention. Since this is particularly an issue for individuals who need civil commitment in a State psychiatric hospital, it is directly related to bed availability in the State hospitals.

The demand for State hospital beds for individuals with the most severe illness remains high. Individuals are often admitted to State hospitals even when community beds are available because of a clinical determination that the individual cannot be safely treated in a community hospital. These same characteristics tend to delay discharge from the state hospitals. Often individuals in State hospitals have needs that are high risk and high cost for community settings. Finding appropriate services for these individuals, coupled with lack of flexibility in service definitions, greatly impacts discharge planning. This is discussed, above, in the community service needs section.

Inpatient Services for Co-Occurring Intellectual Developmental Disabilities (I/DD) and Mental Illness. The focus of treatment at the State hospitals is severe mental illness. Individuals who have severe mental illness, along with intellectual and other developmental disabilities (I/DD) may need psychiatric hospitalization. This poses unique challenges, since the interaction between mental illness and I/DD must be considered in treatment programming. To ensure that individuals with these co-occurring diagnoses are served in the most appropriate setting, State statutes(S.B. 859) require that individuals who have or are suspected of having I/DD be admitted to a community setting for people with I/DD and Mental Illness (I/DD-MI). This legislation mandates that admission to a State psychiatric hospital should occur only when the individual is dangerous to others, deaf or medically fragile. Ideally, individuals with I/DD who are admitted to the State hospitals have borderline or mild levels of I/DD and the hospitals make necessary modifications to active treatment and the treatment milieu to accommodate intellectual limitations.

With the loss of dedicated diversion sites for people who have I/DD-MI, the State hospitals receive more referrals for people who do not meet the S.B. 859 criteria and/or who have much more severe I/DD (moderate to profound range). Currently, only two community hospitals accept I/DD-MI individuals – Vidant in Pitt County for adults and Brynn Marr in Onslow County for children. Because of this, individuals wait for admission while the referral source works to find an appropriate option. Often, the wait results in exacerbation of symptoms and behavior dangerous to others. At this point, the individual meets the S.B. 859 criteria and the State hospital can admit the individual.

Individuals with I/DD are also admitted because no other option is available. While the State hospitals are the safety net, they are not the best environment for treating people with I/DD-MI who have more severe functional limitations. Hospital units are large and filled with adults who have severe mental illness. The symptoms of the other individuals can be difficult for someone with I/DD to understand and tolerate. To ensure their safety, the hospitals assign staff to remain with the person who has I/DD around the clock. The result is a significant resource drain on the State hospitals without adequately meeting the

treatment needs of the individual. Individuals with I/DD-MI and their families find the process of admission and discharge very difficult.

Services for Persons with Traumatic Brain Injuries. Many of the referrals coming to the State neuro-medical treatment centers, psychiatric hospitals and ADATCs are for individuals with Traumatic Brain Injury (TBI) whose behavioral needs prevent them from being served elsewhere in the community. The staffing, environment and overall services being provided to these individuals in the State-operated facilities are not specifically designed for individuals with these complex needs. Additionally, the few treatment facilities in NC that do serve this population are private, expensive and do not accept Medicaid funding.

Without a program specifically designed for individuals with TBI, patients stay in other settings much longer, tying up beds for longer periods of time. Additionally, with the Department's implementation of the CMS required plan to complete Institution of Mental Disease (IMD) reviews, the TBI-specific group homes stopped taking patients from the State psychiatric hospitals for fear of being labeled an Institution of Mental Disease, reducing choice in an already limited service arena.

Without a program specifically designed for individuals with TBI, people with TBI will continue to wait for appropriate services; receive out-of-state services at an extremely high cost or receive non-specialized services in the state-operated healthcare facilities without the proper expertise; and add to the backlog of people waiting in emergency departments for state psychiatric hospital services.

Services for Persons on Incapacity to Proceed Status. Incapacity to Proceed (ITP) is a court order for individuals whose mental illness impacts their ability to understand their charges, understand the court process and assist with their defense. Increasingly, individuals with severe mental illness find themselves in the criminal justice system, causing ITP admissions to State hospitals to increase as well. This has a tremendous effect on bed availability for individuals in need of beds for civil commitment, a group who are often waiting in the EDs. Court orders require that individuals ordered for admission for ITP to be admitted without delay. State hospital admissions offices manage and prioritize individuals waiting for a bed based on severity and location. Individuals in EDs have priority, but still wait days to weeks for admission to a State hospital, because ITPs must be admitted without delay.

Treatment for individuals on ITP status includes both psychiatric management of symptoms and restoration of capacity to proceed. Restoration of capacity to proceed may be complicated by the chronicity of the individual's impairment in cognitive functioning due to mental illness, psychiatric symptoms that do not respond to treatment, and co-occurring intellectual and other developmental disabilities (I/DD).

Psychiatrically, an individual on ITP status may have achieved maximum benefit from hospitalization, but continue to be incapable of proceeding to trial. The hospital must work with the court system to resolve the legal issues. Success depends on the charges, the county court system, and the availability of staff with court expertise. Note that the length of stay for an individual on ITP status averaged three times that of an individual not on ITP in FY 2014.

The average length of stay at the State hospitals is increasing while admissions are decreasing. This is due, in part, to the increase in the percentage of individuals in the facilities on ITP status (2% of all patients served in SFY 2007 and 10.1% in SFY 2014). Most individuals admitted with ITP status are males on the adult admission units. As a result, adult men have longer delays in EDs because fewer State hospital beds are available for them. Until there are easily accessible and adequate treatment options in the community for individuals with severe mental illness, the increase in ITPs in the State hospitals will continue.

Continuity of Care. In order for individuals to achieve positive outcomes after an inpatient stay, it is imperative they make the transition from inpatient to outpatient care. Follow-up care after an inpatient stay is important to the successful transition of an individual back to the community and to avoid repeat, inpatient admissions. Through the discharge planning process, the State psychiatric hospitals and ADATCs work closely with the LME-MCOs to ensure smooth transitions as patients are discharged from their inpatient stay. LME-MCO Care Coordination is essential to manage post-inpatient care across various settings. Care coordinators, e.g., ensure that individuals make it to their outpatient appointments (especially immediately following the inpatient stay) and monitor their progress in the community, long-term. To this end, integrated health information technology (HIT; electronic medical records) is vital to provide communication across the continuum of behavioral health (inpatient and outpatient settings) and primary care systems, including community hospitals/emergency departments. The ability of LME/MCOs to leverage real-time, accurate information from these various data systems is key in providing quality patient care and reducing readmissions to acute care settings.

Considerations for Recommending Adequate Quantity of Inpatient Beds

- **This report covers publicly funded beds** (Medicaid, three way contract beds in community hospitals, State psychiatric hospitals and ADATCs). There are psychiatric beds in community hospitals that are also paid for by Medicare and Private Insurance. It may be noted that people who have private insurance may be treated in a State psychiatric facility and their insurance is billed. If the insurance will not pay the person is funded via the State hospital allocation.
- **There is no single right answer in terms of the right service to add or the right ratio of inpatient beds.** Instead, the state must agree and commit to *how* the system will be funded—what proportions of services and what funding priorities will attain the sought-after outcomes. This process is continuous, requiring interventions and

shifts in the system, followed by evaluations of the effect of those changes across the system.

- **Inpatient psychiatric beds are not all created equal.** One must look at the system in detail to determine what is causing long ED wait times, overutilization, and waitlists for psychiatric beds. The identified barriers, such as individuals with highly complex specialty care needs, should lead to a more targeted solution than a strict number of beds available.

Community vs. State Facility: Pros and Cons

North Carolina must rely on both its community system and its State facilities. Each portion of the continuum has its strengths and weaknesses. The State has less flexibility to expand and contract the number of beds available; but, it has a history of serving the more complex, special needs. State psychiatric facilities and ADATCs cannot expand and contract psychiatric beds on an as needed basis in the way that a community hospital may. The community hospital is able to increase their efficiency by having flexibility in how they use their beds. State psychiatric hospitals and ADATCs are "safety nets" serving people that community hospitals will not due to liability, high cost and length of stay. A combination of the two systems is needed for inpatient services. The following are considerations for use of community versus state hospital bed capacity:

Medicaid match is only available for community hospitals for ages 22-64; state hospitals cannot use Medicaid for individuals in age 22-64, so the state bears full financial responsibility for those otherwise Medicaid-eligible individuals in state hospitals.

- Community hospitals can help people stay in their communities assisting with access to supportive people/agencies/community programs and support transition.
- Beds in the State psychiatric hospitals and ADATCs are set and cannot be changed quickly as in a community hospital that can repurpose beds. As long as we keep "Incapacity to Proceed" numbers low in state hospitals, we will have sufficient capacity. However, Incapacity to Proceed admissions are increasing and must be studied to determine how to address the concern that if this continues there are fewer State hospitals beds to treat people who are not on ITP.

Recommendations for Inpatient Beds

Generally, our recommendation is not that new hospitals must be built, but that we should continue to capitalize on the specialization of our safety net state psychiatric facilities' ability to serve highly complex populations while maximizing federal contribution for inpatient psychiatric utilization by individuals with Medicaid. For the uninsured and underinsured, the state facility and three-way beds are the only options, so for these individuals, broader reforms may be required, including increased funding for downstream (enhanced, outpatient) services that prevent hospitalization and investigating the potential for obtaining federal match for these individuals.

- Flexibility in staffing for state hospital beds and focus of community hospital bed use to leverage maximum federal funding
- Focus on community hospital beds that can bill Medicaid for 21-65 and capitalize on the Federal Medicaid match

- Additional inpatient beds in rural areas
- Re-analyze data requiring 45 child- and adolescent-specific community beds, taking into account available services and geographical distribution
- Specialization in state facilities
- Better collaboration/coordination between hospitals and LME-MCOs
- Hospital bed registry for children, adolescents and adults
- 15-20 new IDD Hospital Diversion beds for adults and for children (5 beds each in the Western, SW Central and NE Central regions or 10 beds each in the Western and Central State-hospital regions) with enhanced rate
    - To continue to follow the S.B. 859 legislation, the state must develop multiple inpatient diversion sites across North Carolina for children, adolescents and adults who have IDD/MI. This will allow treatment in the appropriate setting and also may improve discharge back to the community, as providers will have the assurance that there are reasonable options available in times of crisis. Timely assessment and treatment will also help people with IDD/MI remain in community.
    - Funding that is dedicated to community hospitals and 24-hour crisis centers specifically for people who have IDD/MI could reinstate the system of IDD diversion sites from the past.
    - Further development of regional State facility programs available for 24/7 admissions for this population may also be necessary for the individuals with the most severe needs.
- Geographically dispersed residential placements to serve as step-up/step-down treatment before and after inpatient admission
- Project need for additional geriatric and neuro-medical beds as the NC age-distribution changes
- Increase capacity to serve individuals with TBI and I/DD, and other special populations, in the state facility safety net system
- Focus on the pending crisis of state facility beds being primarily used for persons on ITP status. More study and planning with statewide partners is needed.

Community Inpatient Bed Incentives

Although incentives may be necessary, DHHS will continue to work with the LME-MCOs to analyze utilization trends. This information will assist us in determining where community beds will be most effective. Initially, targeting efforts in a limited area will determine whether options for incentivizing the beds are necessary. Often, as long as a hospital can be guaranteed payment for utilization at a rate that covers the necessary staffing for the level of complexity of the consumers, they will be willing to open a unit. Commitment to stability and fair reimbursement should initially act as incentives. If we cannot reach our goals, we will explore other opportunities, with feedback from the hospitals themselves.

SECTION 2: Crisis Services

This section addresses elements (2) and (3) of SL 2014-100 Section 12F.3(a). as related to crisis services. This is a template and demonstration for how we intend to implement future recommendations that will ultimately lead to an effective and efficient system.

Crisis services are an important part of the mental health and substance use disorder treatment continuum, but they are treated separately here because of their unique mission and our current emphasis on improvements. Crisis services provide the "downward pressure" in the system that keeps people at the lowest needed level of service. Timely crisis identification, intervention, stabilization and disposition are key to an effective and balanced system, with inpatient services reserved for those who really need it rather than those whose crises have escalated due to inadequate intervention.

Recommendations and Findings on Increasing Access and Availability of Outpatient Crisis and Emergency Services

Crisis services are essential components of any comprehensive behavioral health system. As is true in many states, North Carolina's crisis service system has become increasingly stressed over the last decade. This has resulted in an over-reliance on the use of hospital emergency departments for behavioral health crisis care, extended emergency department wait times (psychiatric boarding) for individuals in need of inpatient care, and repeat visits to emergency departments. In addition the criminal justice system and local jails have increasingly felt the strain of an inmate population with a high incidence of mental illness and substance use disorder needs. The crisis system continuum is an important element of the community service array. A robust system ensures that individuals in crisis receive the right kind of treatment in the midst of a crisis. Crisis services facilitate stabilization and quick referral back into the community service system at the right level of care or transfer to the right inpatient psychiatric facility.

In December of 2013, Secretary Wos announced the Crisis Solutions Initiative to address this critical issue. This report will specifically address the work of the Crisis Solutions Initiative to date and offer a plan to implement and sustain alternatives to the over-use of emergency departments for behavioral health crisis care. The Crisis Solutions Initiative has involved extensive partnership with LME-MCOs as well as other stakeholders and users of these services.

Crisis Solutions Initiative as Planning Infrastructure. One of the key strategies of this initiative has been the formation of the *Crisis Solutions Coalition.* The Crisis Solutions Coalition was established to provide a forum for cross-system partnership. The meetings are designed around short presentations on innovative crisis intervention strategies. The presentations offer a springboard for question/answer periods and robust discussion. Participants contribute solution-based recommendations from their home communities or organizations. The Coalition has identified five objectives for the system:

- Recommend and establish community partnerships to strengthen the continuum of care
- Promote education and awareness of alternative community resources to the use of emergency departments

- Make recommendations related to data sharing to help identify who, when and where people in crisis are served, and what the results of the nature of the services
- Create a repository of evidence-based practices and provide technical assistance to LME-MCOs, providers, and other partners on how to respond to crisis scenarios
- Recommend legislative, policy and funding changes to help break down barriers associated with accessing care

The Coalition participants include partners from a diverse set of stakeholders. DHHS and our LME-MCO partners understand that building a strong crisis continuum will include funding appropriate paid services. Each of the nine LME-MCOs are reviewing and planning for more robust crisis services. In SFY14, each LME-MCO submitted three documents addressing the crisis continuum—responses to the DHHS crisis survey[4], a Local Business Plan with measurable goals an action steps to enhance crisis services and reduce ED wait times, and an assessment of gaps in the crisis system as part of a larger Gaps Analysis and Network Development Plan.

Although the LME-MCOs are engaged in planning for a robust crisis system, the work must go beyond that to recognize and value the involvement of law enforcement and magistrates, schools, healthcare providers, paramedics, emergency departments, community health centers, advocacy groups, and others. Solutions must include active participation by the other systems that encounter individuals in behavioral health crisis.

The Coalition drafted a list of priorities after its first meeting in December 2013[5]. Based on that list, a variety of crisis intervention strategies are under further research. DMH/DD/SAS staff are visiting local community crisis coalition meetings, provider agencies, and LME-MCOs. State-wide data points were agreed upon and are being reported publicly. Internal review and trend analysis of LME-MCO specific data has recently begun[6].

Current State of Crisis Services—Needs and Solutions. Good service models exist in pockets throughout the state. LME-MCOs, service providers, community hospitals, and other local stakeholders such as police, EMS, schools, consumer and family advocates, and county governments have made progress in coalition-building and established commitments to find collaborative solutions. However, a comprehensive array of integrated services and supports which emphasizes diversion from emergency department use, inpatient hospitalization, and inappropriate use of the legal and criminal justice systems is still lacking in the North Carolina behavioral health system.

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[4] What are the top three things your LME-MCO does that make a positive difference to consumers in crisis? Do you have a creative or innovative program in the crisis continuum that you'd like to showcase? If yes, please describe; What is the most useful thing the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) could do to support your efforts to obtain positive outcomes for consumers in crisis?

[5] See Crisis Coalition Priorities document

[6] See CSI Scorecard. Data is now available through SFY14, 3rd quarter. This is just the first quarter after the Crisis Solutions Initiative began. Future quarters will be needed in order to assess impact.

Crisis services must be understood as a continuum. We have historically placed emphasis and funding on the high-end crisis response services and underutilized strategies which prevent crisis or which are useful in earlier intervention. Crisis services are but one element of a robust system of care. The funding and provision of crisis services must be integrated into the other services and supports used by an individual in recovery. An array[7] of effective, recovery-oriented community based services and supports will:

- prevent many crises from occurring
- help to de-escalate some crises from rising to the level of requiring intensive crisis response and stabilization
- facilitate and maintain recovery after crisis stabilization

Policy Recommendations for Crisis Services. Statewide systemic solutions are needed to overcome some of the obstacles interfering with the development of sustainable alternatives to the over-reliance on emergency departments and inpatient care in both community hospitals and state facilities. Payer mix complexities, an inefficient array of service definitions, lack of funding for crisis prevention strategies, and difficult-to-navigate licensure rules have had the effect of constraining the development of modern alternative crisis services. The following are recommendations for addressing the current barriers and improving the system:

- **Acute crisis services must be available to all citizens.** The mix of patients in behavioral health crisis in emergency departments includes about equal thirds of privately insured, uninsured, and Medicaid insured individuals. In particular, individuals who are underinsured or uninsured who do not have adequate access to crisis services will likely be served in the ED (at cost directly to providers) and in our state facilities where state funds will be spent for crises that might have been prevented or assessed with the expenditure of fewer resources in the community.
- **Develop specialized behavioral health urgent care centers.** Models of these exist in several NC communities. They rely heavily on local funding streams. Shifting care away from hospital EDs to the BH urgent care centers will require more standardization of expectations for the providers. In addition, agreement is needed across payers so that reimbursement is available from Medicaid and private insurance to avoid cost-shifting to state and local funding.
- **Require parity between physical emergency department care and facility-based crisis and urgent care coverage among other (including private) payers.** In some cases, Medicaid funds levels of care which are both clinically preferred and cost effective, but not covered under many private insurance plans. For instance, a short term stay (3 – 5 days) in a local Facility Based Crisis Center (FBC) might be the preferred level of care for certain consumers, and cost ½ - 2/3 less than inpatient hospitalization. However, because most private insurance plans do not offer FBC in their benefit packages, these consumers will be referred for inpatient hospitalization instead. This contributes to more intrusion in the consumer's life, as well as heavier demands on limited inpatient bed capacity, and on the law enforcement agencies that transport the consumers to distant inpatient facilities. Additionally there are not

[7] See Section 12F.3.(a) (1) for a more complete description of the proposed service arrays.

sufficient funds in the system for FBC providers to absorb the cost to the system involved in serving individuals with insurance plans that will not cover FBC.

- **The array of services funded by both Medicaid and DMH/DD/SAS state funds needs updating to include coverage of crisis service alternatives.** For instance, programs in NC and states allow reimbursement for appropriately trained EMS paramedics to divert consumers from hospital emergency departments to BH urgent care centers and other community alternatives. Some other states also allow Medicaid reimbursement for "23 hour crisis observation" – a service recently reported as cost effective in a national study[8]. These are just two examples of a list of cost effective and evidence based services which need further investigation in North Carolina.

Plan for Crisis Services. DHHS, in collaboration with the LME-MCOs, will continue to focus on increasing access to, and availability of, community-based outpatient crisis and emergency services.

- **Provide a crisis continuum asset mapping tool,** and technical assistance in completing it, to be used in the next LME-MCO Gaps Analysis and Network Development Plan. The tool will support each LME-MCO to report in a standardized method the extent of crisis services available for each age/disability portion of the population in its catchment area. Results will inform planning and recommendations in future years. Investment in community based crisis services will be a multi-year effort.
- **Proceed with distribution of Mental Health Block Grant, Substance Abuse Block Grant, and state appropriations identified to begin funding the priorities identified by the Crisis Solutions Coalition.** These include:
    - *Behavioral Health Urgent Care Centers*: DMH/DD/SAS has convened a workgroup of providers and LME-MCOs to establish recommendations for standard expectations and operating models. Those recommendations will underpin parameters for this funding which will support enhancements in walk-in crisis centers to expand hours, operating capability, or facility security updates so the centers may function as viable alternative sites to hospital emergency departments.
    - *Facility Based Crisis Units*: BH Urgent Care Units are ideally situated when they provide gateways to facility based crisis units. DMH/DD/SAS and DMA will undertake a review of the adult units currently operating to assess strengths, weaknesses, and geographical gaps. In addition, the service definition for Facility Based Crisis – Adolescent units will be promulgated for publication.

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[8] "The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care. The main outcome of 23-hour observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation." Page 9, *Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.* HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

- *Critical Time Intervention (CTI):* CTI is a time-limited case management service designed to prevent adverse outcomes and repeated crisis episodes following discharge from hospitals, shelters, prisons and other institutions. DMH/DD/SAS and DMA will work collaboratively to develop a new Medicaid service definition while this funding supports piloting and start-up costs.
- *Peer Support Hospital Diversion*: Overnight short stay programs, operated and staffed by certified peer support specialists, provide alternatives to emergency department and inpatient care. There are no current programs in NC, and this funding will support necessary training and start-up of 2 pilot sites. Sites will be expected to have 4 - 6 beds each.
- *Community Paramedic Mobile Crisis Management*: Provide a payment option for LME-MCOs to contract with EMS departments to assess and transport consumers with MH/SA needs to non-hospital. DMH/DD/SAS will work in collaboration with DHSR/OEMS, and with longer term investigation with DMA for Medicaid funding possibilities.
- *Addiction Recovery Community Centers*: Provide training and start-up funding for peer run/volunteer supported community education and activity centers for people in recovery. Collaborations with public universities will be considered to engage and support young adults in recovery.
- *MH First Aid*: Fund a train-the-trainer contract and workbook costs to spread the use of MH First Aid for youth and adults, a strategy for teachers, faith partners and other community lay people to intervene early with individuals in crisis. Deliver instructor trainings + workbooks for participants
- *Group Home Employee Skills Training (GHEST)*: Developed and piloted by the UNC Center for Excellence in Community Psychiatry in conjunction with NAMI advocates, GHEST is designed to help .5600A group home staff more effectively assist adult residents with mental health crises. Group homes have a disproportionate number of emergency room visits and crisis calls requiring law enforcement involvement.
- *Innovative Technology Tools*: Support the development and use of innovative health, assistive, and wellness management technologies that assist consumers to prevent and avoid crisis escalation. Examples include mobile apps, smart home technology, and med monitoring systems.

- Research revisions to the current Mobile Crisis Management definition as well as alternative best practice models in use elsewhere, and convene a forum for stakeholder input into a new vision for the service.
  - Develop a draft Request for Proposal and associated cost projections to develop and implement two educational and marketing packages to inform key stakeholders about community based alternatives to hospital emergency department and inpatient treatment settings. Key stakeholders include hospital emergency department personnel and the general public.
  - Facilitate and support negotiations between DHHS and private insurers to provide adequate coverage of non-hospital levels of care such as BH Urgent Care and Facility Based Crisis Services.

- Create data sharing expectations between DHHS, CCNC, and the NC Hospital Association.

SECTION 3: Use of Existing Cherry Hospital Facilities

This section addresses Section (6) in Session Law 2014-100 on *Recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. In developing its findings and recommendations, the Department shall conduct a study that includes development of an inventory and assessment of the condition of every building located on the existing Cherry Hospital campus. The study shall include an examination of the feasibility of using the existing Cherry Hospital facility to provide community-based and facility-based behavioral health services, including additional child and adolescent inpatient beds.*

Findings and Existing Facility Survey of Cherry Hospital

Cherry Hospital, one of three psychiatric hospital operated by the State, is located west of Goldsboro, North Carolina and serves the eastern North Carolina counties. The campus dates back to the late 1860's; however, no original buildings exist.

Although many of the buildings are currently in use by Cherry Hospital, there are significant repair and renovation requirements if the buildings continue to be utilized after Cherry Hospital vacates them. This is especially true if used for patient or consumer services. The hospital is located at the intersection of West Ash Street, Old Smithfield Road and Steven Mill Road. This intersection forms four quadrants of the campus:

- The west quadrant will be kept by DHHS – Cherry Hospital for various support functions and includes the Royster Building, the Conference Center, Warehouse #2. There are a few houses in this quadrant that will not be used.
- The north quadrant contains the Old Water Treatment Plan, not used for many years, five residences not expected to be used by Cherry Hospital and the old Nurses Home which has not been used for many years. None of these structures are required for the new Cherry Hospital operations.
- The east quadrant contains three old patient buildings. Richardson and the Criminally Insane Buildings have been out of use for over three decades and have not been in environmental conditioning. They will never be used again. The Linville Building houses long term patient records. It will be used until more suitable space is developed for this function. Also in the quadrant are the maintenance shops: carpentry, garage, paint, grounds and the car wash.
- The south quadrant contains the major patient buildings including Woodard, U-1, U-2, U-3, U-4 and The Therapeutic Center. There are other buildings for support services in this quadrant. The Museum, Courts and Human Resources functions are in this area. The Kitchen, Occupational Therapy and Chapel support functions are in this area. The Laundry is operated by the Department of Public Safety and the building and parking has been allocated to them as well as associated parking. The main boiler plant and Engineering Offices are located in this zone. There are other recreation facilities such as shelters and recreational fields located in the quadrant.

Cherry Hospital Infrastructure

The south quadrant contains the major patient buildings and there are other support functions and facilities associated with the campus of Cherry Hospital within the quadrant, such as: sewer lift stations that are on long term easements to the City of Goldsboro and that support not only the old campus but the New Cherry Hospital campus and associated buildings upstream including the DART Program and MacFarland Building. Specific details on the infrastructure are provided below:

- ***Heating and Cooling*:** The campus buildings are predominately served by a central boiler plant for heating and central cooling plant located in the lower level of the U-3 Building. The cooling towers required for the cooling functions are located southeast of the U-3 Building. The boiler plant currently is a manned 24/7/365 operating plant that produces high temperature hot water that serves the campus as well as the O'Berry Center Campus to the northwest of Cherry Hospital. A new boiler plant to serve O'Berry is currently out for bids and will replace their need for services. It is assumed that as the current Cherry Hospital functions are moved to the new campus these heating and cooling loads will be reduced and eventually turned off. Buildings that have been identified to be retained by Cherry Hospital in the west quadrant have already been removed from the campus heating and cooling systems and placed on independent systems.
- ***Electrical:*** All building electrical systems are fed from pad mounted transformers provided and maintained by Duke Energy. They are individually metered. The site lighting is maintained by the Cherry maintenance staff. The site lighting infrastructure and fixtures are old and considered to be an ongoing maintenance issue. Many of the buildings are served by emergency generators of varying ages. If emergency power is a requirement for future uses each generator and power needs would need to be analyzed.
- ***Natural Gas:*** The campus is served by Piedmont Natural Gas. The primary loads are for the central boiler plant and the kitchen. The loads for buildings Cherry Hospital will continue to use in the west quadrant have been taken off of the campus hot water distribution and isolated. Once the hospital locates to the new campus most of this infrastructure will not be used. The natural gas is not individually metered to the buildings nor are facilities located near all buildings.
- ***Water:*** Water and sewer service for the campus is provided by the City of Goldsboro. The campus has a loop system and the buildings are not individually metered. Cherry maintains the campus owned system for domestic and fire distribution. It will be an issue to segregate a single building off of the loop for other uses.
- ***IT Systems:*** The campus is fed by a central IT system from the Royster Building. This includes data and voice. AT&T is the major provider for the voice and date connections on the WAN. Buildings are fed from this location and independent service from AT&T would be required for uses other that those associated with Cherry Hospital. Those connections would be from subject buildings to the rights-of-way where AT&T services would be available. Easements would have to be granted across the campus to isolate any requirements.

- ***Parking and Internal Roadways:*** The campus has internal roadways and parking lots as exhibited on the attached document. The nature of a psychiatric hospital does not require the parking proximity of other medical facilities. Use of any of the buildings that are not to be used by Cherry Hospital especially in the south quadrant will require consideration for parking and access capability. All of the current facilities are located on the Cherry Hospital Campus and non State owned uses of the facilities would require leases or easements for access.

Cherry Hospital Building Assessments

- **U 1, U 2, U 3 & U 4 Buildings**
  - Built: Between 1939 and 1949
  - Square Footage: Between 53,120 and 58,946
    Construction: 3 stories; reinforced concrete column and beam system with brick veneer exterior on tile partitions. The flat roofs are covered with a single ply membrane.
  - Current Uses: These four buildings house a majority of the patients on the campus.
  - Narrative: The U Buildings have served as the major patient units for Cherry Hospital for over seven decades. Minor repairs and renovations have been done over the years since they were built such as installing central HVAC systems and fire alarms. However, the HVAC system as well as the original plumbing infrastructure is beyond normal expected useful life. The common area bathrooms are in need of complete renovation due to constant use. The buildings do not have fire sprinkler systems and if installed a fire booster pump would be required. All of the hydraulic elevators that serve these buildings are 10 to 15 years beyond normal expected useable life and are currently experiencing many problems or are not working at all. The exterior of the building including the roofing membrane needs much repair or replacement. The windows need to be replaced. The brick veneer has many cracks in it. A complete renovation and updating would require to completely gut the structures and start over.
  - Cost to Update: 218,355 s.f. x $285.00 s.f. = $62,231,175
  - Allowable Use: If a healthcare use similar to the current psychiatric hospital were desired it would be allowed in the current buildings without much updating, according to the NC DHHS Division of Health Service Regulation. Other uses may require stricter code compliance.
- **Woodard Building**
  - Built: 1939
  - Square Footage: 62,995
  - Construction: 3 & 4 stories; reinforced concrete column and beam system with brick veneer exterior. The flat roof is covered with a built up roofing membrane.
  - Current Use: This is one of the five major patient buildings on campus.
  - Narrative: Woodard has served as one of the major patient buildings for over seven decades. Minor repairs and renovations have been done over the years including adding HVAC systems, fire alarm system and upgrading one of the two elevators. The major systems are nearing the expected useable life and would need replacement if long term use were considered. The common area bathrooms

and plumbing systems have gone beyond expected useful life and need to be replaced. The building does not have a fire sprinkler system. The hydraulic elevator near the middle of the building needs to be renovated. The interior walls are difficult to move and making changes to allow for current practices in patient care is difficult. A substantial renovation is required should long term uses be desired.
    - Cost to Update: 62,995 s.f. x $180.00 s.f. = $11,339,100
    - Allowable Use: If a healthcare use similar to the current psychiatric hospital use were desired it would be allowed without much updating, according to the NC DHHS Division of Health Service Regulation. Other uses may require stricter code compliance.
- **Chapel**
    - Built: 1950
    - Square Footage: 16,730
    - Construction: 2 stories; load bearing masonry with steel framing. Flat roof with Built up roof membrane.
    - Current Use: Religious Functions and Staff Development
    - Narrative: The Chapel serves the campus for religious functions and other uses such as Staff Development. No major renovations have been performed on this building. The building currently does not meet the ADA requirements. If future uses required the use of both floors the ADA codes would have to be addressed. The air conditioning system is an old split system. The building does not have a fire sprinkler system.
    - Cost to Update: 16,730 s.f. x $100.00 s.f. = $1,673,000
- **O.T. Building**
    - Built: 1929
    - Square Footage: 21,750
    - Construction: 2 stories; load bearing masonry with steel framing. Flat roof with built up roof membrane.
    - Current Uses: Physical Therapy, Mail Room, Sewing Rooms, Laundry Distribution Center, Beauty Shop, Warehouse #1 and Staff Canteen
    - Narrative: The OT Building serves a variety of functions. No major renovations have been performed on the building. The building currently does not meet ADA requirements. If future uses required the use of both floors the ADA codes would have to bee addressed. The building is served by window air conditioning units. The building does not have a fire sprinkler system.
    - Cost to Update: 21,730 s.f. x $100.00 s.f. = $2,170,300
- **Main Kitchen**
    - Built: 1950
    - Square Footage: 35,221
    - Construction: 3 stories; load bearing masonry with steel framing. Flat roof with built up roof membrane.
    - Current use: Nutritional Services – Cooking, Dietary Administration, Food Storage including coolers and freezers.
    - Narrative: The Main Kitchen serves the campus for all meals prepared and distributed. No major renovations have been performed however some of the

equipment has been replaced over the years. Air conditioning (cooling) was installed a couple of years ago. The building does not meet ADA codes. The building does not have a fire sprinkler system. The electrical system is the original and would need significant updating for other uses. Although the kitchen could be used for its current use the kitchen equipment would be a factor.

- Cost to Update: 35,221 s.f. x $150.00 s.f. = $5,283,150

- **Richardson and Criminal Insane Buildings**
  - Built: Richardson – 1948; Criminal Insane - 1945
  - Square Footage: Richardson – 33,742; Criminal Insane – 40,212
  - Construction: Each is 3 stories; reinforced concrete column and beam with brick veneer exterior. Flat roof.
  - Current Use: Not used for decades.
  - Narrative: These two buildings were taken out of service decades ago and nothing has been done to them since then. They are in very poor shape and have been on the annual Repair and Renovation funding requests to get them demolished. There is not good roof on them, the windows are not functioning and the water has been allowed to penetrate the building. No heat or conditioned air has been on the building since they were cut off from the campus systems. There is no possible use for these.
- **Linville Building**
  - Built: 1935
  - Square Footage: 22,885
  - Construction: 2 Stories; reinforced concrete column and beam with brick veneer exterior. Flat roof with built up roofing membrane.
  - Current Use: Medical Records – long term storage
  - Narrative: Linville was converted to support functions and now it is used for Medical Records storage. The building has had no major upgrades in over 45 years. It does not have a fire sprinkler system. The building does not currently meet ADA codes. Although the cooling system was upgraded several years ago, most of the systems in the building are nearing the end of useful life. If a new use was desired it would require that the building be brought up to current building and life safety codes.
  - Cost to Update: 22,885 s.f. x $250.00 = $5,721,250
- **Human Resources**
  - Built: 1939
  - Square Footage: 13,410
  - Construction: 2 stories; load bearing masonry with wood framed floors and roof. Sloped roof with metal roofing.
  - Current Use: Human Resources
  - Narrative: The building has had no major renovations and does not meet current building codes including the ADA accessibility. There is no elevator for access to the second floor. The air conditioning (cooling) is from window units. Heat is from old radiators. The bathrooms need to be upgraded to be compliant. Electrical service would need to be upgraded. All finishes would need to be upgraded.
  - Cost to Update: 13,410 s.f. x $180.00 s.f. = $2,413,800

- **Court House**
  - Built: 1939
  - Square Footage: 2,922
  - Construction: 2 stories; load bearing masonry with wood framed floors and roof. Sloped roof with metal roofing.
  - Current Use: Courtroom and District Attorney's Office
  - Narrative: The building has had no major renovations and does not entirely meet current building codes including ADA accessibility. Renovations would depend on use. The building has no elevator. All systems would need to be upgraded as well as finishes
  - Cost to Update: 2,922 s.f. x $200.00 = $584,400
- **Carwash / Greenhouse, Grounds Shop, Carpenter Shop, Garage, Paint Shop**
  - Built: 1925 to 1946
  - Square Footage (all combined): 23,692
  - Construction: 1 story; load bearing masonry with either wood framed roof or steel truss roof (Carpenter Shop). Metal roofing, shingles or membrane.
  - Current Uses: Maintenance Support Functions
  - Narrative: These buildings are used for shops of the various maintenance groups. The buildings are functional. Upgrades may be necessary but that depends upon desired future uses.
- **Engineering Office**
  - Built: 1938
  - Square Footage: 2,770
  - Construction: 1 story; load bearing masonry with wood framed roof. Flat roof with built up roofing.
  - Current Use: Engineering Offices
  - Narrative: The Engineering Office is where the Maintenance Directors office is as well as offices and records for trade supervisors and support functions. The building is in reasonable shape given the age and not much is necessary for renovations at this time.
- **Boiler Plant**
  - Built: 1985
  - Square Footage: 10,580
  - Construction: 1 story; load bearing concrete block and brick veneer. Steel framing. Flat roof with EPDM membrane.
  - Current Use: main heating source for majority of campus buildings as well as for O'Berry Center.
  - Narrative: The boiler plant utilizes a high temperature hot water system (HTHW). When it was built, it served more buildings than it currently does. It also serves O'Berry Center to the west of the Cherry Hospital Campus. It is a manned plant requiring staff 24/7/365. The system requires a great deal of skill to operate it and currently is capable of producing more HTHW than is used. A new plant to supply the O'Berry Center is in the bidding stages. After it is up and running the current Cherry Hospital Boiler plant will no longer be necessary. The buildings that Cherry Hospital has indicated they will utilize after they relocate the new facility have been taken off of the campus hot water system and therefore

it is planned to close this boiler plant. The current system is too large and requires full time supervision and is therefore not economically feasible for only a few buildings should that be desired. If the boilers were removed the building might be able to house alternate functions.

- **Nurses Home**
  - Built: 1954
  - Square Footage: 11,083
  - Construction: 2 stories; load bearing masonry and steel framing. Flat roof with built up roofing.
  - Current Use: Not used
  - Narrative: This was a nurse's dormitory. It has been out of active use for many years. It has not been air conditioned during that time and it is now in poor shape. The exterior envelop has many problems and there is no air conditioning or heating source. It is about a quarter mile from the main campus and is of no use to Cherry Hospital or others such as O'Berry Center. To use this building for any function would require a complete gut and renovation including all windows, doors, bathrooms, ADA access, electrical and HVAC systems and all finishes.
- **Four Houses on Stevens Mill Road (301, 303, 401, & 405)**
  - Built: 1939-1940
  - Square Footage (total): 4,872
  - Construction: 1 story; load bearing masonry with wood framed roof. Fiberglass shingle roofing.
  - Current Uses: Environmental Services, Police and Advocate Offices
  - Narrative: These former residences were converted to hospital functions over time. Currently all of the functions housed in them will move to the new facility therefore Cherry Hospital will not utilize them. They are currently set up for office type functions. They all have stand alone heating and cooling systems. Utilities would have to be separated for individual metering. These do not meet current codes for use in a commercial setting including ADA and accessibility. If a new use was desired the buildings would have to, at minimum, meet the ADA codes.
- **Five Houses on West Ash Street (1607, 1609, 1611, 1613 & 1615)**
  - Built: 1932 – 1946
  - Square Footage (total): 6,910
  - Construction: 1 story; load bearing masonry with wood framed roof. Fiberglass shingles or metal roofing.
  - Current Uses: Three are used by outside agencies, one is not used and one is used by Cherry Hospital
  - Narrative: These residences have served with little more than repairs from time to time. The HVAC systems were added. Utilities will have to be separated for metering depending on future use. These residences have no major outstanding code violations if these will be used for residential purposes. Cherry Hospital does not have a use for these.
- **Old Water Treatment Plant**
  - Built: 1945
  - Square Footage: 36,924

- Construction: Reinforced concrete column and beams. Brick veneer exterior walls. Flat roof.
- Current Use: Not being used / out of service
- Narrative: This water treatment plant was retired from service when the City of Goldsboro brought water service the area. There is no use for this specialized facility and it has been out of service for four decades. Former plans were to demolish this but no funding was available.

As part of this report, included within the appendices is information providing a summary of the existing buildings on Cherry Hospital's campus, along with campus and parking maps and a visual overview of the location site. This section of the report was developed in consultation with the NC Department of Health and Human Services, Purchase and Construction Office.

SECTION 4: Implementation Method for Tracking and Reporting on Inventory of Inpatient and Behavioral Health Beds for Children and Adolescents

This part of the report focuses on Section (7) in Session Law 2014-100 on a method the NC Division of Health Service Regulation (DHSR) can begin tracking and separately reporting on in the inventory of inpatient behavioral health beds for children ages 6-12 and for adolescents over the age 12. In order to address this issue, the required data captured with the annual license renewal application process has been amended for licensed Mental Health/Developmental Disabilities/Substance Abuse Facilities, licensed Mental Health/Substance Abuse Hospitals and Licensed Acute Care Hospitals. Beginning with the 2015 license renewal applications, the section asking for the inventory of inpatient behavioral beds for children, has been further delineated by the age categories of less than 6, 6-12 and 13-17. The providers will submit data on these required categories on the renewal application for licensure by January 1, 2015. The bed inventory data received on the renewal applications will be entered into a database housed in the Medical Facilities Planning Branch.

In conclusion, the Department of Health and Human Services would like to thank the North Carolina General Assembly Joint Legislative Oversight Committee on Health and Human Services for the opportunity to present recommendations and plans for improvements to the mental health and substance use disorder system. We look forward to taking a long-term, deliberate and planned approach to pursuing the vision and goals set forth in this document. We are committed to continuous quality improvement, engaging all stakeholders in planning and implementation, evaluating progress, and being innovative leaders in shaping our system to serve our citizens effectively and efficiently.