Plan for Closure of John Umstead and Dorothea Dix Hospitals

Pursuant to the Opening of Central Regional Hospital

Presented to
The Joint Legislative Commission
on Governmental Operations
and
The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

In accordance with
Session Law 2007-323
Section 10.49(t)

August 8, 2007

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In 2003 the General Assembly approved construction of Central Regional Hospital (CRH) to replace the aging John Umstead (JUH) and Dorothea Dix Hospitals (DDH). This legislation represented North Carolina's commitment to providing treatment and care to individuals with mental illness in a safe, efficient and therapeutic environment.

The opening of Central Regional Hospital and the subsequent closing of John Umstead and Dorothea Dix Hospitals will result in treatment and services to individuals in an improved setting. CRH, which will be located in Butner, will have the same capacity and capability as JUH and DDH combined. Community services in the catchment area affected by CRH continue to develop. Access to services upon discharge will not be detrimentally affected as a result of the individual being served at CRH rather than JUH or DDH. In order to geographically accommodate admissions to 3 instead of 4 State hospitals, a 3 Region Model is being proposed. All counties and Local Management Entities (LMEs) will continue to be served by the hospital designated for their region. Although this model will result in increased admissions to Cherry and Broughton Hospitals, plans have been developed to minimize the impact on those two hospitals.

The Department of Health and Human Services, the Division of MH/DD/SAS, the CRH Executive Team and the staffs from both JUH and DDH have planned diligently to ensure the smooth transfer of patients, staff, equipment and records to CRH and the subsequent closing of JUH and DDH. Although there are several factors that could extend the proposed time line, the current plan is for all patients and staff to be transitioned to CRH by Thanksgiving 2007.

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 that addresses the following:

(i) 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.

Central Region Hospital, with a 115 bed overflow unit, will have the capacity to serve the same number of individuals as are currently being served at both DDH and JUH. Both long term secure and acute beds will be provided at CRH to adult, child, adolescent, geriatric and forensic patients. Prior to the opening of CRH, 50 forensic beds will be transferred to Broughton Hospital to serve individuals from the western half of the State.

The Division of MH/DD/SAS is also working to realign catchment areas for each of the State operated facilities. The rules to effect this change have been approved by the Commission of MH/DD/SAS and are in the process of public posting. Once this plan is implemented admissions from some LMEs will go to Cherry or Broughton Hospitals rather than CRH (see section iv). Additionally, increased utilization of R.J. Blackley Alcohol and Drug Abuse Treatment Center (ADATC) for acute substance abuse admissions from the South Central Region is expected to decrease the number of admissions to CRH.

The physical design of CRH allows maximum flexibility to increase one type of service unit (i.e. adult admissions) and reduce another so that the projected number of beds for each service type at CRH can be adjusted within the total number of beds.

Although the established operating capacity of the main CRH facility is 432, each unit has the ability to expand by 2 beds, resulting in the maximum capacity of 468. The last column of the charts below shows capacity using the expansion beds. The total possible number of beds at CRH, including overflow and expansion, is 583, higher than the current combined operational beds at JUH/DDH and higher than the combined average daily census of the two hospitals.

The table below shows the current average daily census at both DDH and JUH (including all LMEs currently admitting to these hospitals) in comparison to the capacity at CRH.

Average Daily Census (ADC)

	DDH ADC 5/25/07	JUH ADC 5/25/07	Bed Transfers to Other Hospitals	Total ADC (after bed transfer)	CRH (includes 115 bed overflow unit)	CRH (includes overflow and expansion)
Adult Admissions	78	111		189	182	196
Adult Long Term	52	54		106	98	106
Gero-Psychiatric	25	26		51	46	50
Child/Adolescent	27	42		69	77	77
PRTF	10	7		17	38	38
Medical	4	11		15	16	18
Research	9	0		9	12	12
Forensic/Pre-Trial	102	0	50	52	78	86
Total	307	251	50	508	547	583

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

The table below shows a comparison of current operating capacity for DDH/JUH and CRH.

Operating/Staffed Capacity

	DDH	JUH	Bed Transfers to Other Hospitals	Total (after bed transfer)	CRH (includes 115 bed overflow unit)	CRH (includes overflow and expansion)
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
PRTF	26	12		38	38	38
Medical	13	34		47	16	18
Research	7	0		7	12	12
Forensic/Pre-Trial	93	0	50	43	78	86
Total	307	296	50	553	547	583

(ii) An inventory of existing capacity in the community within the catchment area for patients to access crisis services, appropriate housing, and other necessary supports.

The LMEs that will comprise the Central Hospital region are: Alamance-Caswell-Rockingham (ACR), CenterPoint, Durham, Five County, Guilford, OPC, Sandhills and Wake.

Crisis Services Following is an inventory taken as of September 1, 2006 of the LMEs listed above regarding access to crisis services in the region. Please note that some of the LMEs utilize the same providers for certain services, but have contracted with those agencies for a specific number of beds/services that are not intended to overlap.

LME	Mobile Crisis	Crisis Respite	23 Hour Observation	Facility Based Crisis Center	Detoxification
ACR	1- Psychotherapeutic Services Inc.	4- Ralph Scott Life Services; Addiction Recovery; Easter Seals; RTS	None	2- RTS; Hilford House	3- RTS; ARCA (Winston-Salem); Freedom House of Chapel Hill
CenterPoint	1-Daymark	None	None	None	ARCA (Winston-Salem)
Durham	1-Freedom House	1-Caring Family Network	1-Durham Center Access	1-Durham Center Access	None
Five County	1-Holly Hill	2- RHA Health Services; Creedmoor Respite Home	None	1-Halifax Regional Medical Center (20 beds)	None
Guilford	None	None	2- Moses Cone; High Point Regional Hosp	2- RTS of Alamance ARCA (Winston-Salem)	4- Moses Cone; High Point Reg Hosp; Alamance Reg Hosp; RTS of Alamance
OPC	1-Freedom House	2- Caring Family Network 5 sites for adults with disabilities	1-Freedom House	2- Freedom House RTS of Alamance	2- Freedom House RTS of Alamance
Sandhills	None	None	1- First Health Moore Reg Hospital	3- Sandhills Reg Medical Ctr First Health Moore Reg Hospital Moses Cone	4- First Health; Moore Regional Hospital; Freedom House; ARCA (Winston-Salem) Bethesda, Inc.
Wake	2- (not named)	1 bed DD/MI	1- Wake Crisis and Assessment	None	3- Wake County Human Services Alcohol Treatment Center; Wake Crisis and Assessment Services; The Healing Place

(Source: Crisis Inventory as reported by LMEs 9/2006; Central Region only.)

Local Management Entities received additional funds to enhance the crisis continuum in FY 06-07 and it is anticipated that by the time the CRH opens, there will be additional crisis services available to avert some hospitalizations to the State Hospital. The Wake LME has contracted with Holly Hill Hospital for 44 additional beds, but those beds will not be available until the end of 2008.

Local Psychiatric Inpatient Beds The following table indicates how many local hospital inpatient beds are available in the central region at this time:

LME	Hospital in LME Region	Hospital Location	# of Psych. Beds Available	Serves Involuntary Commitments	Ages Served	Disability Type Served
ACR	Alamance Region Medical Ctr	Burlington	30	Yes	All	All
Center-Point	1- Wake Forest University Baptist Medical Hospital	Winston-Salem	38	Yes	All	All
	2-Forsyth Medical Center	Winston-Salem	37			
Durham	1-Duke University Medical Center	Durham	12	Yes	Adult	MI
	2-Durham Regional	Durham	23	No	N/A	N/A
	3-Holly Hill	Raleigh	20	Yes	All	MI, MI/SA
Five County	Halifax Regional Medical Center	Henderson	20	No	Adults	MI, MI/SA
Guilford	1-Moses Cone Hospital	Greensboro	80	Yes	All	All
	2-High Point Regional Hospital	High Point	26	Yes	Adult	All
OPC	UNC Hospitals	Chapel Hill	76	Yes	All	MI, MI/SA, MR/MI
Sandhills	1-Sandhills Regional Medical	Hamlet	10	Yes	All	All
	2-First Health-Moore Regional Hospital	Pinehurst	24	Yes	All	All
Wake	Holly Hill	Raleigh	80	Yes	All	MI, MI/SA
Total Beds			**476***			

(Source: Crisis Inventory as reported by LMEs 9/2006, Community Inpatient Capacity Survey conducted by DMH/DD/SAS-SOS 12/2006. Central Region only.)

* Although there are 476 available beds these hospitals often do not make all of these beds available due to issues such as high acuity and insurance/funding sources.

Housing Since the mid 1980's, significant amounts of housing has been developed in North Carolina that has been funded by the Federal Housing and Urban Development. The HUD Section 811 program makes capital advances to finance the development of rental housing and group homes with the availability of supportive services for persons with disabilities. The advance is interest free and does not have to be repaid as long as the housing remains available for very low-income persons with disabilities for at least 40 years. Project-based rental assistance covers the difference between the HUD-approved operating cost of the project and

the tenants' contributions toward rent and utilities (usually 30 percent of monthly adjusted income) in the rental housing units. There are currently group homes and apartments with a total of 489 beds in operation that have been funded in the catchment areas that would be affected by the closure of Dix.

In fall 2005, the first rental assistance payments from the NC Dept of Health and Human Services and the NC Housing Finance Agency's Key Program were made. The Key Program provides an operating subsidy in the form of rental assistance for persons with disabilities in targeted Low-Income Housing Tax Credit (LIHTC) units. The Key Program is jointly funded by the NCHFA HOME Match funds and the Mental Health Trust Fund.

Building on the partnership between the Department and NCHFA, in July 2006, the North Carolina General Assembly created a new endeavor called the "Housing 400 Initiative". This Initiative is designed to increase the supply of "independent and supportive living apartments for persons with disabilities" that are affordable to persons with incomes at the level of Supplemental Security Income (SSI). To make this goal a reality, $10,937,500 was allocated to the North Carolina Housing Finance Agency (NCHFA) for the development of rental housing and $1,205,000 was allocated to the North Carolina Department of Health and Human Services (DHHS) to provide rental assistance. There is active involvement of the LMEs in the catchment areas that would be affected by the closure of Dix. In addition to the capital expenditures, the Housing 400 Initiative will fund up to 250 targeted units with Key Program assistance through the LIHTC development program. There will be 495 units that will be developed and targeted to serve persons with disabilities through the Key Program and the Housing 400 Initiative.

In addition, the North Carolina State Oxford Houses provide a clean and sober housing option for individuals in substance abuse recovery. The first North Carolina Oxford Houses were established in Durham, NC and Asheville, NC in the spring of 1991. As of March 2007, there are 112 houses in North Carolina, with locations in 26 cities. With an average of 9 beds per house, there are more than 800 Oxford House beds in the state. Individuals typically enter an Oxford House after completing a drug and alcohol treatment program. Individuals living in a house are expected to participate in a recovery program in the community during their residence. In the catchment areas that would be affected by the closure of Dix, Oxford Houses currently have 509 beds. All Oxford House residents are required to pay monthly rent and their percentage of all household utilities, averaging approximately $500 - $600 per month.

Intensive Support Services Following is an inventory of intensive support services contracted by LMEs in the Central Region.

LME	Assertive Community Treatment	Community Support Team	SA Comprehensive Outpatient Treatment	SA Intensive Outpatient Program
ACR	4- Easter Seals-UCP ASAP (3); Psychotherapeutic Services	1- Triumph	None	2- Alcohol and Drug Services; Rockingham MHC
CenterPoint	1- Triumph	2- AIM Health Services; Triumph	1- Partnership for Drug Free NC	2- Partnership for Drug Free NC; Daymark Recovery Services
Durham	2- Easter Seals-UCP ASAP; TelecareMH of NC	3- Resources for Human Development; Triumph (2)	None	None
Five County	2- Alliance Rehab Care; MHA-NC	2- Central Comm. Services; Premier Family Health Care	None	2- Edwards Assessment & Counseling
Guilford	3- Envisions of Life (2); Psychotherapeutic Services	2- Community Connections Residential; Psychotherapeutic Services	None	2- Alcohol and Drug Services East; Alcohol and Drug Services West
OPC	2- Cross Disability Svcs; Lutheran Family Svcs	1- ANNAS Resources	2- Family Wellness & Recovery; UNC Horizons	None
Sandhills	3- MHA-NC (3)	None	1- Robeson Health Care Corp.	1- Robeson Health Care Corp.
Wake	3- Wake Co Human Svcs; Easter Seals-UCP (2)	3- Resources for Human Development; Triumph; Visions of Hope	None	3- Wake Co. Human Services; Southlight (2)

(Source: Medicaid paid claims data for Oct. 2006 to May 2007; Central Region only)

The Division and LMEs continue to work to increase availability of intensive substance abuse services such as Substance Abuse Comprehensive Outpatient Treatment and Substance Abuse Intensive Outpatient Programs.

(iii) 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.

Local Management Entities have been working on different reimbursement arrangements with providers to help stabilize payments across the entire fiscal year and to address some of the challenges presented by the fee-for-service reimbursement process. In addition, conducting relational contracting practices that offer providers a more significant portion of the population to be served are being considered. With these funds, LMEs are able to concentrate their referrals with no less than two providers based on the demand for services, resulting in an incentive for providers to contract with the LME.

Monitoring of qualified private providers will be a requirement in the contracts, with specific performance criteria indicated.

Central Regional Hospital, consistent with the other State-operated psychiatric hospitals, will rely on employees rather than private providers for the care and treatment of patients. Although each of the North Carolina State-operated psychiatric hospitals is impacted by nation-wide shortages in certain areas such as nursing, CRH benefits from two factors. The geographical proximity to Raleigh, Durham and Chapel Hil as well as the academic relationships with University of North Carolina at Chapel Hill and Duke University tend to attract professional staff. In the event that vacancies are unfilled, both JUH and DDH currently have contracts with agencies who supply nursing and other classifications of staff. These contracts will be continued by CRH.

(iv) The impact of the closure on remaining State facilities.

Since the General Assembly authorized funding for the construction of a new hospital in Butner that would replace JUH and DDH, the Division of MH/DD/SAS has recognized that the current hospital admitting patterns would change from a 4 region model (West Region to Broughton Hospital, East to Cherry Hospital, North Central to John Umstead Hospital and South Central to Dorothea Dix Hospital) to a 3 region model which merges the North and South Central Regions into a Central Region that admits to CRH. However because of population and geographical (driving distance) inequities, the Division determined that the regions for State facility admission would be realigned. In the proposed realignment, the following counties/LMEs will admit to the State hospital in a different region. This results in a net decrease in the total population base for the CRH of 762,519 less than currently served by John Umstead and Dorothea Dix Hospitals:

County/LME	Population	Current Region	Proposed Region
Davie County (CenterPoint)	38,930	West	Central
Davidson County (PBH)	154,294	South Central	West
Johnston County	146,312	South Central	East
Cumberland County	305,173	South Central	East
Southeastern Regional	251,923	South Central	East
Halifax County (5 County)	56,253	East	Central

(Source: 2005 Certified County Population Estimates; Office of State Budget and Management)

As presented in section (i) of this plan, CRH will have the capacity to serve individuals from the current North and South Central Regions, including those in the chart above. Cherry and Broughton Hospitals are often at or near their capacity on their admissions units, particularly adult admissions units. Therefore, the Division of MH/DD/SAS will institute a protocol that the CRH will serve as a diversion for both Broughton and Cherry for the counties/LMEs listed above when census at those 2 hospitals is high. Diversions to sister hospitals currently occur so this plan will be consistent with current practices. However, specific protocols will be established to minimize "long distance" diversions. Implementation of this diversion plan will utilize state-wide hospital resources efficiently and minimize impact on the remaining State-operated hospitals. In addition, the number of beds will be increased in the new hospital currently being designed to replace Broughton and Cherry to address this issue on a permanent basis.

The State-operated Alcohol and Drug Abuse Treatment Centers (ADATCs) are currently in the process of increasing their capacity to admit patients to acute substance abuse units. As their acute capacity continues to expand, it is anticipated that the total number of admissions to State-operated hospitals of individuals with primary substance abuse needs will decrease. Collaborative efforts between the ADATCs, hospitals and LMEs have been underway to ensure that currently, and as the acute capacity increases, patients are admitted to the treatment setting which best address their needs.

No impact is anticipated on Developmental Centers or Neuro-medical Centers as a result of the closing of DDH and JUH and the opening of CRH.