Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Presentation to the Joint Legislative Oversight Committee

Review of Plan for Closure of John Umstead and Dorothea Dix Hospitals

September 25, 2007

Overview

- General Assembly approved construction of new hospital for central region of North Carolina in 2003 in House Bill 684.
- Consultant studies in past years have recommended downsizing in the number of beds and the number of hospitals operated by the state
    - MGT Study in 1998 recommended reduction in hospital beds
    - PCG Auditor's Report in 2000 recommended bed reduction and decrease to 3 hospital system
    - MGT Study in 2001 confirmed recommendations for reductions in dependence on State psychiatric hospitals
- Timeline for design, construction, and operation of Central Regional Hospital (CRH)
    - Prototypical design developed in November 2003
    - Construction started April 2005
    - Construction slated to conclude January 2008
    - Programmatic planning began October 2005
    - Hospital Director selected August 2005
    - Executive Team selected 2006
    - Management staff selected March 2007
    - Non-managerial staff assigned positions beginning April 2007
    - Transition to CRH and opening by March 2008
- CRH design features
    - Observation: nursing stations have unobstructed view of corridors
    - Flexibility: ward sizes may flex up and down with hallway doors to meet changing census conditions
    - Predominantly private rooms with bathrooms
    - Treatment areas easily accessible for all patients, no more than one floor away
    - Multiple treatment hubs (malls) each with dining facilities
    - Easy access to protected outdoor space (enclosed courtyards)
    - Light, airy, attractive and modern environment

Closure Plan:

Pursuant to G.S. §122C-112.1a(30)(b) and HB 1473 10.49.(t)(2), the Secretary of Health and Human Services shall present a plan for the closure of each hospital or unit thereof

- The capacity of any replacement facility and the catchment area to meet the needs of those consumers who require long-term secure services as well as acute care
    - CRH, with a 115 bed overflow unit, will have the capacity to serve the same number of individuals as are currently being served at JUH and DDH combined, as shown in Table 1.

Table 1: Average Daily Census (ADC) FY2007

	DDH	JUH	Forensic Bed Transfer to Broughton	Total ADC (after bed transfer)	CRH (includes 115 bed overflow unit)	CRH (includes overflow and double rooms)
Adult Admissions	79	111		190	182	196
Adult Long Term	52	54		106	98	106
Gero-Psychiatric	25	26		51	46	50
Child/Adolescent	27	42		69	77	77
Adolescent Residential	11	7		18	38	38
Medical	4	10		14	16	18
Research	9	0		9	12	12
Forensic/Pre-Trial	101	0	50	51	78	86
Total	309	252	50	508	547	583

(Source: DMH/DD/SAS HEARTS Data System)

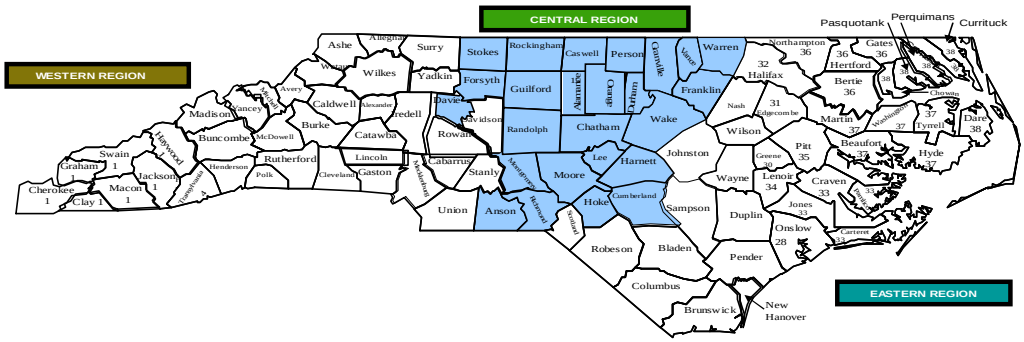
- Similarly, the operating capacity of CRH will equal or surpass the operating capacity of JUH and DDH combined, as shown in Table 2.

Table 2: Operating/Staffed Capacity

	DDH	JUH	Forensic Bed Transfer to Broughton	Total (after bed transfer)	CRH (includes 115 bed overflow unit)	CRH (includes overflow and double rooms)
Adult Admissions	78	118		196	182	196
Adult Long Term	45	60		105	98	106
Gero-Psychiatric	20	20		40	46	50
Child/Adolescent	25	52		77	77	77
Adolescent Residential	26	12		38	38	38
Medical	13	20		33	16	18
Research	7	0		7	12	12
Forensic/Pre-Trial	93	0	50	43	78	86
Total	307	282	50	539	547	583

- CRH design allows flexibility in number of beds per ward in two ways:
  - Each ward (patient care unit) has 2 rooms that are appropriately sized for double occupancy when necessary
  - Doors in connector hallways may be closed or opened to expand or contract the number of bedrooms per patient care unit as necessary to achieve correct proportion of beds by service type

- An inventory of existing capacity in the community within the catchment area for patients to access crisis services, appropriate housing, and other necessary supports.
  - Closure of JUH and DDH and the opening of CRH will not decrease access to State-operated inpatient services, nor will capacity of crisis services, housing or other supports be adversely impacted



  - CRH catchment area:
    - Alamance-Caswell-Rockingham (ACR)
    - CenterPoint: Davie, Forsyth, Stokes
    - Durham
    - Five County: Franklin, Granville, Halifax, Vance, Warren
    - Guilford
    - Orange-Person-Chatham
    - Sandhills: Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond
    - Wake
  - Crisis services in catchment area: Plan details inventory of crisis services as of September 2006. Bonnie Morrell will be presenting an update later today.

- Local psychiatric beds: at least 442 inpatient psychiatric beds are in operation as of 12/20/2006 in the catchment area. Most of these units accept involuntarily committed patients, but many may not accept referrals of aggressive or medically fragile psychiatric patients. Various LMEs, such as Wake, have developed or are working on agreements with local inpatient psychiatric providers for crisis or other services to help divert admissions from CRH.
- Housing: A variety of housing options continue to be provided in the catchment area
  - 489 beds in group homes and apartments in DDH catchment area have been funded through HUD Section 811 program.
  - 495 units under development to serve persons with disabilities under the DHHS-NC Housing Finance Agency Key Program and the Housing 400 initiative. LMEs in the DDH catchment area are actively involved in these programs.
  - 509 beds in Oxford Houses in DDH catchment area for clean and sober housing option for persons in recovery.
- Intensive support services: Inventory listed in table on pages 6-7 of Plan.

- How the State and the LMEs in the catchment area will attract and retain qualified private providers that will provide services to State-paid non-Medicaid eligible consumers.
  - Closure of JUH and DDH and the opening of CRH is not anticipated to adversely impact the ability of LMEs and the State to recruit and retain qualified providers.
  - LMEs have been working on different reimbursement arrangements with providers to equalize payments across the fiscal year. In addition, contracting practices that offer providers a more significant portion of the population to be served are being considered to concentrate their referrals, resulting in an incentive for providers to contract with the LME.
  - Consistent with other State-operated facilities, CRH will employ qualified providers, including most psychiatrists, psychologists, social workers, and nurses to provide care and treatment.
    - Recruitment benefits of proximity to Research Triangle for recruitment of professionals
    - Training and research arrangements with UNC and Duke Schools of Medicine and other educational institutions facilitate recruitment of highly qualified professional staff.
    - Modern, new physical facility with advancing electronics to support quality care and treatment should be recruitment plus.
    - Contracting options exist for hard to recruit or shortage areas.
- The impact of the closure on remaining State facilities
  - To equalize catchment areas for Broughton, Cherry, and CRH, a 3 region model is being proposed to combine North Central and South Central regions. Following counties will be relocated into new hospital catchment area:

- Davie County from West to Central
- Davidson County from South Central to West
- Halifax from East to Central
- Johnston County from South Central to East
- Cumberland County from South Central to East
- Bladen, Columbus, Robeson, Scotland (SER) from South Central to East

- DMH/DD/SAS will implement protocol to divert admissions from counties above, when necessary from Broughton and Cherry, to CRH.
- Alcohol and Drug Abuse Treatment Centers (ADATC) are developing or expanding their capacity for acute detoxification admissions and revising their long-term rehabilitation service to a more focused, sub-acute model of care. Expansion of acute services, which will reduce admission of patients with substance abuse problems at the psychiatric hospitals, is shown in Table 3.

Table 3: ADATC acute bed expansion by September 2008

Bed Type	RJB		WBJ		JFK	
	Acute	Sub-Acute	Acute	Sub-Acute	Acute	Sub-Acute
Current Capacity	20	25	24	56	10	70
Expanded Capacity	30	50	24	56	30	50
Increase	10	25	0	0	20	-20

- No impact is anticipated on the developmental centers or the neuro-medical treatment centers.