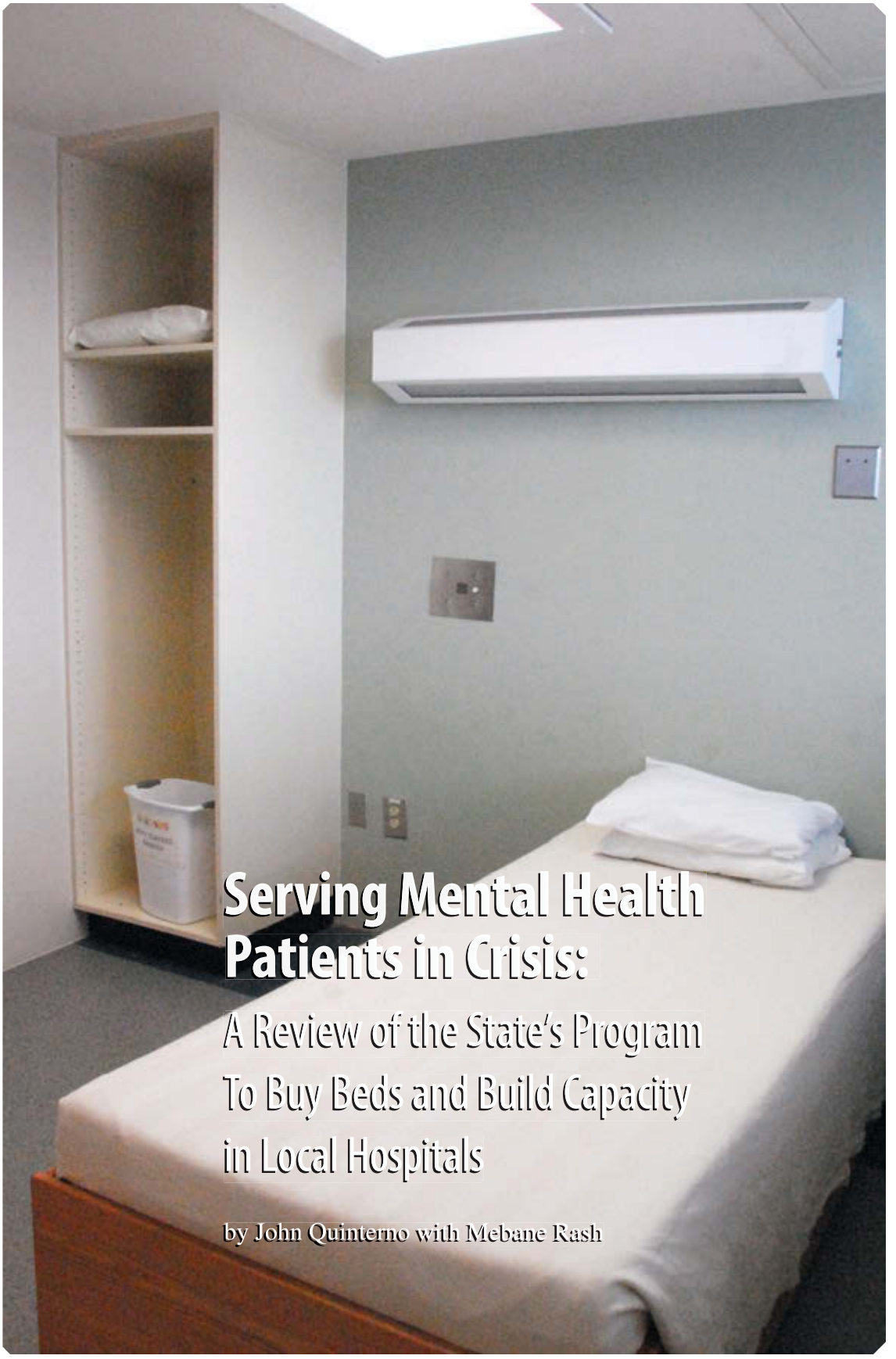

Serving Mental Health Patients in Crisis:

A Review of the State's Program To Buy Beds and Build Capacity in Local Hospitals

by John Quinterno with Mebane Rash

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Executive Summary

In 2008–09, the legislature first funded "three-way contracts" among the N.C. Department of Health and Human Services (DHHS), local mental health management entities (LMEs), and local hospitals. The goal of these contracts is to increase bed capacity within the community by paying hospitals for short-term care of mental health patients in crisis. The contracts allow adults needing inpatient psychiatric services to be treated for up to seven days and patients needing medical detoxification services for substance abuse to be treated for up to four days. With approval from the LME, patients may be treated in the local hospital for as long as necessary to stabilize them or transfer them to a state facility. Most of those served are a danger to themselves or others, or they are unable to care for themselves as a result of their mental health crisis. Others have relapsed in their substance abuse treatment. Without these contracts, individuals experiencing short-term crises often turn instead to a state psychiatric hospital for care—care that may be far from home, detached from the support of family and local health care providers, and costs more than local options. This detracts from a state facility's ability to serve patients needing long-term mental health care.

The Design of the State's Initiative

In theory, the project is designed to yield the following benefits:

- *Patients* will obtain mental health treatment in their own communities that is well-integrated into larger continuums of care.
- *Hospitals* will receive payments for serving patients needing mental health care who are otherwise uninsured.
- *Local areas* will strengthen their continuums of care for mental health, especially their services for patients in crisis.
- *The state* will reduce short-term admissions to state psychiatric hospitals, freeing up beds for individuals that require treatment longer than seven days.

The three-way contracts were developed as a way of moving North Carolina closer to the comprehensive local service system envisioned by the 2001 mental health reform legislation. The program's purpose is to increase capacity for treating mental health patients in crisis at local hospitals and to close service gaps.

Trends in the Number of Beds Available for Mental Health Care

While increasing the number of beds for those in crisis that can be treated in seven days or less is essential to the larger task of statewide mental health reform, few communities in North Carolina have enough beds. Due to financial and practical constraints, the total number of psychiatric inpatient beds in North Carolina declined from 1,958 beds in 2000 to 1,744 beds in 2010—a decline of 214 beds. Compounding this trend is the reduction in state psychiatric hospital bed capacity. Over an almost 20-year span between 1992 and 2011, the state psychiatric hospitals lost 1,879 beds, and between 2000 and 2011, they went from serving 16,789 people to serving just 5,754 people. This kind of care has been expensive for community hospitals to provide because insurance companies did not always cover mental health care, and if they did, the payment rates were often less than the cost to the hospital of providing inpatient care.

Without enough beds available, those in crisis began turning to their local hospital emergency rooms for help. In 2010, more than 135,000 people across the state were seen in a hospital emergency room for a mental health crisis. Community hospitals have responded to the need for more patient beds, and between 2009 and 2011, the number of patients served in community hospitals increased by 22.8 percent, rising from 15,442 to 18,966. At the same time, the number of patients served through three-way contracts nearly quadrupled, rising from 1,531 to 5,650—almost as many as those now served by the state's psychiatric hospitals. This means the state hospitals can focus on patients with more complex needs requiring longer care. Even so, the demand for these beds still often exceeds supply.

Meanwhile, local mental health management entities (called LMEs, these are the local agencies responsible for managing the provision of mental health services in the area served), worry that the need for more inpatient beds is constraining their ability to provide the comprehensive mental health services expected of them, especially care for patients in crisis. Many also are coping with state and local funding reductions, mounting service demands, and caseloads of individuals who are difficult to serve. Many LMEs also are in flux as they merge into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services. The waiver and the merger of the LMEs should not affect the three-way contracts because the shift to MCOs is primarily a change

in organizational structure and purpose that will not change the need for the contracts or the need for short-term beds.

The Center's Findings in Its Research on the Three-Way Contracts: A Qualified Success

During its first year of operation in fiscal year 2008–09, the legislature provided $8.1 million to purchase beds serving mental health patients on a short-term basis at local hospitals. This paid for 13 contracts involving the purchase of 77 beds. In 2009, the N.C. General Assembly increased funding by $12 million, bringing total funding for fiscal year 2009–10 to $20.1 million. This led to the signing of seven additional contracts for another 26 beds for fiscal year 2009–10, bringing the total to 103 beds. In 2010, the legislature increased the funding by $9 million, bringing total funding for fiscal year 2010–11 to $29.1 million. In 2010–11, the number of contracts (20) remained the same, but 10 beds were added, bringing the total to 113 beds. For fiscal year 2011–12, the appropriation remained the same at $29.1 million, with 21 contracts for 122 beds. In 2012, the legislature appropriated an additional $9 million, bringing the total appropriation to $38.1 million and providing funding for up to 186 beds.

The contracts receive generally positive reviews from the state mental health agency, local mental health management entities, hospitals, and patient advocates. Based on a review of progress to date, the N.C. Center for Public Policy Research finds that the three-way contracts have been a *qualified* success. Although this review did not attempt to establish a causal relationship, the Center finds:

- The number of patients served under three-way bed contracts is almost as many served each year by the three state psychiatric hospitals combined.
- Readmission rates for people served under the three-way contracts are lower than for those served in state hospitals.
- Short-term admissions to state hospitals (seven days or less) have dropped from 51 percent of total admissions in 2008–09 to 21 percent in 2011–12.
- The average length of stay in emergency departments for those who were transferred to a community hospital (only some of which were operating under three-way contracts) was more than

12 hours shorter than the average length of stay for those that were transferred to a state psychiatric hospital.

- The average length of stay for patients served through the three-way contracts at all hospitals is less than seven days—as intended.

The program's success is qualified by certain unresolved issues that may undermine the long-term effectiveness of this strategy. These concerns involve the project's structure, financing, long-term mental health reform goals, patient treatment, and the adequacy of the available work force.

The Center's Insights

Our research highlights six insights that need to be considered as this program is maintained and expanded:

Insight #1: ***Even with the 122 beds added by the three-way contracts, the number of beds available to mental health patients in crisis that can be treated in seven days or less falls short of the need in North Carolina. The state needs a methodology that provides a consistent way to determine the required ratio of beds to population that would adequately serve diverse areas of the state.***

Some experts contend that a state needs 50 psychiatric beds per 100,000 residents, but other studies support the need for between 22–31 beds per 100,000 residents. Counting the 1,744 beds in licensed psychiatric facilities and the 864 beds in the state psychiatric hospitals, North Carolina currently has a total of 2,608 psychiatric inpatient beds—26.8 beds per 100,000 residents. In an article in the *North Carolina Medical Journal*, Marvin Swartz with the Duke University School of Medicine and Joseph Morrissey with the Sheps Center for Health Sciences Research at UNC-Chapel Hill note, "The larger problem underlying the growing shortage of psychiatric beds in North Carolina is the absence of a rational bed-need methodology for determining the required ratio of beds to population that would adequately serve diverse areas of the state."

Regardless, under the State Medical Facilities Plan, seven local mental health management entities will need at least 73 more beds providing adult inpatient psychiatric care by 2014. Furthermore, the hospitals continue to want to add beds at this rate. In the fall of 2011, six hospitals wanted to add new three-way contracts totaling 26 beds and nine hospitals with existing contracts wanted to add a total of 36 beds. In sum, the hospitals

requested an additional 62 beds. Waiting times in emergency departments across the state also underscore the need for more beds.

Insight #2: ***When selecting where to establish new contracts or to expand existing contracts, equitable distribution among the three broad geographic regions of the state is one factor required by the legislature, but other factors also are important.***

When selecting where to establish new contracts or to expand existing contracts, several factors should be considered in addition to equitably placing them among the Eastern, Western, and Central regions of the state. Three-way contracts work best for hospitals with capacities they want to preserve or expand. Local mental health management entities that currently do not have contracts and are in areas where the state predicts a need for additional adult beds should have priority. Kent Woodson, program manager of the three-way contracts for the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, emphasizes the importance of awarding contracts based on data that indicates where the beds are most likely to be used. And, although the primary goal of the contracts should be to provide beds for those in crisis, having those beds located closer to home is a real benefit to patients.

Insight #3: ***Priority transfers for those served under three-way contracts to the state psychiatric hospitals are often difficult to arrange.***

One of the most serious problems with the three-way contracts is the difficulty in arranging transfers of patients from the local hospitals to the state psychiatric hospitals. Patients who require more intense care are supposed to receive priority admission to the state psychiatric hospitals under the standard provisions of the three-way contracts. Many hospitals are not interested in treating these patients with short-term care without the assurance that if long-term care is needed, the state facilities will provide it.

Nevertheless, local stakeholders report that priority transfers are difficult to arrange. The lack of priority transfers may be due to unclear processes at state psychiatric hospitals or to delays in admission caused by staffing reductions. Or, it could be a by-product of the reduction in the number of staffed beds at the state psychiatric hospitals. The staff at the Division of Mental Health say some of the confusion results from local hospitals thinking that all of their patients qualify for priority transfers,

not just those served in the three-way beds. The Division staff also say that priority transfers have to be balanced with high-needs patients in the emergency departments. Whatever the cause, transfers to state psychiatric hospitals are a serious issue for the local hospitals and must be addressed.

Insight #4: ***At least every five years, the N.C. Department of Health and Human Services and the Joint Legislative Oversight Committee on Health and Human Services should re-examine whether the flat rate paid per day (currently set at $750) is adequate.***

The limitations of the flat rate include that it only covers inpatient services, it does not cover emergency department charges, it does not vary by severity of condition and treatment, it does not account for administrative costs, and it does not cover training for staff. However, those limitations *may be* outweighed by the benefits of having a flat rate. Furthermore, the hospitals continue to want to add beds at this rate. That said, the state needs to re-examine the rate at least every five years, especially given the implementation of national health care reform.

Insight #5: ***The state should continue to ensure that, over time, the three-way contracts serve the state's long-term goals in mental health reform.***

The three-way contract was developed as a way of moving North Carolina closer to the comprehensive local service system envisioned by the 2001 mental health reform legislation. While the program's purpose is to build capacity for mental health services in local hospitals and close service gaps, it also may run counter to some of the larger long-term goals driving mental health reform and exacerbate system problems. For example, the state's involvement in the three-way contracts seemingly detracts from the role the local mental health management entities were supposed to play in developing and coordinating local service systems.

Insight #6: ***Stakeholders have concerns about staffing requirements for substance abuse services and the inadequacy of local follow-up treatment for patients with substance abuse problems.***

While the three-way contracts allow for the provision of inpatient detoxification and substance abuse treatment, the substance abuse is often connected to a mental health problem. This is important because many stakeholders are concerned about the growing number of people with "dual diagnoses"—for example, a mental health diagnosis and substance abuse.

At only five of the participating hospitals does the provision of substance abuse services account for more than 20 percent of the billing under the three-way contracts. According to stakeholders, some hospitals are reluctant to provide substance abuse services, as required under the contracts. If the primary reason for treatment is substance abuse detox, then hospitals worry their treatment of those needing substance abuse services will preclude their treatment of those needing crisis psychiatric care.

Furthermore, the hospitals have raised concerns about whether their provision of substance abuse services under the three-way contracts meets staffing requirements under the state's rules for health and human services. For example, Division of Mental Health regulations require a full-time counselor for every 10 clients, at least one registered nurse, one direct care staff for every 20 clients, and a physician at the facility or on call 24 hours a day. The Medical Care Commission has additional rules for licensure of hospitals.

And while it is difficult to obtain follow-up mental health services, it is even harder to find follow-up services for substance abuse. Four reasons for this are identified in a 2008 report by the General Assembly's Program Evaluation Division: (1) a shortage of intensive outpatient substance abuse services statewide, (2) consumers not covered by Medicaid, (3) fewer hospital liaisons for consumers hospitalized with substance abuse problems, and (4) consumers who do not comply with treatment plans even when follow-up is attempted. Beth Melcher, chief deputy secretary of the N.C. Department of Health and Human Services, responds, "The problem is not availability of services, but lack of payers/reimbursement for services."

The Center's Recommendations

Based on its research on the three-way contracts, the N.C. Center for Public Policy Research makes four recommendations:

Recommendation #1: ***The Center recommends that the Secretary of the N.C. Department of Health and Human Services develop a strategy to ensure timely payments under these contracts.***

The timeliness of payments is a major concern for hospitals that, if left unresolved, could lead some local hospitals to terminate their contracts. While the state's problems with cash flows because of the Great Recession were the primary reason for delays in payments in the early days of this program, billing lags and slow payments continue to persist. The

standard state contract limits payment, as follows: "Division [of Mental Health] payment for approved inpatient services or approved bed capacity purchases shall be limited to the current fiscal year *availability of Division funds* in the psychiatric inpatient hospital fund reserve."

Another significant issue in the payment process is that the contract has been amended over time. The initial contract required the Division to pay the local mental health management entity (LME) within 60 days of receipt. This clause has been excluded from more recent contracts. And now, the *contract* states the LMEs must pay the hospital within 10 working days of receipt of funds from the state while *legislation* passed by the General Assembly says the LMEs must pay the hospital within 30 working days of receipt of funds from the state. Any additional billing issues that result from the state's decision to expand the federal Medicaid waiver statewide also need to be addressed expeditiously.

Recommendation #2: ***The Center recommends that the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services publicize that they have a designated staff person serving as a liaison for the three-way contracts, as well as a state working group for the three-way contracts that addresses clinical concerns.***

It is important to local hospitals to have the state involved in these contracts. It signifies to them a longer-term state commitment, standardization across the contracts, and accountability for timely payments. Stakeholders reported that relationships with local mental health management entities were stronger than with the state, and they wanted better communication channels with the state, especially with regard to budget and payment issues. Currently, the state is viewed by many stakeholders as a distant partner, often only involved when there is a problem. Stakeholders suggested having a designated contract liaison within the Division to address these concerns.

In fact, the Division has a program manager intended to serve in this capacity. Ken Marsh was the program manager in 2008–09, Bill Bullington was the program manager from 2009–12, and Kent Woodson now is serving in this capacity. The state needs to do a better job letting hospitals know how to get in touch with the program manager.

The state also has a working group on the three-way contracts to look at the clinical aspects of this program—for example, why hospitals sometimes deny admissions. Dr. Susan Saik and Dr. Ureh Nnenna Lekwauwa

lead the working group. All hospitals with contracts are invited to the meetings of the working group. Stakeholders note that very little information is available about the working group. Stakeholders would like regularly scheduled meetings, advance notice and input on the agendas, and they would like all parties to the contracts to be invited. Another stakeholder suggested that a best practice team member from the Division should be included in the working group.

Recommendation #3: ***The Center recommends that the N.C. Department of Health and Human Services require state psychiatric hospitals to open their existing training programs (currently provided only to their own state direct care employees) to the local community hospitals participating in the three-way contracts.***

It is impractical for most community hospitals to operate their own psychiatric training programs. It also would be more expensive for training to be provided at 21 different local hospitals participating in the contracts. Meanwhile, state hospitals require their direct care employees to prepare detailed annual development plans for their staff and provide staff members with the training required by those plans. With local hospital staff trained to state standards, however, community hospitals would be better equipped to handle patients with mental illness and perhaps serve even more patients locally. And, this might speed up the state's ability to increase the overall mental health work force, an issue for the future in North Carolina. Such training programs might also induce more hospitals to participate in the three-way contracts.

Who would bear the cost of this training would need to be determined, but options include the state hospitals, the local mental health management entities, the local hospitals, or an arrangement where the cost is shared by these entities. Ultimately, the legislature is going to have to provide money for training if it wants the three-way contracts to succeed.

Recommendation #4: ***The Center recommends that the N.C. Department of Health and Human Services develop outcome measures for this program.***

Given the increased investment of state dollars in this program, the three-way contracts are now established enough that program and patient outcomes should be identified, tracked, and reported annually. For instance, stakeholders suggested to the Center the following program measures:

- short-term admissions to state psychiatric hospitals,
- the number of persons in crisis seen in local hospital emergency departments, and
- the average waiting time in the emergency departments for mental health patients transferring to hospitals with three-way bed contracts and state psychiatric hospitals.

Stakeholders also suggested the following patient outcomes:

- number of persons served;
- number of bed days purchased;
- average length of stay;
- re-admission rates after 30 days, 180 days, and one year;
- percent of those served from home LMEs;
- percent of those served from outside the hospital's region;
- total admissions; and
- most importantly, comparing patient outcomes under the three-way contracts with the outcomes of patients served by other community hospitals providing this type of treatment, as well as comparing patient outcomes under the three-way contracts with outcomes of patients served in state psychiatric hospitals.

Some of this data is already captured by current reporting, but all data pertaining to the three-way contracts needs to be reported annually so that the public and policymakers can more easily evaluate how well this program is working. For some of the outcomes suggested by stakeholders, cooperation from the N.C. Hospital Association also may be required.

* * *

North Carolina's ongoing reform of its mental health system is driven by a vision of providing comprehensive services locally. Realizing this, however, requires communities to have local hospital beds dedicated to short-term inpatient psychiatric care—beds that are missing in many communities across the state. The state's recent three-way contract project is a promising attempt to fill this gap, but the concerns described here need to be addressed.

Karen Tam

North Carolina's ongoing reform of its mental health system is guided by a vision of providing comprehensive services in local communities, reserving the state's larger psychiatric hospitals for patients needing long-term care. Achieving this, however, requires communities to have local hospitals with psychiatric units capable of providing short-term inpatient care—care for people who are temporarily unstable, pose a risk to themselves or others, and are unable to care for themselves as a result of their mental health crisis. Others have relapsed in their substance abuse treatment. Absent such psychiatric units, gaps exist in local continuums of care, and individuals experiencing short-term crises often turn instead to a state psychiatric hospital for care—care that often is far from home, detached from the support of family and local health care providers, costs more than local options, and detracts from a state facility's ability to serve patients needing long-term mental health care.

Increasing the number of beds available statewide for those in crisis that can be treated in seven days or less is essential to the larger task of mental health reform, but few communities in North Carolina have enough beds. Due to financial and practical constraints, the total number of psychiatric inpatient beds declined from 1,958 beds in 2000 to 1,744 beds in 2010—a decline of 214 beds (see Figure 1, p. 66). Compounding this trend is the reduction in state psychiatric hospital capacity. Over an almost 20-year span between 1992 and 2011, the four state psychiatric hospitals lost 1,879 beds,[1] and between 2000 and 2011, they went from serving 16,789 people to serving just 5,754 people.[2] This kind of care has been expensive for community hospitals to provide because insurance companies did not always cover it, and if they did, the payment rates were often less than the cost to the hospital of providing the care.

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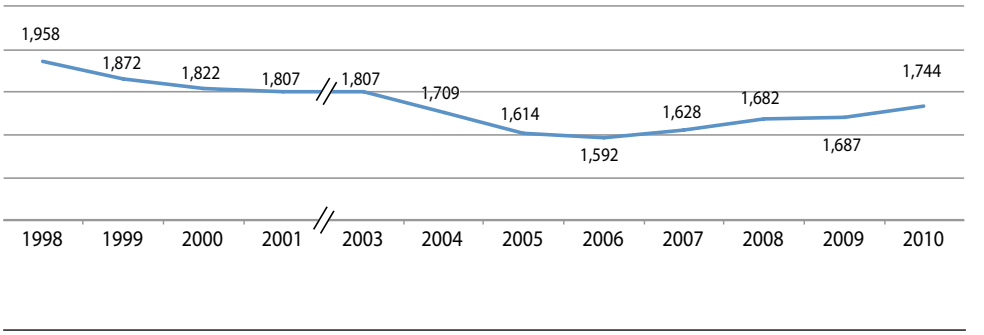
Figure 1. Psychiatric Inpatient Beds in North Carolina, *Excluding* State Facilities, 1998-2010



Sources:

1998 See State Medical Facilities Plan 2001, pp. 219, 224.

1999 See State Medical Facilities Plan 2002, pp. 281, 286.

2000 See State Medical Facilities Plan 2003, pp. 295, 300.

2001 See State Medical Facilities Plan 2004, pp. 303, 308.

2002 None of the State Medical Facilities Plans include 2002 data.

2003 See State Medical Facilities Plan 2005, pp. 289, 294.

2004 See State Medical Facilities Plan 2006, pp. 298, 302.

2005 See State Medical Facilities Plan 2007, pp. 284, 288.

2006 See State Medical Facilities Plan 2008, pp. 302, 306.

2007 See State Medical Facilities Plan 2009, pp. 333, 338.

Note: 2009 Report Discrepancy in total between p. 333 and p. 355 "Bed Supply." The base year is listed as 2006 instead of 2007 on p. 333.

2008 See State Medical Facilities Plan 2010, pp. 349, 355.

2009 See State Medical Facilities Plan 2011, pp. 398, 404.

2010 See State Medical Facilities Plan 2012, pp. 384, 388.

The 2007–12 State Medical Facilities Plans are on the Internet at *http://www.ncdhhs.gov/dhsr/ncsmfp/index.html*, accessed on April 17, 2012.

Those in crisis began turning to their local hospital emergency rooms for help. In 2010, more than 135,000 people across the state were seen in hospital emergency rooms for a mental health crisis.[3] Community hospitals have responded to the need for more beds to serve more patients, and between 2009 and 2011, the number of patients served in community hospitals increased by 22.8 percent, rising from 15,442 to 18,966.[4] At the same time, the number of patients served through three-way contracts nearly quadrupled, rising from 1,531 to 5,650—almost as many as those served by the state's psychiatric hospitals now that they can focus on patients with more complex needs requiring longer care (see Table 1, p. 68).[5] Even so, the demand for these beds still often exceeds supply.

If comprehensive mental health services are to be provided locally, the supply of short-term psychiatric beds available in community hospitals must be maintained and expanded. To that end, the General Assembly provided $8.1 million in fiscal

year 2008–09 to fund "three-way contracts" among the N.C. Department of Health and Human Services, local mental health management entities (LMEs),[6] and local hospitals. The program aims to build inpatient bed capacity within the community by paying hospitals for short-term care provided to indigent mental health patients in crisis. Some of those served are suicidal or a danger to others. Others have relapsed in their substance abuse treatment. In theory, the program will yield the following benefits:

- *Patients* will obtain mental health treatment that is well-integrated into larger continuums of care in their own communities.
- *Hospitals* will receive payments for serving patients needing mental health care who are otherwise uninsured.
- *Local areas* will strengthen their continuums of care for mental health, especially their services for patients in crisis.
- *The state* will reduce short-term admissions to state psychiatric hospitals to free up beds for individuals that require treatment longer than seven days.

> *"My friend … care for your psyche … know thyself, for once we know ourselves, we may learn how to care for ourselves."*
>
> — Socrates

During its first year of operation in fiscal year 2008–09, the legislature provided $8.1 million to purchase beds to serve mental health patients on a short-term basis in local hospitals. This paid for 13 contracts involving the purchase of 77 beds. In 2009, the N.C. General Assembly increased funding by $12 million, bringing total funding for fiscal year 2009–10 to $20.1 million. This led to the signing of seven additional contracts for another 26 beds for fiscal year 2009–10, bringing the total to 103 beds. In 2010, the legislature increased the funding by $9 million, bringing total funding for fiscal year 2010–11 to $29.1 million. In 2010–11, the number of contracts (20) remained the same, but 10 beds were added, bringing the total to 113 beds. For fiscal year 2011–12, the appropriation remained the same at $29.1 million, with 21 contracts for 122 beds. In 2012, the legislature appropriated an additional $9 million, bringing the total appropriation to $38.1 million and providing funding for up to 186 beds (see Table 2, p. 72).[7]

Based on a review of progress to date, the N.C. Center for Public Policy Research concludes that the three-way contracts have been a *qualified* success. All of the stakeholders interviewed for this article support the program's goals, but hospital officials voiced financial concerns, especially about the timeliness of the state's payments to local hospitals. Stakeholders also expressed concern about the flow of communications, partner responsibilities, provider capabilities, and the program's place within the larger landscape of mental health reform. Such concerns must be addressed if the program is to be scalable to cover the whole state and sustainable over time.

Research Background and Methodology

This analysis is part of the N.C. Center for Public Policy Research's ongoing research evaluating the state's mental health reform efforts. In 2009, the Center published a history of North Carolina's mental health reforms since Dorothea Dix's work in the 1800s, detailing the reforms in place since 2001.[8] That study identified various problems with recent reform efforts, one of which was the lack of beds available in local communities to mental health patients in crisis needing short-term care. This article examines state policies and practices regarding the purchase and provision of inpatient psychiatric care at local hospitals. It focuses on the three-way contract program as it currently is the state's main strategy in this

Table 1. A Comparison of the Number of Persons Served and Expenditures, Based on When the Service Is Provided by the Hospital vs. When the Service Is Paid for by the State, 2009–11

	Date of Service			Date of Payment		
State Fiscal Year	# Persons Served	# of Bed Days Provided	Expenditures	# Persons Served	# of Bed Days Purchased	Expenditures
2009	1,531	8,616	$ 6,462,000	1,218	6,880	$ 5,160,000
2010	4,498	24,927	18,693,931	4,336	24,895	18,671,250
2011	5,650	30,148	22,611,000	5,657	32,366	24,273,181

Source: Kent Woodson, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

area, and it is tied to two priorities identified by the N.C. Department of Health and Human Services (DHHS): the "continued development of comprehensive crisis services" and the provision of care through alternatives to hospitalization in state facilities.[9] The goal is to develop a statewide comprehensive crisis continuum, and these contracts providing psychiatric hospitalization are part of that continuum.

Owing to the program's relative youth (a little over four years), neither comprehensive outcome data nor long-term evaluations are available yet. This research represents the first effort to trace the program's development, report initial outcomes, and identify key statewide issues.[10] The research methodology involved reviewing all available documents—primarily government reports—supplemented by interviews with 15 stakeholders and circulation of the draft article to more than 50 outside reviewers. The stakeholders included state mental health officials, local mental health management entities, local hospitals, mental health advocacy groups, psychiatrists, nurses, legislators, and legislative staff. After the draft was circulated, the Center conducted additional research, and then the report was circulated again to 19 reviewers.

Assessing North Carolina's Needs for Additional Inpatient Beds in Local Hospitals

The Division of Mental Health, Development Disabilities, and Substance Abuse Services in the N.C. Department of Health and Human Services is responsible for serving persons with mental health, developmental disabilities, and substance abuse problems who are ages three and older (ages 12 and older for substance abuse).[11] Because the three-way contract program is designed primarily to serve adults with mental health illnesses, this research focuses on that population.[12]

According to the Division, 1.37 million people need mental health, developmental disability, and/or substance abuse (MH/DD/SA) services in North Carolina—14 percent of the state population.[13] Not all of these individuals will seek treatment or use the public mental health system, but overall, the state serves about 52 percent of adults needing mental health services and 12 percent of adults needing substance abuse services.[14] Furthermore, many of the adults who turn to the *public* system are low-income and uninsured. One study found that 80 percent of adult North Carolinians seeking mental health treatment did not qualify for Medicaid in 2006.[15]

Services received by such individuals likely are either state-funded or uncompensated care (i.e., charity care provided by private health care providers).

In any given year, only a subset of the adult population receiving mental health treatment through the public system will require short-term inpatient care. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services says in a report to the legislature, "North Carolina has used its state psychiatric hospitals to provide both acute (30 days or less) and long-term care. In most other states, acute care is provided in community hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stays."[16]

But, relying upon state psychiatric hospitals to provide short-term care is inconsistent with the overriding aim of the state's ongoing reform efforts: the local provision of comprehensive care. It also is inconsistent with the *Olmstead* decision, handed down in 1999 by the U.S. Supreme Court, which requires states to place people with mental disabilities in the least restrictive setting possible and in community settings rather than in institutions.[17] Specific shortcomings of providing short-term care in state institutions include the following:

- Short-term state care often *costs more than comparable local care.*
- Short-term state care often *decreases the number of beds available at state hospitals to offer long-term care.*
- Short-term state care often *requires patients to be served away from their communities.*
- Short-term state care often *is poorly integrated with local systems of care.*
- Short-term state care often *requires sheriffs or other law enforcement officers to transport patients to state hospitals.*
- The availability of short-term state care often *deters local areas from building true continuums of care because this type of care is costly for local hospitals to provide.*

All stakeholders interviewed for this evaluation agreed that many conditions requiring short-term inpatient care can be handled effectively at the local level *if* enough beds exist, *if* trained personnel are available, and *if* follow-up services are accessible. As Victoria Whitt, the CEO of the Sandhills Center for Mental Health, Developmental Disabilities, and Substance Abuse Services in West End says, "In my experience, local hospitals can handle and stabilize most people, provided the funding is there and the support services are there to handle people after discharge."

In the same vein, Dr. Marvin Swartz of the Duke University School of Medicine says that local care "is more of a normalizing experience and one that carries less stigma." He adds that local care also reduces patient interactions with the criminal justice system because law enforcement personnel typically transport people to state hospitals. In 2009, a survey of all of North Carolina's 100 county sheriffs found that there were 32,339 transports of mentally ill residents provided by deputies to serve commitment papers, transport the person to the nearest medical facility for medical clearance, and transport the individual to the nearest hospital with available psychiatric beds. A total of 228,353 hours of deputy time were involved.[18] The Raleigh *News & Observer* reported the story of Dave Descourouez, a deputy in Wake County, "'Oh, I've been to Ahoskie, and Rocky Mount, and Hickory, and Jacksonville,' said Descourouez, who estimates he's taken 150 trips since joining the department six years ago. On these trips, he's not investigating crimes or transporting criminals. He and his colleagues are carrying psychiatric patients from Wake County to mental

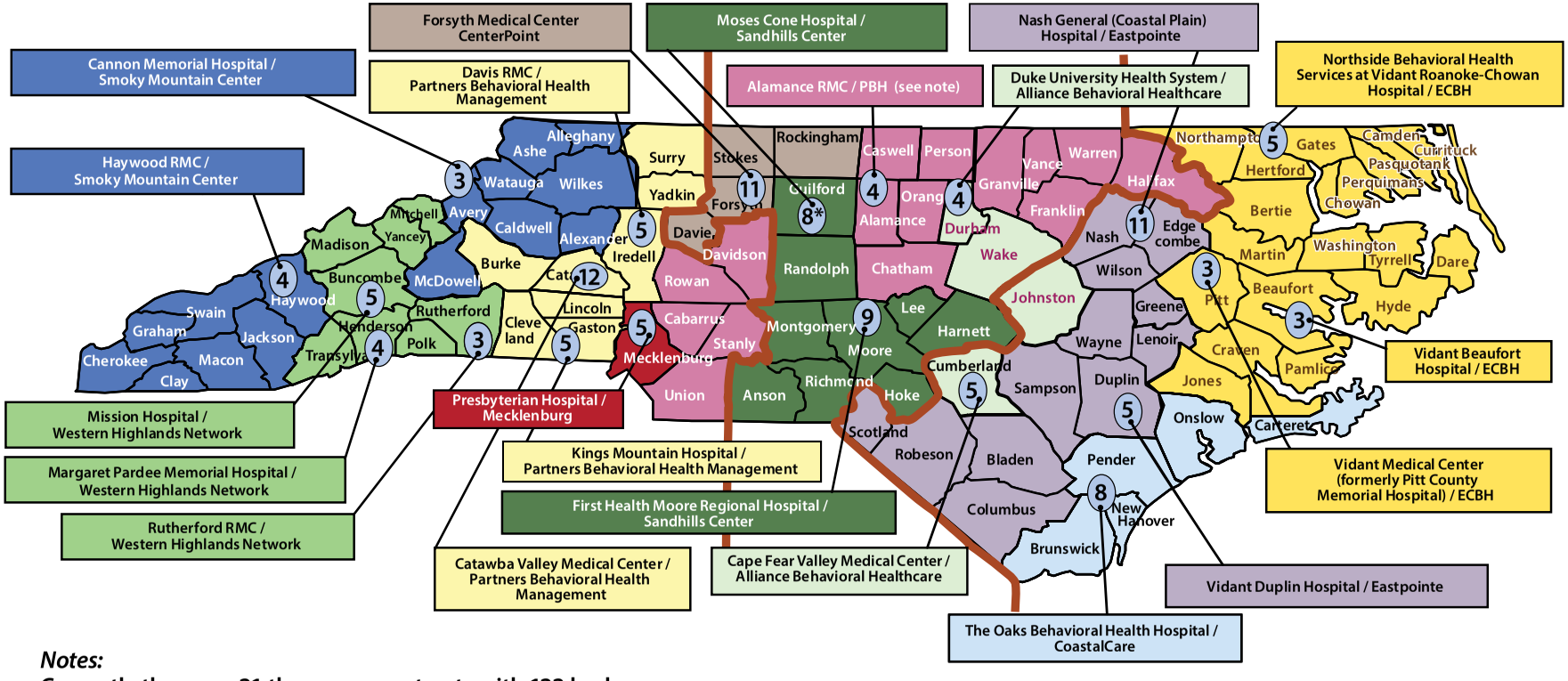
ASHBY WARD

"This is the kitchen
if you want anything . . ."
The husband
and wife
stood
looking.
I
watched her face
crack
to
pieces.

—HEARTPRINTS
BY JOAN WILDER WARLICK

EDITOR'S NOTE:
JOAN WILDER WARLICK WAS AN AWARD-WINNING NORTH CAROLINA POET. SHE WAS TREATED FOR DEPRESSION ON ASHBY WARD AT DOROTHEA DIX HOSPITAL. HER POEMS ARE REPRINTED IN THIS ARTICLE WITH HER SURVIVING DAUGHTER'S PERMSSION.

Figure 2. Three-Way Contract Community Hospital Beds as of March 9, 2012 and Proposed Local Management Entity—Managed Care Organizations (LME – MCOs) To Exist in January 2013



Notes:
Currently there are 21 three-way contracts with 122 beds:
46 in the West, 36 in the Piedmont, and 40 in the East.

= Number of beds under three-way contract

* = Moses Cone Hospital will only have 4 beds after 2011-12

In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: Kent Woodson, N.C. Division of MH/DD/SAS, adapted by NCCPPR, November 2012

health facilities with open beds. And the cost—in man-hours, and ultimately, dollars, of that duty for Wake and other sheriff's departments across the state is staggering."[19]

Unfortunately, many communities in North Carolina lack adequate numbers of short-term psychiatric beds. In 2006, prior to the conception of the three-way contract program, psychiatric beds in North Carolina hit a low of 1,592 beds statewide, a 23 percent drop since 1998 (see Figure 1, p. 66). The relative lack of beds meant that many local mental health management entities had no choice but to send people requiring short-term care to state hospitals—a choice which makes it harder to provide adequate follow-up services because of the distance from the hospitals to communities across the state. The three state psychiatric hospitals in North Carolina are: Broughton Hospital in Morganton, Central Regional Hospital in Butner, and Cherry Hospital in Goldsboro.

Local psychiatric beds are limited because a variety of practical and financial factors have led community hospitals to downsize or shutter their psychiatric services. According to Duke's Dr. Marvin Swartz, "Historically in North Carolina, we've lost over 500 local psychiatric beds due to private insurers' choices." Insurance companies set utilization and reimbursement rates. These limits on the number of days someone can be treated and how much providers are paid can create a disincentive to provide this service. And, many individuals requiring psychiatric care have either public insurance such as Medicaid or no health insurance, which leads to hospitals having to provide uncompensated care. In 2010, North Carolina hospitals provided at least $829 million in charity care (see Table 3, p. 78).[20] Many hospitals consequently reduced psychiatric services in response to these financial realities.

This is not to say that hospitals are insensitive to patients with psychiatric needs. Many view psychiatric care as part of their missions and partner with their local mental health management entities. Says Greg Billings, the administrator of psychiatric/secure care at Catawba Valley Medical Center in Hickory, *—continues on page 76*

Administrator of psychiatric care Greg Billings in the hallway of the adult unit on the 7th floor of Catawba Valley Medical Center.

Karen Tam

Table 2. Inpatient Beds in Local Hospitals Under Three-Way Contracts,

			13 Contracts		
			SFY 2008–09 Contracts		
	Local Management Entity (LME)	Hospital	# of Beds	Contract Amount	Contract Expenditures
1.	Alamance-Caswell (now with Piedmont Behavioral Healthcare)	Alamance Regional Medical Center	8	$ 534,000	$ 262,500
2.	Beacon Center	Nash General (Coastal Plain) Hospital	8	903,750	903,750
3.	CenterPoint	Forsyth Medical Center	8	749,000	354,000
4.	Crossroads	Davis Regional Medical Center			
5.	Cumberland	Cape Fear Valley Medical Center			
6.	Durham	Duke University Health System	2	305,000	303,750
7.	East Carolina Behavioral Healthcare	Vidant Beaufort Hospital	6	763,200	225,000
	East Carolina Behavioral Healthcare	Northside Behavioral Health Services at Vidant Roanoke–Chowan Hospital			
	East Carolina Behavioral Healthcare	Vidant Medical Center (formerly known as Pitt County Memorial Hospital)			
8.	Eastpointe	Brynn Marr Hospital	5	675,000	201,000
	Eastpointe	Vidant Duplin Hospital			
	Eastpointe	Wayne Memorial			
9.	Five County (now with Piedmont Behavioral Healthcare)				
10.	Guilford	Moses Cone Hospital			
11.	Johnston	Johnston Medical Center–Smithfield	0 [d]	250,000	184,411
12.	Mecklenburg	Presbyterian Hospital			
13.	Mental Health Partners	Catawba Valley Medical Center	8	1,700,000	1,686,090
	Mental Health Partners	Frye Regional Medical Center	5	675,000	300,000
14.	Onslow-Carteret				
15.	Orange-Person-Chatham				
16.	Pathways	Kings Mountain Hospital	5	478,000	166,500
17.	Piedmont Behavioral Healthcare				
18.	Sandhills	FirstHealth Moore Regional Hospital	6	500,000	469,500

by Local Mental Health Management Entities, State Fiscal Year (SFY) 2008–12

	20 Contracts			20 Contracts		21 Contracts			SFY 2012–2013 Contracts
	SFY 2009–10 Contracts			SFY 2010–11 Contracts		SFY 2011–12 Contracts			
	# of Beds	Contract Amount	Contract Expenditures	# of Beds	Contract Amount	# of Beds	Contract Amount	Expected Utilization % to Earn Contracts	Contract Amount
	8	$ 1,642,500	$ 1,304,250	4	$ 821,250	4	$ 1,095,000	100%	
	8	3,011,250	2,328,500	11	2,941,500	11	2,658,438	75%	
	8	2,292,500	2,039,175	11	2,941,500	11	2,569,875	75%	
	5	164,160	153,836	5	1,026,562	5	1,026,562	75%	
	5	596,250	218,500	5	1,026,563	5	1,368,750	100%	
	2	760,625	687,750	4	1,048,500	4	1,048,500	96%	
	6	1,231,875	1,072,547	3	615,938	3	821,250	100%	
	5	683,435	683,435	5	1,368,750	5	1,368,750	100%	
				3	460,688	3	615,938	75%	
			245,250 [a]						
	5	600,000	514,500	5	1,095,000	5	1,368,750	100%	
		[b]							
	4	407,250	407,250	4	821,250	8 [c]	1,274,250	100%	
						5	342,000 [e]	100%	
	12	2,763,750	2,804,250 [f]	12	3,285,000	12	3,285,000	100%	
	5	1,026,563	1,069,500 [g]	5	1,026,563	5	1,368,750	100%	
	6	2,737,500	1,483,000	9	2,394,000	9	2,394,000	97%	

Table 2. Inpatient Beds in Local Hospitals Under Three-Way Contracts,

			13 Contracts		
			SFY 2008–09 Contracts		
	Local Management Entity (LME)	Hospital	# of Beds	Contract Amount	Contract Expenditures
19.	Smoky Mountain	Cannon Memorial Hospital	7	$ 828,863	$ 400,000
	Smoky Mountain	Haywood Regional Medical Center	4	540,600	341,750
20.	Southeastern Center	The Oaks Behavioral Health Hospital	5	478,000	0 [h]
21.	Southeastern Regional				
22.	Wake				
23.	Western Highlands	Margaret Pardee Memorial Hospital			
	Western Highlands	St. Luke's Hospital			
	Western Highlands	Mission Hospital			
	Western Highlands	Rutherford Regional Medical Center			
	TOTALS		**77**	**$ 9,380,413**	**$ 5,798,251**
		Continuation Funding			
		Expansion Funding		8,121,644	
		Total Appropriation		$ 8,121,644	

Notes: In Fall 2011, there were 6 new hospitals interested in contracts totaling 26 beds and 9 existing hospitals with contracts wanting increases totaling 36 beds. The total overall known beds requested was 62.

Utilizations refers to the percentage of time beds must be occupied for hospitals to receive the full amount of the contract.

SFY: The state fiscal year runs from July 1 to June 30.

In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

by Local Mental Health Management Entities, SFY 2008–12, *continued*

	20 Contracts			20 Contracts		21 Contracts			SFY 2012–2013 Contracts
	SFY 2009–10 Contracts			SFY 2010–11 Contracts		SFY 2011–12 Contracts			
	# of Beds	Contract Amount	Contract Expenditures	# of Beds	Contract Amount	# of Beds	Contract Amount	Expected Utilization % to Earn Contracts	Contract Amount
	3	$ 1,642,500	$ 1,010,750	3	$ 821,250	3	$ 821,250	100%	
	4	1,300,000	1,161,250	4	1,095,000	4	1,095,000	100%	
	5	1,642,500	1,674,233 [h]	8	2,120,250	8	2,190,000	100%	
	4	440,250	440,250	4	821,250	4	821,250	75%	
	1	136,125 [i]	5,250						
	5	680,625	495,750	5	1,026,563	5	1,026,563	75%	
	2	408,375	322,500	3	615,938	3	615,938	75%	
	103	**$ 24,168,033**	**$ 20,121,726**	**113**	**$ 27,373,315**	**122**	**$ 29,175,814**		
		8,121,644			20,121,644		29,121,644		29,121,644
		12,000,000			9,000,000		0		9,000,000
		$ 20,121,644			$ 29,121,644		$ 29,121,644		$ 38,121,644

[a] Contract expired on June 30, 2010. Contract expenditures in SFY 2010 include dollars paid for services provided in SFY 2009. $52,500 was recouped by the State in SFY 2010 settlement.

[b] Contract for 5 beds for $513,282 in SFY 2010 was never signed.

[c] Contract was increased to 8 beds just for SFY 2012.

[d] Contract canceled after money was provided for start up.

[e] Operational on May 15, 2012.

[f] Contract expenditures in SFY10 include dollars paid for services provided in SFY 2009.

[g] Contract expenditures in SFY10 include dollars paid for services provided in SFY 2009.

[h] Start of contract delayed. Contract expenditures for SFY 2010 include dollars for some services provided in SFY 2009.

[i] Contract expired on June 30, 2010. Western Highlands requested that the contract be allowed to expire due to low utilization and the bed was transferred to Rutherford Hospital.

These LMEs have not contracted for beds.

—*continued from page 71*

"We want the public system to succeed, and our future is interdependent with the public system." Yet from the hospitals' perspective, the economics of psychiatric care is a serious concern.

A lack of psychiatric beds makes it harder for local mental health management entities (LMEs) to provide comprehensive services, especially care for mental health patients in crisis. Under the mental health reform legislation of 2001, LMEs were gradually to assume responsibility for managing services in their areas and must ensure the availability of core services by contracting with private, public, and nonprofit providers.[21] Furthermore, LMEs must incorporate crisis services into their continuums of care.[22] Essential to that task is the availability of beds in local hospitals for people who are temporarily unstable and pose a risk to themselves or others. Absent local inpatient beds, local mental health systems will have a service gap.

Structure and Use of Three-Way Contracts for Local Hospital Beds

The three-way contract program currently is the state's main strategy to maintain and expand the supply of short-term inpatient psychiatric beds. It does so in a way that, at least on paper, reflects the institutional concerns of the N.C. Department of Health and Human Services (DHHS), local mental health management entities (LMEs), and community hospitals—the three partners in the

The Challenges of Serving People Far from Home

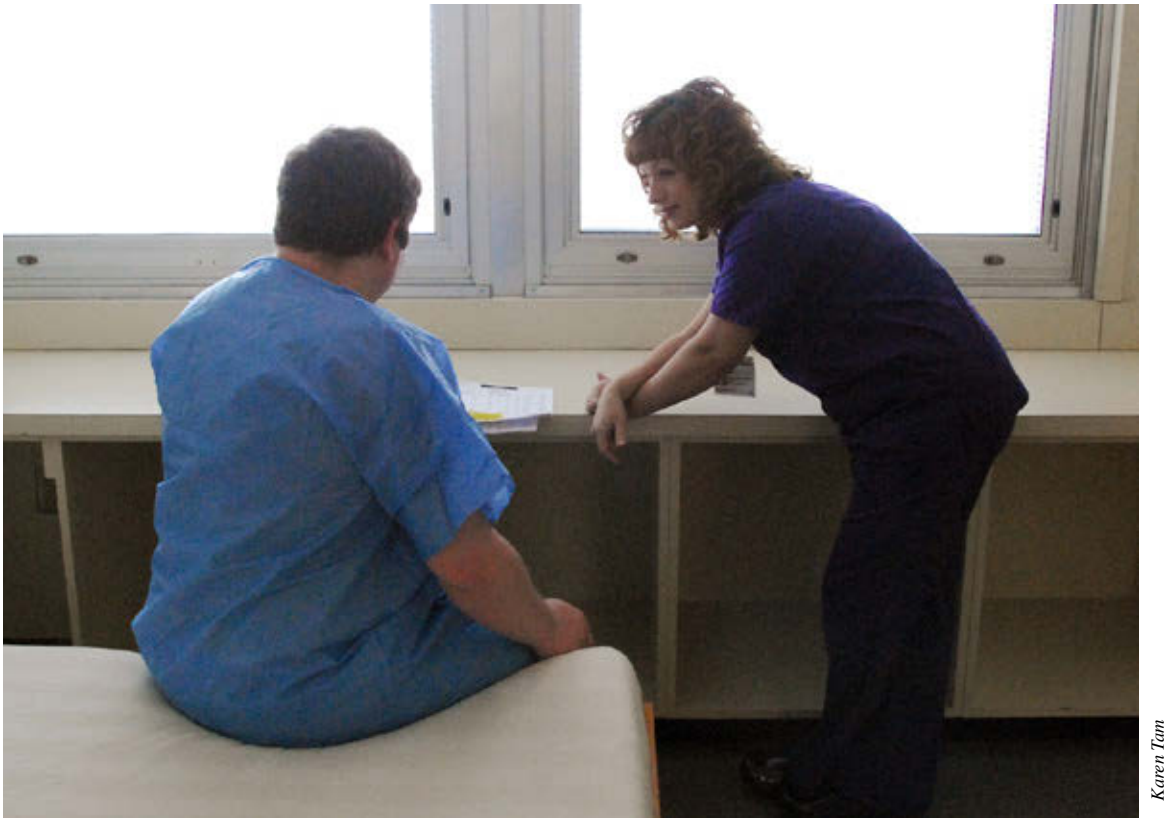
by Mebane Rash with Renee Elder

The three-way contracts are cross area service programs (CASPs) where hospitals treat individuals from outside their LME's service area if asked to do so. The benefit is that beds across the state are made available to those in need despite where they live. The disadvantage is that patients may be served far from home and away from their support network.

Patients often do not know which government program is paying for their bed, so it was difficult to find people to interview who were stable enough to consent to an interview and also knew their bed had been funded through a three-way contract. We did find one 25-year-old male with schizophrenia and bipolar disorder. Although he and his father live in Wake County, the son has been hospitalized twice at Vidant Duplin Hospital in a bed funded under the three-way contracts. The hospital is in Kenansville, which is 80 miles from Raleigh. This hospital uses its three-way contract to serve patients from other LMEs more than any other hospital participating in the program. More than 60 percent of those served by Duplin Hospital are from another LME (see also Table 7, p. 90).

The father said that both times his son was having a psychotic episode, the beds at Duplin Hospital were the ones available. The son said the experience was isolating and caused issues with his medications because the doctors didn't really communicate with his psychiatrist in Raleigh. The dad said the distance made visiting problematic for him and for the social worker in charge of his son's case. Both expressed the need for community support services outside the hospital setting to follow up with medication and paperwork.

The son is now in a group home in Raleigh. His father says the group home has done a good job of providing the support that his son needs to take his medication regularly and establish routines in eating and sleeping. These are the first steps toward getting a job and financial independence.



Karen Tam

Kimberly Yates works with patients admitted to a three-way contract bed.

contracts—in addition to addressing the shortcomings of past efforts. The desired result is better care for patients.

The Interests and Concerns of the Three Parties in the Contracts

All parties to the three-way contracts recognize the advantages of local care and wish to increase the number of beds available statewide for those in crisis. According to Leza Wainwright, the former director of the state's Division of Mental Health, the program begins "to reverse the trend that has been true in North Carolina and across the country of community hospitals going out of the inpatient psychiatric business." Other experts, like Duke's Dr. Swartz agree with that goal, but caution that "North Carolina is getting into this late in the game." The challenge is turning that desire into a form that satisfies stakeholder interests. Or, as Michael Watson, the director of the Division of Medical Assistance which manages the Medicaid program in North Carolina, puts it, "How do we get community capacity increased, and what are the concerns?"

"The three-way contracts use money as a carrot to bring the stakeholders together."

The three-way contracts use money as a carrot to bring the stakeholders together. From the hospitals' perspective, this is a population that, if treated, will lead to uncompensated care, so the ability to receive payment for those patients is an incentive for expanding capacity. From a local perspective, says Victoria Whitt of the Sandhills Center in West End, this approach "likely gets at people with the greatest needs." And, from the state's perspective, this is the population most likely to wind up at a state hospital.

Individual hospitals and the North Carolina Hospital Association participate in the program to receive payments for services that otherwise would be discontinued or provided without compensation. For instance, without three-way contract funds, Cannon Memorial Hospital in Linville would be *—continues on page 82*

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
1.	Alamance Regional Medical Center	Burlington	$ 7,029,744	$ 9,041,202	$ 16,070,946
2.	Albemarle Hospital	Elizabeth City	1,919,294	5,814,595	7,733,889
3.	Alleghany Memorial Hospital	Sparta	286,543	662,528	949,071
4.	Angel Medical Center	Franklin	502,050	2,683,087	3,185,137
5.	Betsy Johnson Regional Hospital	Dunn	4,777,408	7,022,368	11,799,776
6.	Bladen Healthcare, LLC	Elizabethtown	343,214	3,527,209	3,870,423
7.	Blowing Rock Hospital	Blowing Rock	190,764	206,437	397,201
8.	Blue Ridge Regional Hospital	Spruce Pine	448,506	2,326,324	2,774,830
9.	Brunswick Novant Medical Center	Bolivia	6,062,374	1,719,859	7,782,233
10.	Caldwell Memorial Hospital	Lenoir	1,522,757	4,121,278	5,644,035
11.	Cannon Memorial Hospital	Linville	548,218	1,365,245	1,913,463
12.	Cape Fear Valley Medical Center	Fayetteville	21,784,000	23,153,000	44,937,000
13.	CarolinaEast Medical Center	New Bern	3,850,051	10,091,232	13,941,283
14.	Carolinas Medical Center	Charlotte	150,186,025	75,341,871	225,527,896
15.	Carteret County General Hospital	Morehead City	2,385,901	5,456,145	7,842,046
16.	Catawba Valley Medical Center	Hickory	3,689,748	9,475,170	13,164,918
17.	Chatham Hospital	Siler City	133,667	3,685,594	3,819,261
18.	Cleveland Regional Medical Center	Shelby	7,502,817	12,078,921	19,581,738
19.	Columbus Regional Healthcare System	Whiteville	1,574,096	2,984,302	4,558,398
20.	Care Partners Health Services	Asheville	245,543	215,511	461,054
21.	Cone Health	Greensboro	51,428,017	26,613,580	78,041,597
22.	Davie Hospital	Mocksville	101,583	1,264,041	1,365,624
23.	Duke Raleigh Hospital	Raleigh	9,185,199	3,184,301	12,369,500
24.	Duke University Hospital	Durham	37,124,435	67,570,074	104,694,509
25.	Durham Regional Hospital	Durham	17,822,703	2,049,924	19,872,627

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010, *continued*

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
26.	FirstHealth Montgomery Memorial Hospital	Troy	$ 565,386	$ 1,084,825	$ 1,650,211
27.	FirstHealth Moore Regional Hospital	Pinehurst	8,498,148	7,950,830	16,448,978
28.	FirstHealth Richmond Memorial Hospital	Rockingham	1,665,538	2,031,499	3,697,037
29.	Forsyth Medical Center	Winston-Salem	35,417,166	16,932,665	52,349,831
30.	Franklin Regional Medical Center	Louisburg	4,388,005	1,625,617	6,013,622
31.	Gaston Memorial Hospital	Gastonia	13,481,041	13,775,512	27,256,553
32.	Grace Hospital	Morganton	4,874,829	12,294,120	17,168,949
33.	Granville Health System	Oxford	787,166	3,463,656	4,250,822
34.	Halifax Regional Medical Center	Roanoke Rapids	432,252	6,134,512	6,566,764
35.	Harris Regional Hospital	Sylva	1,207,711	4,575,746	5,783,457
36.	Haywood Regional Medical Center	Clyde	2,646,001	4,195,344	6,841,345
37.	High Point Regional Health System	High Point	7,059,950	14,313,180	21,373,130
38.	Highlands-Cashiers Hospital	Highlands	217,981	1,014,607	1,232,588
39.	Hugh Chatham Memorial Hospital	Elkin	1,369,496	5,445,432	6,814,928
40.	Iredell Memorial Hospital	Statesville	6,763,698	6,721,403	13,485,101
41.	J. Arthur Dosher Memorial Hospital	Southport	306,998	2,399,839	2,706,837
42.	Johnston Medical Center	Smithfield	3,044,935	10,007,595	13,052,530
43.	Kings Mountain Hospital	Kings Mountain	7,502,817	12,078,921	19,581,738
44.	Lenoir Memorial Hospital	Kinston	1,234,106	9,381,894	10,616,000
45.	Lexington Memorial Hospital	Lexington	1,259,160	4,689,876	5,949,036
46.	Margaret Pardee Memorial Hospital	Hendersonville	1,317,220	7,727,137	9,044,357
47.	Maria Parham Hospital	Henderson	440,452	6,023,429	6,463,881
48.	Medical Park Hospital	Winston-Salem	1,400,264	1,243,024	2,643,288
49.	Mission Hospital	Asheville	15,395,935	23,893,441	39,289,376
50.	Morehead Memorial Hospital	Eden	1,386,772	5,706,449	7,093,221

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010, *continued*

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
51.	Murphy Medical Center	Murphy	$ 2,357,315	$ 2,327,674	4,684,989
52.	Nash Health Care System	Rocky Mount	3,600,201	12,553,137	16,153,338
53.	New Hanover Regional Medical Center	Wilmington	14,627,816	29,606,304	44,234,120
54.	North Carolina Baptist Hospital	Winston-Salem	46,834,476	13,522,343	60,356,819
55.	Northern Hospital of Surry County	Mount Airy	1,978,851	4,629,692	6,608,543
56.	Onslow Memorial Hospital	Jacksonville	1,966,461	11,503,033	13,469,494
57.	Park Ridge Health	Hendersonville	3,482,959	2,366,102	5,849,061
58.	Pender Memorial Hospital	Burgaw	241,291	2,186,423	2,427,714
59.	Person Memorial Hospital	Roxboro	670,570	2,742,294	3,412,864
60.	Presbyterian Hospital	Charlotte	26,876,532	14,950,138	41,826,670
61.	Presbyterian Hospital Huntersville	Huntersville	5,412,786	3,250,386	8,663,172
62.	Presbyterian Hospital Matthews	Matthews	7,492,171	4,414,364	11,906,535
63.	Randolph Hospital	Asheboro	1,741,904	7,463,234	9,205,138
64.	Rex Healthcare	Raleigh	26,157,374	8,195,089	34,352,463
65.	Rowan Regional Medical Center	Salisbury	10,403,840	4,078,442	14,482,282
66.	Rutherford Regional Medical Center	Rutherfordton	2,732,870	5,105,138	7,838,008
67.	Sampson Regional Medical Center	Clinton	243,095	5,349,687	5,592,782
68.	Scotland Health Care System	Laurinburg	3,243,965	5,383,261	8,627,226
69.	Southeastern Regional Medical Center	Lumberton	3,865,831	14,525,619	18,391,450
70.	St. Luke's Hospital	Columbus	526,195	1,161,125	1,687,320
71.	Stanly Regional Medical Center	Albemarle	3,412,822	4,194,535	7,607,357
72.	Swain County Hospital	Bryson City	90,531	1,165,564	1,256,095
73.	McDowell Hospital	Marion	441,493	2,861,928	3,303,421
74.	The Outer Banks Hospital	Nags Head	1,510,444	3,009,459	4,519,903
75.	Thomasville Medical Center	Thomasville	7,149,299	1,878,158	9,027,457

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010, *continued*

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
76.	Transylvania Regional Hospital	Brevard	$ 1,860,109	$ 2,529,668	$ 4,389,777
77.	UNC Hospitals	Chapel Hill	65,321,115	4,623,924	69,945,039
78.	Valdese General Hospital	Valdese	4,874,829	12,294,120	17,168,949
79.	Vidant Bertie Hospital	Windsor	725,963	888,331	1,614,294
80.	Vidant Chowan Hospital	Edenton	1,624,020	1,972,392	3,596,412
81.	Vidant Duplin Hospital	Kenansville	245,321	4,318,338	4,563,659
82.	Vidant Edgecombe Hospital	Tarboro	2,665,749	3,553,663	6,219,412
83.	Vidant Medical Center	Greenville	33,568,824	24,592,262	58,161,086
84.	Vidant Pungo Hospital	Belhaven	672,701	1,121,168	1,793,869
85.	Vidant Roanoke-Chowan Hospital	Ahoskie	2,200,324	4,106,396	6,306,720
86.	WakeMed Health and Hospitals	Raleigh	67,311,767	10,576,902	77,888,669
87.	Watauga Medical Center	Boone	2,468,283	4,233,964	6,702,247
88.	Wayne Memorial Hospital	Goldsboro	7,535,266	9,825,823	17,361,089
89.	Wilkes Regional Medical Center	North Wilkesboro	2,013,382	3,992,430	6,005,812
90.	Wilson Medical Center	Wilson	6,057,965	4,569,973	10,627,938
	TOTALS		**$ 829,514,394**	**$ 727,986,834**	**$ 1,557,501,228**

Source: Data obtained from the N.C. Hospital Association, North Carolina Hospital Community Benefits Report, 2010. On the Internet at *http://www.ncha.org/public/* and then click on Community Benefits Reports. Items A and S in the reports were used to create this table. Data accessed on April 17, 2012. This data is self-reported by the hospitals and has not been validated. Data not available for all hospitals. Some of the names of the hospitals have been updated.

—*continued from page 77*

unable to maintain the 10-bed inpatient psychiatric unit that it opened late in 2008, says Stephanie Greer, the director of behavioral health for the Appalachian Regional Healthcare System.[23]

But hospitals remain concerned about the economic viability of psychiatric care, and even with the contracts, they often are not able to cover their cost of care. At the same time, past experience in pilot programs have left some hospitals wary of the state's long-term commitment to initiatives. For instance, Greg Billings of Catawba Valley Medical Center notes how past partnerships involving the state and LMEs have been troubled by slow payment and abrupt termination.[24] This has eroded the hospitals' confidence in the reliability of state systems and funding.

For **local mental health management entities**, the availability of local inpatient beds through the contracts has increased their ability to provide the comprehensive mental health services expected of them by the state, especially crisis care. State dollars for this purpose are helpful since many LMEs are coping with state and local funding reductions, mounting service demands, and caseloads that are becoming harder to serve. For instance, in 2009–10, the Division of Mental Health's budget was cut from $820 million to $664 million—a 19 percent reduction in funds. About 20 percent of the dollars have been restored, so in 2012–13, the Division's budget increased to $696 million.[25] Over the same time period from 2009 to 2012, LMEs have increased the number of persons served by more than 30,000, a 10 percent increase from 326,563 to 360,180.[26]

DON'T DO THIS ON MY SHIFT

Just shut up!
Don't scream!
Don't on my shift.

I am having a nervous breakdown
It's with me every minute
No one will listen.

—HEARTPRINTS
BY JOAN WILDER WARLICK

Compounding the challenges facing LMEs is the fact that many of them are in flux as they merge into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services (see Table 4, p. 86). According to the Division, the waiver and the attendant merger of the LMEs should not affect the three-way contracts because the shift to MCOs is primarily a change in organizational structure and purpose that will not change the need for either the contracts or the need for short-term beds. The bottom line is that contract dollars free up LME-MCO funds for other uses.

As for **the state**, it wants to facilitate the transition to a locally-based mental health system. This contributes to the larger state goal of mental health reform and reducing short-term state psychiatric hospital admissions in compliance with the U.S. Supreme Court decision in *Olmstead,* requiring treatment to be provided in the least restrictive setting possible.[27] Although the care provided through the program is state-funded, it typically is cheaper than providing care in state psychiatric hospitals—where care is primarily funded by the state.[28]

The three-way contracts differ from other methods of purchasing psychiatric beds (see sidebar on p. 83) in that they involve the state, LMEs, and local hospitals. Seen one way, the program runs counter to the policy goals of local control, in that the state agency is involved in otherwise local relationships. Yet stakeholders said that the hospitals wanted direct state involvement based on the belief that direct state involvement would signal a deeper commitment, create standardization, and lead to prompt payment. Says Michael Vicario, vice president of regulatory affairs for the North Carolina Hospital Association, "There is a lot of commitment that, I think, goes into establishing a psychiatric service and when you commit to expand it as well. So, I think when local hospitals do that, they deserve some assurance from the state that the program will be continued."[29]

Target Population

The contracts allow adults needing inpatient psychiatric services to be treated for up to seven days and patients needing medical detoxification services for substance abuse to be treated for up to four days. Patients must be referred and authorized by an LME and meet the following criteria: (1) they require inpatient care; (2) they

must be indigent and uninsured; (3) they have been involuntarily committed (though some voluntary commitments are possible); (4) they are otherwise admissible to a state hospital; and (5) they need short-term stabilization. With approval, patients may be treated for as long as needed to stabilize them or transfer them to a state facility.

Patients requiring care typically are facing a destabilizing crisis that makes them a risk to themselves or others. Underlying diagnoses include severe psychotic disorders, schizophrenia, and post-traumatic stress. Crises often are triggered by a medication problem or severe stress. Some patients also may have substance abuse issues requiring treatment.

Responsibilities of the Parties

Although structured as a three-way partnership, much of the day-to-day work revolves around the relationships between local hospitals and their local mental health management entities. LMEs are responsible for managing the contracts on a daily basis and serve as the program's financial pipeline. LMEs work with the participating hospitals to authorize admissions and reauthorizations, if applicable, and also are responsible for coordinating the patient's care and discharge plans. LMEs are responsible, too, for managing admissions requested by other LMEs and making a

Buying Psychiatric Beds in North Carolina

by John Quinterno

Stakeholders in the mental health system are cognizant of the need to maintain and expand local hospital capacity. Over the years, the state and the local mental health management entities (LMEs) have entered into various partnerships with local hospitals. One way to foster capacity is to purchase psychiatric beds in local hospitals, and there have been four ways in which beds could be purchased:

- LMEs may use local funds to purchase beds. Seven LMEs have purchased beds with local funds to date: CenterPoint, Cumberland, Guilford, Mecklenburg, Mental Health Partners, Orange-Person-Chatham, and Wake. In 2010–11, these LMEs spent a combined $22 million to purchase 28,395 actual bed days.
- LMEs may use part of their generic allocation of state funding to purchase beds. In 2010–11, 16 LMEs spent $18 million to purchase 32,304 actual bed days serving 4,513 persons.
- LMEs may use hospitalization utilization project funds to purchase beds. N.C. Session Law 2007-323 provided funds for four LMEs (CenterPoint, Mecklenburg, Smoky Mountain, and Western Highlands) to purchase beds and develop strategies to serve people locally rather than send them to state hospitals.
- Partnerships among hospitals, LMEs, and the state may use three-way contract funds to purchase beds, as discussed in this article.

The services received by a patient do not vary based on funding sources, at least in theory.

Source: See North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Uniform System for Beds or Bed Days Purchased: with Local Funds, from Existing State Appropriations, under the Hospital Utilization Pilot, and from Funds Appropriated under Session Law 2011-145, Section 10.8.(b), Raleigh, NC, April 1, 2009 and May 25, 2012.

Karen Tam

Forsyth Medical Center has eleven beds in the three-way contract program.

"reasonable effort" to coordinate discharge care with the home LME. And, the LMEs receive and approve billings from the hospitals, forward bills to the state, receive payments, and then make payments to the hospitals.[30]

Participating hospitals must add or expand inpatient psychiatric capacity and use program funds to supplement, not supplant, other public funding (federal, state, and local) received for psychiatric services. Hospitals agree to accept referrals (both involuntary and voluntary) coordinated by the LME, reach an admissions decision within two hours of the initial referral or request, and agree not to transfer anyone to a state hospital without the LME's permission. Hospitals must have qualified staffs, work with the LME around discharge planning, and, if needed, provide discharged patients with a seven-day supply of psychotropic medicines—drugs that affect the mind, emotions, or behavior. Hospitals also must satisfy reporting and billing requirements.[31]

The state, meanwhile, is responsible for coordinating the overall program, paying authorized claims, and sanctioning parties for noncompliance. Additionally, the state agrees to grant priority admission at state hospitals to three-way contract patients who prove to have more complex treatment needs. The area LME and regional state hospital must approve transfers.[32]

Payment Rates and Funding

Participating hospitals receive a flat rate of $750 per day. This rate is designed to include a payment for hospital services, a payment for physician services, and a payment for discharge medications. The rate does not vary by condition or treatment type. Payment is made only for inpatient psychiatric services and does not cover other services like emergency room charges and administrative costs. The total amount of funding that a hospital may receive over a 12-month period also is capped.[33]

According to a 2012 report to the legislature by the Division, "[t]he current rate at state psychiatric hospitals ranges from $886 to $1,147 per day."[34] Michael Watson of the Division of Medical Assistance says the Medicaid payment rate is around $480–550 per day, but that does not include physician charges or discharge medication. When making these types of comparisons, Watson cautions that the three-way contracts are targeting a different group of patients needing a different mix of services than these other populations.

Funding for the three-way contracts comes from appropriations by the legislature from the state's General Fund. During state fiscal year 2008–09, the legislature provided $8.1 million in recurring funding. For state fiscal year 2009–10, the legislature added $12 million in recurring funds for a total of $20.1 million. For state fiscal years 2010–11 and 2011–12, the legislature added $9 million in recurring funds bringing the total annual appropriation to $29.1 million.[35] In 2012, the legislature added another $9 million in recurring funds, bringing the total annual appropriation to $38.1 million.[36]

Issues and Concerns

Although just in its fourth year of operation, the three-way contract program has succeeded in expanding the number of beds available statewide for those in crisis at local hospitals and diverting admissions from state hospitals to the local hospitals. The contracts receive generally positive reviews from the state agency, LMEs, hospitals, and patient advocates. Nevertheless, this success is qualified by certain unresolved issues that may compromise long-term effectiveness. These concerns involve the program's structure, financing, the state's long-term mental health reform goals, patient treatment, and the adequacy of the work force.

Increasing Capacity To Serve Patients with Mental Health Needs

By the end of fiscal year 2008–09, contracts had been signed with 13 hospitals for the purchase of 77 beds. These contracts were renewed for fiscal year 2009–10, and another seven contracts for the purchase of 26 additional beds were signed, bringing the total to 103 beds. In fiscal year 2010–11, the number of contracts (20) remained the same, but 10 beds were added, bringing the total to 113 beds. For fiscal year 2011–12, there are 21 contracts for 122 beds (see Table 2, p. 72). This means that the three-way contracts have succeeded in adding 122 short-term psychiatric beds to the state's supply.

The three-way contracts allowed hospitals to serve 1,531 persons in fiscal year 2008–09, providing 8,616 actual bed days. The additional capacity in fiscal year 2010–11 allowed for 5,650 persons to be served through the provision of 30,148 bed days (see Table 1, p. 68). There were 5,975 total admissions. The average length of stay for patients served through the three-way contracts at all hospitals is less than seven days.[37]

Yet even with these 122 beds, the supply falls short of the need. Some experts contend that a state needs 50 psychiatric beds per 100,000 residents.[38] For North Carolina to have 50 psychiatric beds per 100,000 residents, the state would need 4,868 beds statewide, or 2,087 more beds.[39] However, Beth Melcher, chief deputy secretary of the N.C. Department of Health and Human Services, notes that other studies support the need for between 22–31 beds per 100,000 residents. Adding the 1,744 beds in licensed psychiatric facilities (see Figure 1, p. 66) and the 864 beds in the state psychiatric hospitals (see Table 5, p. 87), North Carolina currently has a total of 2,608 psychiatric inpatient beds—26.8 beds per 100,000 residents.

Insight #1: ***Even with the 122 beds added by the three-way contracts, the number of beds available to mental health patients in crisis that can be treated in seven days or less falls short of the need in North Carolina. The state needs a methodology that provides a consistent way to determine the required ratio of beds to population that would adequately serve diverse areas of the state.***

In an article in the *North Carolina Medical Journal*, Marvin Swartz of the Duke University School of Medicine and Joseph Morrissey of the Sheps Center for Health Sciences Research at UNC-Chapel Hill note:

> The larger problem underlying the growing shortage of psychiatric beds in North Carolina is the absence of a rational bed-need methodology

Table 4. Projected Local Management Entities — Managed Care Organizations (LME-MCOs) in North Carolina

	LME-MCO	#	Counties	# of Persons Served	Effective Date
	Western Region				
1.	Piedmont Behavioral Healthcare (PBH)	15	Alamance, Cabarrus, Caswell, Chatham, Davidson, Franklin, Granville, Halifax, Orange, Person, Rowan, Stanly, Union, Vance, Warren	1,390,537	April 2012
2.	Western Highlands Network	8	Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey	511,122	January 2012
3.	Partners Behavioral Health Management	8	Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin	906,746	July 2012
4.	Smoky Mountain Center	15	Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga, Wilkes	525,754	July 2012
5.	Mecklenburg	1	Mecklenburg	909,493	January 2013
	Central Region				
6.	Sandhills Center	9	Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	1,039,175	October 2012
7.	Alliance Behavioral Healthcare	4	Cumberland, Durham, Johnston, Wake	1,670,677	January 2013
8.	CenterPoint Human Services	4	Davie, Forsyth, Rockingham, Stokes	542,942	January 2013
	Eastern Region				
9.	East Carolina Behavioral Health	19	Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington	593,300	April 2012
10.	CoastalCare	5	Brunswick, Carteret, New Hanover, Onslow, Pender	608,215	July 2012
11.	Eastpointe	12	Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, Wilson	802,055	January 2013
	TOTALS	**100**		**9,500,016**	

Note: In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: N.C. Department of Health and Human Services, "Why are Local Management Entities Merging?" On the Internet at *http://www.ncdhhs.gov/mhddsas/communicationbulletins/commbulletin123/lmesmerging-factsheet.pdf*, accessed on July 10, 2012.

> for determining the required ratio of beds to population that would adequately serve diverse areas of the state. Current beds allocations are based largely on historical trends rather than on careful assessments of population needs and the varying availability of state, private, and general hospital psychiatric beds and crisis services that can help to meet needs for intensive care with fewer beds per capita.[40]

But according to the state's own plan, seven LMEs will need at least 73 more beds providing adult inpatient psychiatric care by 2014 (see Table 6, p. 88). Furthermore, demand from the hospitals for additional beds at this rate continues. In fall 2011, six hospitals wanted to add new three-way contracts totaling 26 beds and nine hospitals with existing contracts wanted to add a total of 36 beds. In sum, the hospitals requested an additional 62 beds.

And, wait times in emergency departments across the state also underscore the need for more beds. For instance, during fiscal year 2010, 135,536 people were treated in hospital emergency departments across the state for a mental health crisis. More than 20 percent were transferred to a community psychiatric hospital bed—only some of which were operating under three-way contracts. Only 239, or 2.7 percent, were sent to a state psychiatric hospital. The average length of stay in emergency departments for those that were transferred to a community hospital was 14 hours and 7 minutes. The average length of stay for those that were transferred to a state psychiatric hospital was 26 hours and 38 minutes—more than 12 hours longer.[41]

When selecting where to establish new contracts or to expand existing contracts, several factors should be considered. Because the state's goal is to divert patients from admission to a state psychiatric hospital, the state wants to add capacity to areas

Table 5. Number of Beds at State Psychiatric Hospitals in North Carolina

State Psychiatric Hospital	Number of Beds 2011–12	Beds Added by 2012 Legislature	Total Number of Beds 2013
Broughton Hospital, Morganton	278	19	297
Cherry Hospital, Goldsboro	190	124	314
Central Regional Hospital (including Dorothea Dix Hospital), Butner	396	0	396
Total	**864**	**143**	**1,007**

Source: Division of State Operated Healthcare Facilities

Table 6. Comparison of Adult Inpatient Psychiatric Beds, Excluding State Hospitals, with the State's Projection of Beds Needed in 2014 and Allocation of 3-Way Contract Beds by Local Mental Health Management Entities

	LME	Total # of Adult Beds	Projected Surplus or Deficit of Adult Beds in 2014	# of Beds Under 3-Way Contracts in SFY 2011–12
1.	Alamance-Caswell (PBH)	36	13	4
2.	Beacon Center	67	29	11
3.	CenterPoint	154	86	11
4.	Crossroads	28	–2	5
5.	Cumberland	28	8	5
6.	Durham	42	16	4
7.	East Carolina Behavioral Healthcare	125	34	11
8.	Eastpointe	86	51	5
9.	Five County (PBH)	33	–3	0
10.	Guilford	74	7	8
11.	Johnston	20	0	0
12.	Mecklenburg	165	–6	5
13.	Mental Health Partners	144	98	12
14.	Onslow-Carteret	22	–5	0
15.	Orange-Person-Chatham	58	29	0
16.	Pathways	50	–3	5
17.	Piedmont Behavioral Healthcare	87	14	0
18.	Sandhills	72	13	9
19.	Smoky Mountain	32	–23	7
20.	Southeastern Center	62	23	8
21.	Southeastern Regional	33	3	0
22.	Wake	68	–37	0
23.	Western Highlands	131	35	12
	Total	**1,617**		**122**

Note: In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: The N.C. Division of Health Service Regulation, State Medical Facilities Plan 2012. On the Internet at *http://www.ncdhhs.gov/dhsr/ncsmfp/index.html,* accessed on April 17, 2012.

that have mental health needs, but institutional and practical concerns also come into play.

A budget provision in 2011 required that "[t]he Department shall work to ensure that these contracts are awarded equitably around all regions of the State."[42] Currently, there are signed three-way contracts in 16 of the state's LMEs. Beds purchased through the three-way contract program are allocated across the state's three major geographic regions—46 beds in the Western Region, 36 beds in the Central Region, and 40 beds in the Eastern Region (see Figure 2, p. 70).

But there are other important considerations. First, if a hospital doesn't offer mental health services, the three-way contract is a much harder sell because the hospital needs to create the unit from scratch, and the three-way contract does not provide an incentive to do so. In some cases, start-up costs have been provided: for instance, $100,000 in start-up costs was provided for the contract with Davis Regional Medical Center in Statesville and the Crossroads LME. Three-way contracts work best for hospitals with capacities they want to preserve or expand.

Insight #2: ***When selecting where to establish new contracts or to expand existing contracts, equitable distribution among the three broad geographic regions of the state is one factor required by the legislature, but other factors also are important.***

Second, determining where the beds are needed most can be difficult. LMEs that currently do not have contracts and are in areas where the state predicts a need for additional adult beds should have priority. According to the State Medical Facilities Plan, seven LMEs will need at least 73 more beds providing adult inpatient psychiatric care by 2014: Crossroads needs two beds, Five County under management of Piedmont Behavioral Healthcare needs three beds, Mecklenburg needs six beds, Onslow-Carteret needs five beds, Pathways needs 3 beds, Smoky Mountain needs 23 beds, and Wake needs 37 beds (see Table 6).[43]

Third, Kent Woodson, program manager for the three-way contracts for the Division, emphasizes the importance of awarding contracts based on data that

Greg Billings, administrator of psychiatric care, prepares a seclusion room with only a mat.

Karen Tam

Table 7. Cross Area Service Plan Analysis for Three-Way Contracts: Percent of Contract Beds Used by Hospitals Inside Their Local Mental Health Management Entity's Service Area

	Hospital	% of Contract Beds Used by Hospital for Their LME
1.	Vidant Duplin Hospital	39%
2.	Vidant Beaufort Hospital	47%
3.	Catawba Valley Medical Center	47%
4.	Cannon Memorial Hospital	50%
5.	Duke University Health System	52%
6.	Northside Behavioral Health Services at Vidant-Chowan Hospital	58%
7.	Kings Mountain Hospital	71%
8.	Nash General (Coastal Plain) Hospital	76%
9.	Davis Regional Medical Center	77%
10.	Moses Cone Hospital	83%
11.	Alamance Regional Medical Center	89%
12.	Vidant Medical Center (formerly known as Pitt County Memorial Hospital)	89%
13.	Haywood Regional Medical Center	93%
14.	Forsyth Medical Center	94%
15.	Cape Fear Valley Medical Center	95%
16.	FirstHealth Moore Regional Hospital	95%
17.	Margaret Pardee Memorial Hospital	96%
18.	The Oaks Behavioral Health Hospital	97%
19.	Rutherford Regional Medical Center	97%
20.	Mission Hospital	98%

Source: Kent Woodson, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

indicates where the beds are most likely to be used. The state should continue to evaluate the number of short-term admissions at state psychiatric hospitals coming from each LME, wait times in emergency departments, and cross area service plan data when it considers where to award or expand contracts. For instance, although the primary goal of the contracts should be to provide beds for those in crisis, having those beds closer to home is a real benefit to the program's structure and a benefit to patients. For four participating hospitals, at least 50 percent of their beds are for people who are not from their home LME (see Table 7).

The Division's research suggests that participating hospitals have neither increased the lengths of patients stays to draw down extra money, nor have they swapped one kind of publicly-funded bed for another (e.g., switching from Medicaid patients to charity care patients), according to Leza Wainwright, the former director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.[44] And as Victoria Whitt of the Sandhills Center in West End notes, this dynamic has freed up funds which LMEs can redirect to other services. Additionally, Michael Vicario of the N.C. Hospital Association says that other hospitals are interested in joining the program.

Concerns About Transfers to State Psychiatric Hospitals

One of the most serious problems with the three-way contracts is the difficulty in arranging transfers of patients from the local hospitals to the state psychiatric hospitals.[45] Patients who require more intense care are supposed to receive priority admission to the state psychiatric hospitals under the provisions of the three-way contracts. Many hospitals are not interested in treating these patients with short-term care without the assurance that if long-term care is needed, the state facilities will provide it. Nevertheless, local stakeholders report that priority transfers are difficult to arrange. One hospital administrator says,

> In our experience, patients served by three-way contracts do not receive priority. Fortunately, our LME has continued to reauthorize the longer stays. It seems that referrals are triaged as presented and those being held in emergency departments generally take priority. Given the volume, it is hard to fault those on the front lines making these decisions. Once a patient is admitted to an inpatient unit, they automatically drop down the wait list. In our experience, typically there are approximately 25 males on the Broughton [one of the state's psychiatric hospitals] list at any given time. As proven again yesterday, a patient has to actually cause harm and/or damage before they are expedited to a state bed. We had an extremely aggressive patient for a week before he was accepted to Broughton, one of the state's psychiatric hospitals. It took several staff assaults and significant unit damage before the transfer took place. And, although we accept patients from across the state, it is virtually impossible to get a bed in either the central or eastern region if a patient requires that disposition after being admitted to our unit. We have continued to harden our environment and increase the level of training for our staff, but there are limits to what any community hospital can manage.

Insight #3:
Priority transfers for those served under three-way contracts to the state psychiatric hospitals are often difficult to arrange.

The lack of priority transfers may be due to unclear processes at state psychiatric hospitals or to delays in admission caused by staffing reductions. Or, it could be a by-product of the reduction in the number of staffed beds at the state psychiatric hospitals. The staff at the Division of Mental Health says some of the confusion results from local hospitals thinking that all of their patients qualify for priority transfers, not just those served in the three-way beds. The Division staff also say priority transfers have to be balanced with high-needs patients in the emergency departments.

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Susan Saik, the medical director for the Division of State Operated Healthcare Facilities, says, "There is a structured process in place for transfers. Delays are never due to staffing problems in the admitting office. There are a fixed number of inpatient beds, which is associated with the number of staff that the state has authorized and funded to operate those beds." Whatever the cause, transfers to state psychiatric hospitals are a serious issue for the local hospitals and must be addressed.

Cristy Williams[46] is a nurse at Catawba Valley Medical Center in Hickory, and she is the patient care coordinator in the psychiatric unit. She is in charge of the three-way contracts at her hospital. Williams says that in her experience referring patients who require more intensive or longer-term care to state hospitals can be difficult due to bed shortages. "My biggest challenge is getting patients to state facilities when longer-term residential treatment is required. If I have a patient who is violent, I can call and that helps with priority, but still, if they don't have a bed, they don't have a bed." (See Williams' sidebar on "The Admissions Process Begins the Discharge Process," p. 93).

Insight #4: ***At least every five years, the N.C. Department of Health and Human Services and the Joint Legislative Oversight Committee on Health and Human Services should re-examine whether the flat rate paid per day (currently set at $750) is adequate.***

Financial Concerns

Financial concerns were the single most important issue raised by those interviewed. The concern was especially prominent among hospital stakeholders. Three specific issues were raised: (1) the adequacy of the $750 per day rate paid by the state to the local hospitals, (2) the timeliness of the payments, and (3) the fairness of the payments.

The Admissions Process Begins the Discharge Process: Three-Way Contracts at Catawba Valley Medical Center in Hickory

An Interview with Cristy Williams, BSN, RN-BC, Patient Care Coordinator by Mebane Rash

Cristy Williams is the patient care coordinator in the psychiatric unit of the Catawba Valley Medical Center in Hickory. Her work involves a mix of direct care and middle management responsibilities. "I oversee the more complex patients in our unit, which now includes the three-way contract beds," she says. Three-way contracts among the N.C. Department of Health and Human Services, local mental health management entities (LMEs), and local hospitals build capacity by paying hospitals for short-term inpatient care. Williams makes sure that a patient is eligible for services under the three-way contract, that patients receive the appropriate discharge medications, and that the appropriate connections to post-discharge services are made. "I make sure that patients come full circle back into the community."

Much of Williams' work involves the three-way contract because Catawba Valley's 30-bed unit is one of the largest involved in the project with 12 beds, and it has a high level of utilization. Within her hospital, she described her role as being "the center that makes the project come together."

Williams says there are many advantages to providing care locally, including short-term crisis care. Catawba Valley admits patients both from their local area and patients from other LMEs. In fact, they have had patients from as far away as Eastern North Carolina.

Williams also notes that providing short-term care at a community hospital can lead to better follow-up services and coordination of care. For instance, Catawba Valley has a strong working relationship with the LME. It is harder, however, to serve patients from different local areas. She says, "It is much more difficult because we don't have the same working relationships."

Regardless of a patient's home region, Williams says there is an advantage to providing care through community hospitals. That is because the community hospitals specialize in providing short-term acute care and don't mix short-term and long-term care patients, as happens in the state psychiatric hospitals.

She says that "the admissions process begins the discharge process." By that, she means that she and her colleagues are thinking about the services a patient will need once he/she is stabilized and discharged. She adds, "We have a plan in place by the time each patient is stabilized." To that end, she and her colleagues look at the patient's symptoms and the severity of those symptoms and also consider the patient's history. While in the hospital, patients receive a combination of services appropriate to their situations (e.g., medication, psychiatric treatment, detoxification/substance abuse treatment, case management, or social services).

In terms of the logistics of serving more patients, Williams says, "We're evolving as we need to and as the contract does in order to provide optimal care." But she adds, "If we were going to serve more patients, we would need more staff."

"We are providing acute care to patients who otherwise would go to state psychiatric hospitals," says Williams, adding that reductions in the number of long-term beds in state hospitals will result in more people with complex needs living in communities, thereby increasing the importance of community services.

Williams says the kind of care provided to patients doesn't vary based on the payment source. "It doesn't matter where they came from or who the payer source is. We're providing the patients with the same services. The only difference is who I send the paperwork to." She adds, "I love it. I love my patients."

PILL TOWN

Some count time until
It's time to
Ease time to
Stop

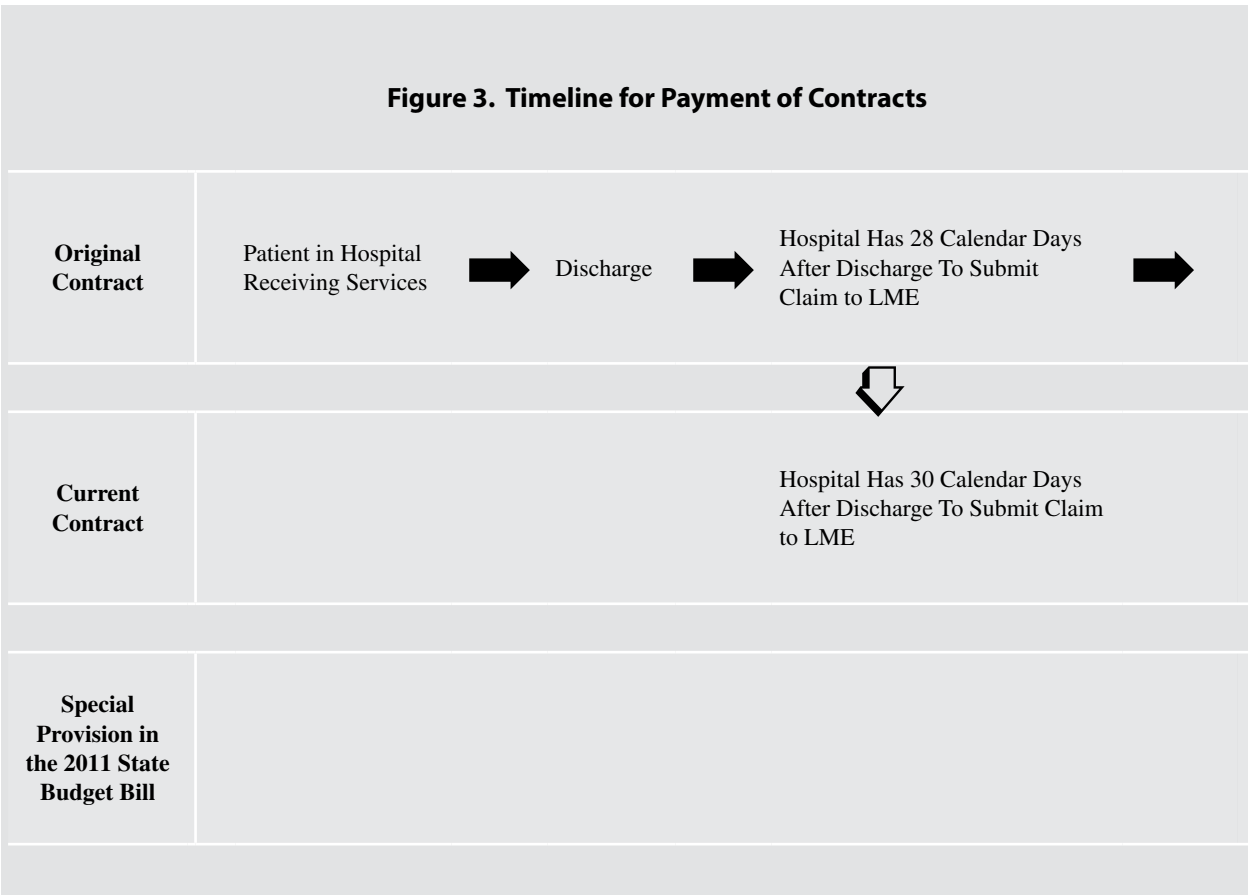
—HEARTPRINTS
BY JOAN WILDER WARLICK

All hospital respondents expressed concerns about the rate of $750 per day. All indicated that it was comparable to Medicaid payment rates, though Medicaid does not require hospitals to provide discharge medication. However, the rate does not fully capture costs, and neither do Medicaid payments, they say. Specific limitations include the following:

- The rate only covers inpatient services, not emergency room charges.
- The rate does not apply to potentially less-expensive services like beds used for observation instead of treatment.
- The rate does not vary by severity of condition and treatment, whereas Medicaid rates do vary.
- The rate does not account for the significant administrative costs incurred by the program.
- The rate may need to be re-evaluated given the implementation of health care reform nationally.

Glenn Simpson, administrator of health services at Pitt County Memorial Hospital, and Jo Haubenreiser, vice president of Novant Health in Winston-Salem, both made presentations at the legislature in 2011 about their hospitals' three-way bed contracts. They noted that patients served under three-way bed contracts often have multiple diagnoses, often making it more difficult to treat them. Haubenreiser said that these medically-complex patients make the $750 inadequate, and the hospitals can't begin to cover their costs with the flat rate.

Figure 3. Timeline for Payment of Contracts



On the other hand, those limitations might be outweighed by the benefits of having a flat rate. For instance, trying to vary the rates by the severity of the condition could require new rates and new service codes, prior authorization, and payment through the state's Integrated Payment and Reporting System (IPRS), which tracks, pays, and reports on all claims submitted by providers for mental health services. Furthermore, the hospitals continue to want to add beds at this rate. Hospitals requested at least 62 more three-way contract beds in the fall of 2011, according to the Division. A state three-way bed working group looks at clinical aspects of the program, and the group has discussed the concept of tiered-rates.

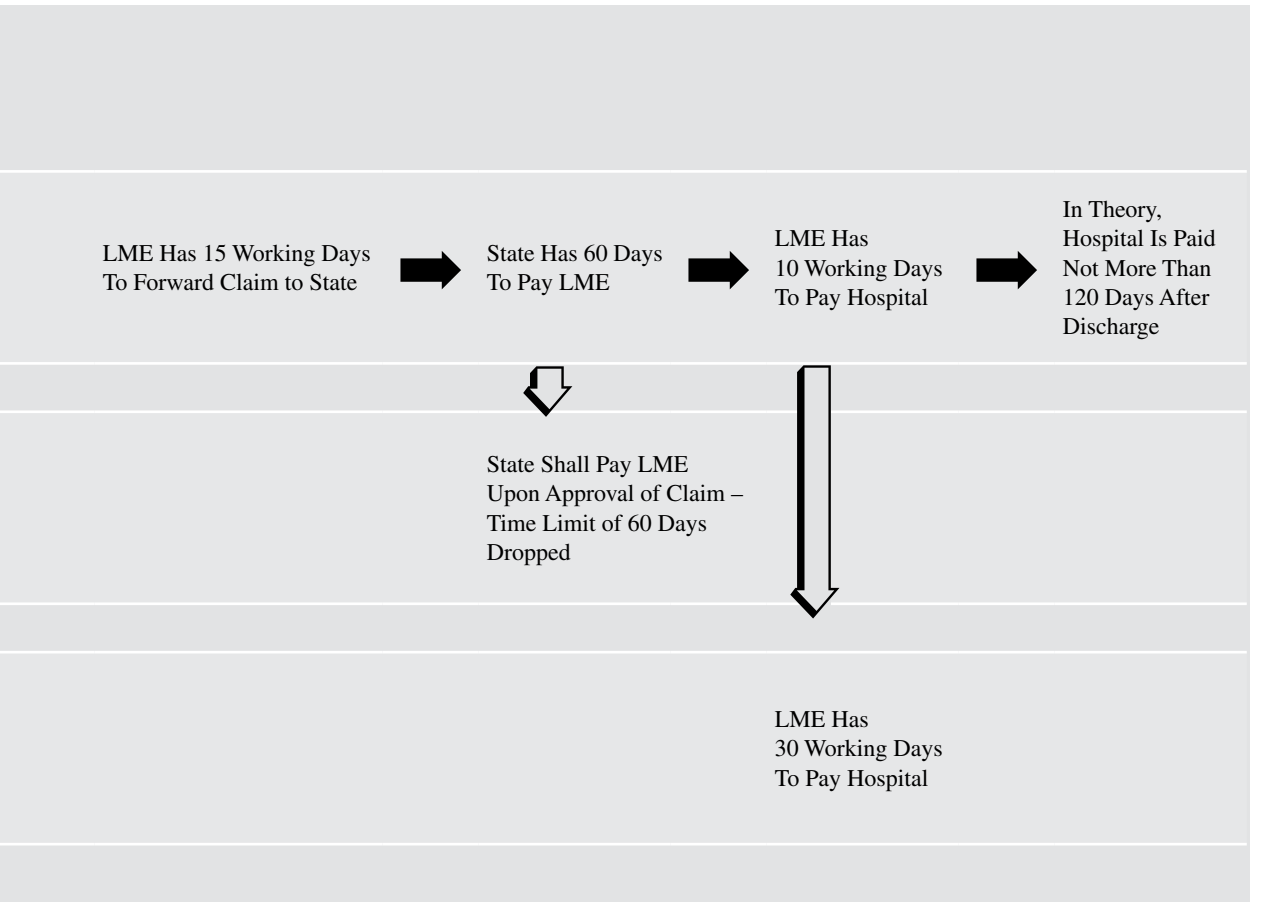
While sharing similar concerns about reimbursement rates, hospital respondents varied in their assessment of the financial usefulness of the contracts. Says Dr. Marvin Swartz of Duke University School of Medicine about the three-way contracts, "It covers some of the cost, but there is no real financial incentive to participate." Other hospitals like Catawba Valley in Hickory, Cannon Memorial in Linville, and FirstHealth in Pinehurst had a more positive experience, though all say it takes a great deal of oversight and management (e.g., controlling prescription costs) to make the numbers work. In some ways, the financial attractiveness may depend upon a hospital's service area and cost structure competitiveness. Nevertheless, all three indicated that the contracts have helped to expand their psychiatric wings and that the beds are well-used and generating revenue. Catawba Valley actually added more beds to its contract.

Perhaps even more important than the rate level is concern about timeliness of payments. Based on the timelines specified in the *original* contract documents, hospitals should have received payment no more than 120 days after patient discharge.

RX

Paraldehyde makes your stomach quit feeling like it's gonna fly out through your throat

*—**HeartPrints***
BY JOAN WILDER WARLICK



The Benefits of Serving Patients Closer to Home

by Mebane Rash with Greg Billings

A 34-year-old patient was admitted to Catawba Valley Medical Center in Hickory after a 12-hour wait in an emergency department in Western North Carolina—much quicker than the last time he was in crisis. The patient said the care he received at the medical center was better than when he had been sent to Broughton Hospital in Morganton, one of the state's psychiatric hospitals. Because the waiting lists are so long to get into state psychiatric hospitals, he had previously waited three days in the emergency department before he could be admitted to Broughton. He was so anxious because of the extended wait that he hit staff, was restrained, and given several shots of drugs to calm him down. Being able to get into Catawba Valley Medical Center more quickly alleviated a lot of his stress and decreased the amount of time he needed to get back on track. The patient's family expressed gratitude for the opportunity to come and speak to the treatment team, an option that had been impossible when he was served at the state hospital. The patient and his family had a higher degree of comfort being served in a community hospital closer to home. He was able to identify with other patients, and his family did not have any concerns about his safety while he was away.

Hospitals had 28 calendar days to submit bills; LMEs had 15 working days to forward clean claims to the state; the state had 60 calendar days to pay; and LMEs had 10 working days to make payment. Holidays or billing problems could extend the timeline (see Figure 3, p. 94).

In the early days of the three-way contracts, the availability of cash to pay the contracts was a primary reason for delays in payments. In many ways, this was a by-product of the national economic recession and the resulting state budget crisis. The state faced a $4.6 billion budget shortfall (about 22 percent of the state's 2008–09 budget) as the legislature prepared its 2009–10 budget. The budget was not passed until August 2009, a month after the new fiscal year 2009–10 started on July 1, 2009. The state also slowed all payments—such as tax refunds and these payments to local hospitals for mental health services—as a way to manage its very tight cash flow. State officials were aware of the problem of timeliness of payments to local hospitals. Michael Watson directly acknowledged the problem, and the Division and the DHHS Secretary's office worked to make these payments a priority. For instance, on January 1, 2010, the payment process was changed to address this issue, with three-way contract payments being taken out of the state's Integrated Payment and Reporting System (IPRS) and payments being given priority.

Billing lags and slow billings to IPRS continued into 2011. The slow billings were usually a delay in the hospitals giving billing information to the LMEs—perhaps as the hospitals tried to make sure there was no third party insurance or Medicaid coverage which could pay. In response, in February 2011, the Division started asking for weekly bed census information from each local hospital to more accurately project potential utilization of expenditures, according to Kent Woodson, a budget officer in the Division, who now manages the three-way contract program. This continues to be a valuable tool, but delays in payment persist.

For example, one contract went six months without being paid for care provided after July 1, 2011. Most of what was due was received on December 23, 2011. But one month later, more than $500,000 was pending payment again on this contract.

Several problems remain with the timeliness of contract payments. The contract limits payment: "Division payment for approved inpatient services or approved bed capacity purchases shall be limited to the current fiscal year *availability of Division funds* in the psychiatric inpatient hospital fund reserve." According to the Division, current payments schedules are developed at the end of each month and dollars are distributed to LMEs based on cash availability.

Another significant issue in the payment process is that the standard three-way contract has been amended over time. The initial contract required the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay the LME within 60 days of receipt. This clause has been dropped (see Figure 3, p. 94).

And, now there is a difference between when the contract states the LMEs must pay the hospital (within 10 working days of receipt of funds from the state) and when the General Assembly says the LMEs must pay the hospital (within 30 working days of receipt of funds from the state) (see Figure 3, p. 95).[47] According to a budget provision enacted in 2011, the funds appropriated for these contracts are to be held in a statewide reserve at the Division. LMEs are to submit claims for payment to the Division within 15 working days of receipt of a clean claim, and the LME is to pay the hospital within 30 working days of receipt of payment from the Division. The Department now has the authority to contract with another LME to manage the beds or it may pay the hospital directly, but it has not had to do so yet.[48] Although the state's cash flow issues are real, the timeliness issue is a major concern for hospitals that, if left unresolved, could lead some to terminate their three-way contracts with the state.

Other billing issues may result from the state's decision to expand the federal Medicaid waiver statewide. One provider in Western North Carolina has been practicing submitting claims for three-way contracts since April 2012 in anticipation of the Smoky Mountain Center's waiver start date of July 1, 2012. The provider notes that although the process is "exceptionally frustrating at times," the Smoky Mountain LME-MCO has been responsive and most of the glitches have had fairly simple technical fixes. That said, as of mid-July 2012, approximately 60 percent of the claims are still being erroneously rejected. The problem is that the billing systems for the waiver are not compatible with some components of the billing systems for the three-way contracts and other pilot programs. Furthermore, they are often different from standard hospital-based billing practices.

Aixander Duda

The Smoky Mountain Center has been working to process claims for three-way contracts after implementing the federal Medicaid waiver.

Rep. Verla Insko (D-Orange), the sponsor of the 2001 mental health reform legislation, says, "All the provider agencies want and actively lobby for having a state-run system. It is easier and less expensive to them to work with one person than with all the LMEs.[49] It is also easier for them to influence one person in Raleigh than to influence all the LME directors at the local level. That influence might be for less oversight, more money, or a favorable policy, but it is almost never solely to benefit the consumer or protect the taxpayer. The stated interest that state involvement ensures continuity is probably right, but it is not true that it ensures prompt payment. The reason LMEs can't pay providers on time is because the State Budget Office doesn't release the money to DHHS and/or DHHS doesn't release the money to the LMEs."

Finally, some hospitals have raised concerns about the fairness of the contracts to local hospitals that have a long tradition of providing uncompensated care. Prior to the creation of the three-way contract program, some nonprofit and public hospitals had provided inpatient psychiatric care to indigent patients as part of their missions, knowing the services probably would go uncompensated; other hospitals did not provide much charity care. Under the program, some hospitals that had not provided uncompensated care previously are participating and drawing money. This has led some hospitals that long have provided free care to ask if, as Leza Wainwright former Director of the Division puts it, "no good deed goes unpunished."[50]

Concerns About Meeting the Long-Term Goals of Mental Health Reform: The Role of the State

The three-way contract was developed as a way of moving North Carolina closer to the comprehensive local service system envisioned by the 2001 mental health reform legislation. While the program's purpose is to build capacity for local mental health services in local hospitals and close service gaps, it also may run counter to some of the larger long-term goals driving mental health reform and exacerbate systemic problems.

For example, the state's involvement in the three-way contracts seemingly detracts from the role the local mental health management entities were supposed to play in developing and coordinating local service systems. Granted, the local hospitals wanted the state involved in the program due to institutional concerns, but that does not change the fact that the state arguably is involved in a local function.

As mentioned previously, the contracts were designed as a three-way partnership with state involvement driven by the hospitals' belief that state involvement would lead to long-term commitment and timely payment. On a daily basis, hospitals and local mental health management entities deal with each other in a manner similar to their dealings on other projects involving public funds. The state pays the bills but does so through the LMEs. Some partners consequently view the state as a distant partner. "The three-way title for the project is just a title in a lot of ways," says Greg Billings of Catawba Valley Medical Center in Hickory. He adds that the state only seems to become involved when there are problems.

Insight #5: ***The state should continue to ensure that, over time, the three-way contracts serve the state's long-term goals in mental health reform.***

LMEs voiced concerns that the three-way contract structure appears to be inconsistent with the concept of a local service system. LMEs see themselves as the conduit that makes the program run and have wondered if similar outcomes could be achieved more directly if funds were just appropriated directly to LMEs. Rep. Insko says, "The concept of the LME as the local manager of the entire mental health system was to include control of both the Medicaid and state dollars and eventually the state facilities money as well." Yet stakeholders said that the hospitals wanted direct state involvement based on the belief that direct state involvement would signal a deeper commitment, create standardization, and lead to prompt payment.

All stakeholders, especially local ones, attributed the program's successes to strong working relationships between local hospitals and area LMEs. Says Mary Silverman, the administrative director of FirstHealth of the Carolinas in Pinehurst, "You have to have a solid relationship with an LME to make this work." Some stakeholders reported that relationships with the state were much weaker and would be helped by more communication, especially with regard to budget and payment issues. Specifically, some hospitals have asked to have a designated program liaison within the Division of Mental Health.

In fact, the Division has a program manager intended to serve in this capacity. Ken Marsh was the program manager in 2008–09, Bill Bullington was the program manager from 2009–12, and Kent Woodson, a budget officer with the Division, now is serving in this capacity. The state needs to do a better job letting hospitals know how to get in touch with this program manager.

To re-align the need for a state contact with the larger goals of mental health reform, Dr. Nicholas Stratas, Sr., a psychiatrist in Raleigh, suggests instead of a state liaison that "a more practical recommendation is to identify someone at each state psychiatric hospital to work with the local management entities covered by each state hospital. This would begin to tie the state hospitals to the LMEs, thus allowing for better collaboration and providing consultation from the state hospital to the LMEs (something which used to happen but no longer does)."

SELF DIAGNOSIS

Once in awhile
I try to tell them something
In words fitly framed
So they will understand . . .

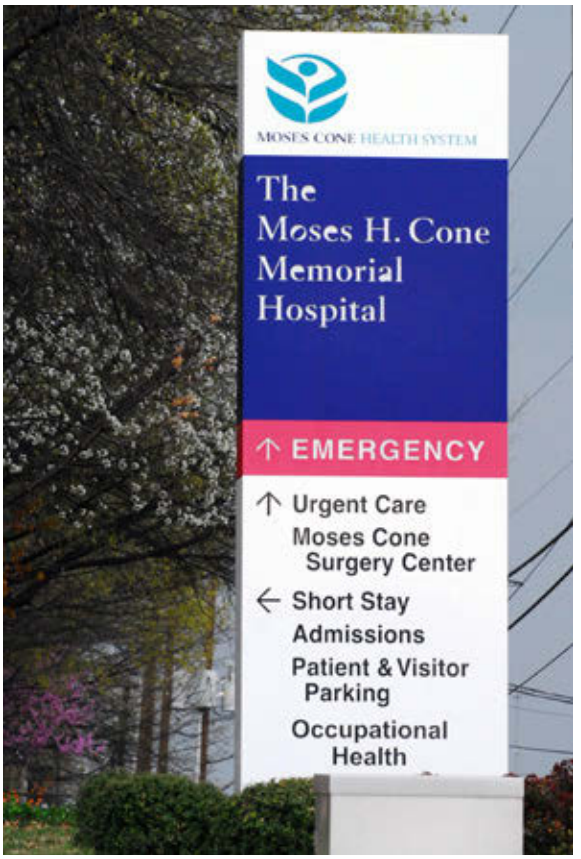
—HEARTPRINTS
BY JOAN WILDER WARLICK

The state also has a working group for the three-way bed contracts that looks at the clinical aspects of this program—for example, examining why hospitals sometimes deny admissions. Dr. Susan Saik and Dr. Ureh Nnenna Lekwauwa, the medical directors of the Division of State Operated Healthcare Facilities and the Division of Mental Health, respectively, lead this working group.

But stakeholders note that very little information is available about the working group. According to one provider, the last meeting of the working group was held on December 8, 2011. Stakeholders would like regularly scheduled meetings, advance notice and input on the agendas, and they would like all parties to the contracts to be invited. Another stakeholder suggested that a best practice team member from the Division should be included in the working group.

Another concern involves the role of the state psychiatric hospitals. The three-way contracts reflect the idea that the state hospitals' primary mission should be the provision of long-term care for patients with more severe mental health problems such as schizophrenia—an idea supported by advocacy groups for the patients. At the same time, North Carolina long has relied upon its state hospitals to provide short-term care. Even now, 62 percent of patients stay in the hospitals for 30 days or less.[51] This has led some analysts at the legislature's Fiscal Research Division to ask if stakeholders are clear about the state hospitals' mission and when the move away from short-term care will manifest itself in data on admissions to state hospitals.

An initial analysis of outcomes for the three-way contracts indicates that short-term admissions to state hospitals (seven days or less) have dropped from 51 percent in the first quarter of fiscal year 2008–09 to 39 percent in the first quarter of fiscal year 2009–10 to 32 percent in first quarter of fiscal year 2010–11 to 21 percent in the first quarter of fiscal year 2011–12 (see Figure 4, see p. 101).[52] However, the reduction in the short-term admission rates to state hospitals is also a function of bed reductions and admission delays at the state hospitals. And, it may be that the criminal justice system is now becoming an unintentional provider of beds. As Dr. Stratas says, "In fact, there is reason to believe or at least suspect that the reduction of state hospital census is more likely due to the increase in the mentally ill entering our prisons."



Karen Tam

Moses Cone had eight beds in the program in 2011–12.

Concerns About Patient Treatment

Another area of concern involves the treatment provided to patients under the contract. Three specific issues were raised.

First, interviewees cautioned that care provided in local hospitals may not necessarily be "local" care. "Sometimes local hospitals are no more local than state ones," says Dr. Marvin Swartz of Duke University Health System. What makes inpatient care local, he says, is its integration into larger continuums of care, which is why discharge and follow-up services are so critical. This explains why good relationships between hospitals and LMEs are critical to success and why some participants have concerns about serving patients from LMEs outside their area. Out-of-area admissions complicate discharge planning and can make it harder to connect patients to follow-up services (see Table 7, p. 90).

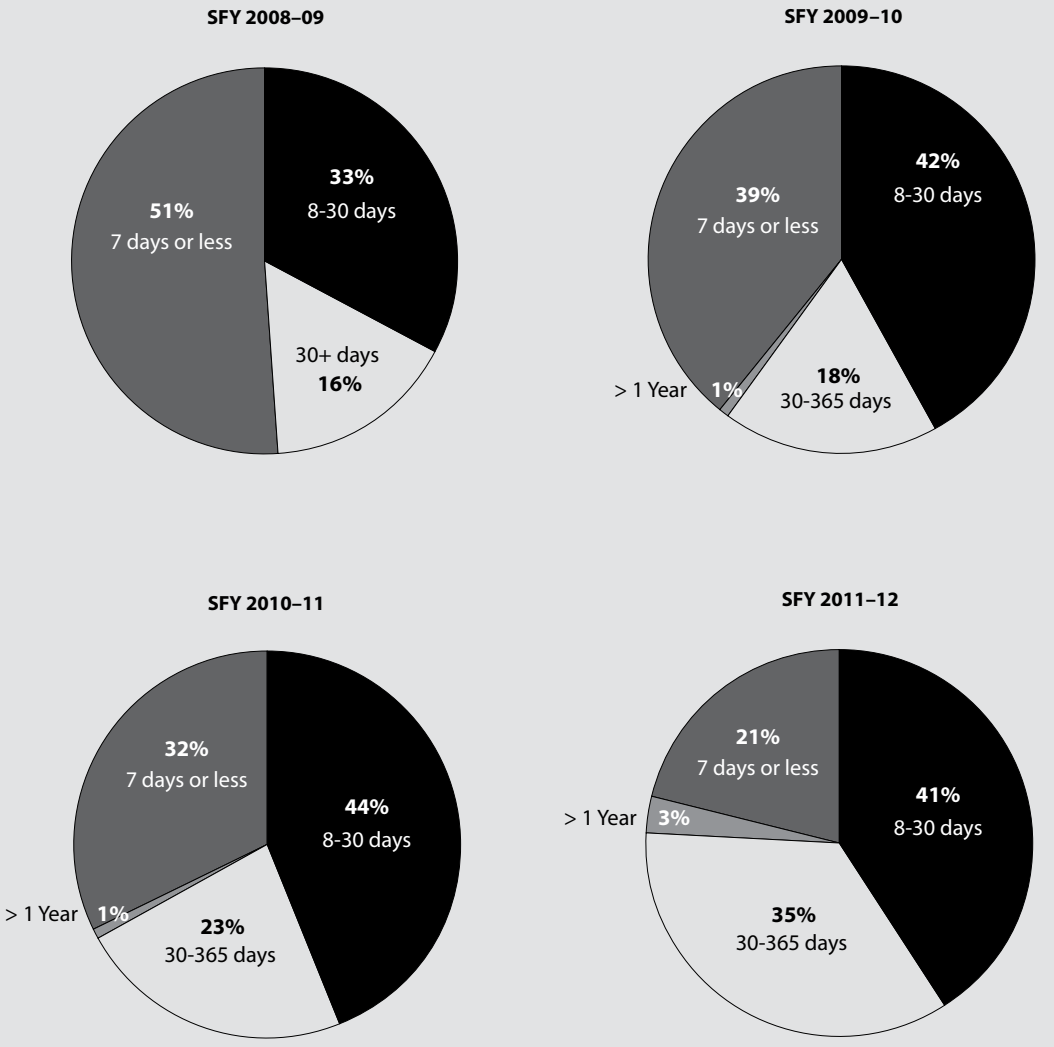
Second, the adequacy and availability of follow-up services for those discharged from local hospitals is important. A 2008 study by the General Assembly's Program Evaluation Division (a study based on data collected *prior* to the establishment of the three-way contract program) found that patients hospitalized in community hospitals were more likely to receive follow-up services than those treated in state psychiatric hospitals (69 percent vs. 50 percent). The study found, "[C]loser connections exist between community-based hospitals and local outpatient service providers, and therefore consumers discharged from these hospitals [are] more likely to receive community-based services." [53]

At the same time, patients discharged from local hospitals tended to receive low-intensity services (e.g., medication management or community support) due in large part to the difficulties in obtaining psychiatric services locally. Absent the ability to access moderate-intensity services (e.g., psychiatrist), patients run the risk of requiring re-hospitalization in the future. "Access to a psychiatrist or physician … is critical to ongoing treatment in the community because establishing an immediate relationship with a psychiatrist after discharge is key to minimizing recurrent crises and hospital readmissions," says the study.[54] Beth Melcher, chief deputy secretary of DHHS, notes that the development of walk-in psychiatric services and improved crisis support through mobile teams will help going forward.

Stephanie Greer, the director of behavioral health at Appalachian Regional Healthcare System in Watauga County and a former state psychiatric hospital administrator, agrees that follow-up after discharge is an important part of the benefits to consumers of the three-way contracts. She says, "Delivery of local support services after discharge has been done very well and is a true benefit of the three-way contract program. Local support is available in a very different way than it is at state hospitals like Broughton. There is a significant difference in quality."

Readmission rates for people served under the three-way contracts are lower than for those served in a state hospital.[55] The readmission rate *after 30 days* is 10 percent at state hospitals, but it is 6.3 percent for patients served by three-way contracts. The readmission rate *after 180 days* is 21 percent at state hospitals, but it is 11.2 percent

Figure 4. Short Term Care for Consumers in State Psychiatric Hospitals in North Carolina, State Fiscal Years 2009–12



Note: SFY = The state fiscal year runs from July 1 to June 30.

Source: N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Reports, Spring Reports, Raleigh, NC, April 1, 2009–12, Table 3.2.a.

Table 8. Percent of Three-Way Contract Billing for Substance Abuse by Local Mental Health Management Entity, State Fiscal Year 2012

LME	Participating Hospitals	Three-Way Contract Billing for Substance Abuse
Sandhills	FirstHealth Moore Regional Hospital	42.04%
Mental Health Partners	Catawba Valley Medical Center	34.80%
Alamance-Caswell	Alamance Regional Medical Center	34.13% [a]
CenterPoint	Forsyth Medical Center	33.32%
Guilford	Moses Cone Hospital	28.49%
Pathways	Kings Mountain Hospital	26.61%
Piedmont Behavioral Healthcare [c]	Alamance Regional Medical Center	16.05% [a]
Smoky Mountain	Haywood Regional Medical Center Cannon Memorial Hospital	15.03%
Western Highlands	Margaret Pardee Memorial Hospital Mission Hospital Rutherford Regional Medical Center	14.30%
Cumberland	Cape Fear Valley Medical Center	12.80%
Beacon Center	Nash General (Coastal Plain) Hospital	6.06%
Eastpointe	Vidant Duplin General	5.15%
Crossroads	Davis Regional Medical Center	4.19%
Durham	Duke University Health System	2.55%
Southeastern Center	The Oaks Behavioral Health Hospital	0.40%
East Carolina Behavioral Healthcare	Vidant Beaufort Hospital Northside Behavioral Health Services at Vidant Roanoke-Chowan Hospital Vidant Medical Center (formerly known as Pitt County Memorial Hospital)	–0.16% [b]

Notes:

[a] Note the drop in percentage of substance abuse treatment for those treated at Alamance Regional Medical Center under management of Piedmont Behavioral Healthcare. The percentage for Alamance-Caswell is for services through October 2011.

[b] This negative percentage is because the hospital had to reimburse the state for some units that were paid in error.

[c] In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

SFY = The state fiscal year runs from July 1 to June 30.

Source: Jim Jarrard, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

for patients served by three-way contracts.[56] The readmission rate *after one year* for those patients served by three-way contracts is 17.3 percent.[57] The comparable rate for state hospitals is not available.

Finally, numerous interviewees described substance abuse services as being a missing part of the treatment equation. While the three-way contracts allow for the provision of inpatient detoxification and substance abuse treatment, the substance abuse is often connected to a mental health problem. This is important because many stakeholders are concerned about the growing number of people with "dual diagnoses."

At only five of the participating hospitals does the provision of substance abuse services account for more than 20 percent of the billings under the three-way contract: FirstHealth Moore Regional Hospital (42%), Catawba Valley Medical Center (35%), Forsyth Medical Center (33%), Moses Cone Hospital (29%), and Kings Mountain Hospital (27%) (see Table 8). When Alamance Regional Medical Center was in the Alamance-Caswell LME, 34 percent of the billings under the three-way contracts were for substance abuse services; however, since November 2011, when the LME for Alamance Regional Medical Center changed to Piedmont Behavioral Healthcare, the percentage has dropped to 16 percent. According to stakeholders, hospitals may be reluctant to provide substance abuse services because if the primary reason for treatment is substance abuse detoxification, then hospitals could fill all of their beds under the contracts 24 hours a day, seven days a week, providing just that treatment to the exclusion of serving those needing crisis psychiatric care.

Furthermore, the hospitals have raised concerns about whether their provision of substance abuse services under the three-way contracts meets staffing requirements under the state's rules for health and human services.[58] For example, Division of Mental Health regulations require a full-time counselor for every 10 clients, at least one registered nurse, one direct care staff for every 20 clients, and a physician at the facility or on call 24 hours a day. The Medical Care Commission has additional rules for licensure of hospitals.

Insight #6:
Stakeholders have concerns about staffing requirements for substance abuse services and the inadequacy of local follow-up treatment for patients with substance abuse problems.

While it is difficult to obtain follow-up mental health services, it is even harder to find follow-up services for substance abuse. The 2008 report by the General Assembly's Program Evaluation Division identifies the following four reasons:

> First, there was a lack of intensive outpatient substance abuse services in 2007, which remains the case today in spite of reform. Second, most consumers with substance abuse do not have Medicaid coverage. As a result, many go untreated after discharge. Third, whereas hospital liaisons triage care for mental health consumers in most Local Management Entities, there are fewer liaisons for consumers hospitalized with substance abuse problems. Finally, many consumers with substance abuse may be noncompliant with treatment protocols even when follow-up is attempted.[59]

Duke's Dr. Marvin Swartz adds, "Many more substance abusers are uninsured, and there are fewer local treatment options for them." But Beth Melcher with DHHS says, "The problem is not availability of services but lack of payers/reimbursement for services."

Concerns About the Adequacy of the Mental Health Work Force

All stakeholders interviewed for this review expressed concerns about both the availability of mental health workers and their training. While the availability of such caregivers varies across the state, they play a critical role in the provision of inpatient

psychiatric services and follow-up care at the local level. In North Carolina, 30 counties do not have a psychiatrist, and an additional 14 counties only have one.[60]

Although work force shortages typically are seen as a problem related to follow-up care, they also bear on the ability of local hospitals to provide short-term care. According to Stephanie Greer of Appalachian Regional Healthcare System in Watauga County, financial concerns are not the sole barrier preventing community hospitals from providing inpatient care. They also need physical and medical resources, but perhaps most importantly, they need direct care workers *trained* to handle varying levels of mental health issues. Without such workers, hospitals will be unable to serve all the patients they could and will refer patients to state psychiatric hospitals even if local beds are funded.

Cristy Williams, the nurse at Catawba Valley Medical Center, says, "It is a totally different way of thinking when dealing with psychiatric patients." She stressed the need for "safety, safety, safety," and how that involves tasks such as knowing where patients are at all times and ensuring that doors are locked.

Because it is impractical and too expensive for most community hospitals to operate their own psychiatric training programs, Stephanie Greer and other community leaders argue that the state psychiatric hospitals should open their existing training programs for their own state hospital employees to the local community hospitals participating in the three-way contract program. Says Greer, "The community hospital can't

Opening Up State Training Programs to Local Mental Health Workers

by Stephanie Greer, Director, Behavioral Health Services, Appalachian Regional Healthcare System in Watauga County

There are two fundamental components to building inpatient behavioral health capacity. The first component is the development of the physical capacity, which is what the state historically has focused on. I believe that the second component of capacity is developing the clinical skills in milieu management, de-escalation, and crisis prevention necessary to be able to treat the level of crisis that is routinely seen in the state psychiatric hospital setting. It is this lack of clinical capacity that results in lengthy waiting lists at the state hospitals while there are still vacant beds in the communities.

I worked as an administrator at Broughton Hospital, a state psychiatric hospital, for 11 years prior to accepting my current position. I have become acutely aware of the fact that in a small community setting it is extremely difficult to duplicate the level of training needed to manage truly acute psychiatric patients. Across our state, small hospitals are forced to "reinvent the wheel" by developing training programs that focus on a psychiatric patient population without the economies of scale and level of expertise available at our state psychiatric hospitals.

I support the proposal that we develop collaborative relationships between our state hospitals and local hospitals who are actively participating in the three-way contracts for training opportunities in milieu management, de-escalation, and crisis prevention. This would involve shared training opportunities in which community employees would participate in training exercises with state hospital employees in the areas mentioned above. This initiative would simply mean opening up the already scheduled and staffed training calendars to the community hospitals to fill any vacant class slots. In doing this, we would be developing more consistency in training and enhancing the provision of clinical services to the patients served under the state

recreate the training for dealing with acute psychiatric care patients that exists at the state hospitals." With staff trained to those standards, however, community hospitals would be better equipped to handle patients with mental illness and perhaps serve even more patients locally (see Greer's sidebar on "Opening Up State Training Programs to Mental Health Workers" below).

Specifically, Greer and others think that the state and the state hospitals should play an active role in work force training. For instance, state hospitals require their direct care employees to prepare detailed annual development plans for their staff and provide the staff with the training required by those plans. Why couldn't such existing programs in areas like patient *de-escalation* (workers trained in techniques that reduce a patient's agitated behaviors, like pacing, cursing, spitting, and throwing items) and *milieu management* (workers trained on how to arrange the hospital setting to promote safety as well as stabilization and recovery of their patients) be opened to employees from community hospitals participating in the three-way contracts? Says Greer, "Just open all the existing training programs at state hospitals to three-way contractors because they are state agents."

Community hospitals, particularly rural ones, might have difficulties in arranging release time for employees to attend training or covering training-related absences. But, the work force improvements and ability to better utilize local inpatient beds might make the inconveniences worthwhile.

contracts. This would develop true capacity in the communities by developing or enhancing the clinical skill sets of community employees and by developing more positive working relationships between the state and community service providers. In fact, at least two community hospitals have already contracted with state trainers to provide this instruction at the community hospital. The results of that experience have been overwhelmingly positive and directly correlate to fewer denials by local hospitals related to psychiatric acuity and/or physical aggression.

In addition, geographic location is often a limiting factor in the ability to recruit and develop expertise in dealing with acute psychiatric patients for the clinical staff. This has been an issue for Cannon Memorial Hospital in Linville, and I believe it will be an issue for other small rural hospitals if they choose to attempt to develop inpatient psychiatric services.

The benefit of the participation in the three-way contract is especially powerful in a small rural community. In fiscal year 2009, Cannon Memorial Hospital admitted almost 900 consumers in our 10-bed unit. Fifty-seven percent of those patients were served under this contract and would have been forced to receive treatment at a state hospital, or at the nearest inpatient facility which is more than 40 miles away. These patients were often experiencing their first inpatient psychiatric admission and were able to receive care close to home; close to their support systems including family members and doctors; and in an area where strong discharge planning can occur between the inpatient service provider and the outpatient service provider. And, without the presence of this contract, this small unit would not be able to maintain financial viability over the long term.

"This would develop true capacity in the communities by developing or enhancing the clinical skill sets of community employees and by developing more positive working relationships between the state and community service providers."

I believe there are ample opportunities to continue to improve the provision of behavioral health services in our state. But, this will require direct collaboration between state systems and community service providers in order to equip our communities to meet the wide range of patient and community needs.

Dr. Swartz of Duke cautions, "Calling on the state to train non-state folks is ill-advised. The state has very limited training capacity and is already well beyond its capacity for training. They are looking for help with their workers. There needs to be a serious investment in workforce training, but not by the state."

The state's 11 Area Health Education Centers (AHECs) may be another option. Bob Morrison, the retired President/CEO of Randolph Hospital, says, "There is one AHEC for each region, and they operate a wide variety of professional education programs. Typically, the faculty for the programs are practicing clinicians who work in the region. North Carolina has one of the best AHEC systems in the country, and the community hospitals and health professionals across the state are already accustomed to receiving continuing education through their AHECs."

Jim Jarrard, the acting director of the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, says, "State hospitals, as centralized sites in the three regions, can contract with AHECs to provide training on hospital grounds. Continuing education units (CEUs) may not be attached, but effective, inexpensive training can be provided with certificates of attendance."

As these options are evaluated, Susan Saik with the Division of State Operated Healthcare Facilities notes that logistics, staffing, resources, and legal and regulatory issues will need to be considered by the state.

Who would bear the cost of this training would need to be determined, but options include the state hospitals, the local mental health management entities, the local hospitals, or an arrangement where the cost is shared by these entities. Ultimately, the legislature is going to have to provide money for training if it wants the three-way contracts to succeed. Either way, such a training program may induce more hospitals to participate in the three-way contracts or add capacity.

Expanding the Number of Local Hospitals Beds Going Forward

North Carolina's ongoing reform of its mental health system is driven by a vision of providing comprehensive services locally. Realizing this, however, requires communities to have local hospital beds dedicated to short-term inpatient psychiatric care—beds that are missing in many communities across the state. The state's recent three-way contracts are an attempt to fill this gap. Based on a review of progress to date, the contracts have been a *qualified* success.

Although this review did not attempt to establish a causal relationship, the Center finds:

Karen Tam

- The number of patients served under three-way bed contracts is almost as many served each year by the three state psychiatric hospitals combined.
- Readmission rates for people served under the three-way contracts are lower than for those served in state hospitals.
- Short-term admissions to state hospitals (seven days or less) have dropped from 51 percent in 2008–09 to 21 percent in 2011–12.
- The average length of stay in emergency departments for those that were transferred to a community hospital was more than 12 hours shorter than the average length of stay for those that were transferred to a state psychiatric hospital.
- The average length of stay for patients served through the three-way contracts at all hospitals is less than seven days as intended.

At the same time, stakeholders have concerns. These concerns involve the program's structure, financing, the state's long-term mental health goals, patient treatment, and the adequacy of the mental health work force.

Our research examines these findings and concerns and highlights six insights that need to be considered as this program is maintained and expanded.

Insight #1: ***Even with the 122 beds added by the three-way contracts, the number of beds available to mental health patients in crisis that can be treated in seven days or less falls short of the need in North Carolina. The state needs a methodology that provides a consistent way to determine the required ratio of beds to population that would adequately serve diverse areas of the state.***

Insight #2: ***When selecting where to establish new contracts or to expand existing contracts, equitable distribution among the three broad geographic regions of the state is one factor required by the legislature, but other factors also are important.***

Insight #3: ***Priority transfers for those served under three-way contracts to the state psychiatric hospitals are often difficult to arrange.***

Insight #4: ***At least every five years, the N.C. Department of Health and Human Services and the Joint Legislative Oversight Committee on Health and Human Services should re-examine whether the flat rate paid per day (currently set at $750) is adequate.***

Insight #5: ***The state should continue to ensure that, over time, the three-way contracts serve the state's long-term goals in mental health reform.***

Insight #6: ***Stakeholders have concerns about staffing requirements for substance abuse services and the inadequacy of local follow-up treatment for patients with substance abuse problems.***

The Center's Recommendations

Based on its research on the three-way contracts, the N.C. Center for Public Policy Research makes four recommendations:

Recommendation #1: ***The Center recommends that the Secretary of the N.C. Department of Health and Human Services develop a strategy to ensure the timely payment of these contracts.***

The timeliness of payments is a major concern for hospitals that, if left unresolved, could lead some local hospitals to terminate their contracts. While the state's problems with cash flows because of the Great Recession were the primary reason for delays in payments in the early days of this program, billing lags from the local management entities (LMEs) and slow payments by the state continue to persist. The standard state contract limits payment, as follows: "Division [of Mental Health] payment for approved inpatient services or approved bed capacity purchases shall be limited to the current fiscal year *availability of Division funds* in the psychiatric inpatient hospital fund reserve."

Another significant issue in the payment process is that the contract has been amended over time. The initial contract required the Division to pay the local mental health management entity (LME) within 60 days of receipt. This clause has been excluded from more recent contracts. And now, the *contract* states the LMEs must pay the hospital within 10 working days of receipt of funds from the state, while *legislation* passed by the General Assembly says the LMEs must pay the hospital within 30 working days of receipt of funds from the state. Any additional billing issues that result from the state's decision to expand the federal Medicaid waiver statewide also need to be addressed expeditiously.

Recommendation #2: ***The Center recommends that the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services publicize that they have a designated staff person serving as a liaison for the three-way contracts, as well as a state working group for the three-way contracts that addresses clinical concerns.***

It is important to local hospitals to have the state involved in these contracts. It signifies to them a longer-term state commitment, standardization across the contracts, and accountability for timely payments. Stakeholders reported that relationships with LMEs were stronger than with the state, and they wanted better communication channels with the state, especially with regard to budget and payment issues. Currently, the state is viewed by many stakeholders as a distant partner, often only involved when there is a problem. Stakeholders suggested having a designated contract liaison within the Division to address these concerns.

In fact, the Division has a program manager intended to serve in this capacity. Ken Marsh was the program manager in 2008–09, Bill Bullington was the program manager from 2009–12, and Kent Woodson now is serving in this capacity. The state needs to do a better job letting hospitals know how to get in touch with the program manager.

The state also has a working group on the three-way contracts to look at the clinical aspects of this program—for example, why hospitals sometimes deny admissions. Dr. Susan Saik and Dr. Ureh Nnenna Lekwauwa lead the working group. Stakeholders note that very little information is available about the working group. Stakeholders would like regularly scheduled meetings, advance notice and input on the agendas, and they would like all parties to the contracts to be

invited. Another stakeholder suggested that a best practice team member from the Division should be included in the working group.

Recommendation #3: ***The Center recommends that the N.C. Department of Health and Human Services require state psychiatric hospitals to open their existing training programs (currently provided only to their own state direct care employees) to the local community hospitals participating in the three-way contracts.***

It is impractical for most community hospitals to operate their own psychiatric training programs. It also would be more expensive for training to be provided at 21 different local hospitals participating in the contracts. Meanwhile, state hospitals require their direct care employees to prepare detailed annual development plans for their staff and provide staff members with the training required by those plans. With local hospital staff trained to state standards, however, community hospitals would be better equipped to handle patients with mental illness and perhaps serve even more patients locally. And, this might speed up the state's ability to increase the overall mental health work force, an issue for the future in North Carolina. Such training programs might also induce more hospitals to participate in the three-way contracts.

Who would bear the cost of this training would need to be determined, but options include the state hospitals, the local mental health management entities, the local hospitals, or an arrangement where the cost is shared by these entities. Ultimately, the legislature is going to have to provide money for training if it wants the three-way contracts to succeed.

Recommendation #4: ***The Center recommends that the N.C. Department of Health and Human Services develop outcome measures for this program.***

Given the increased investment of state dollars in this program, the three-way contracts are now established enough that program and patient outcomes should be identified, tracked, and reported annually. For instance, stakeholders suggested to the Center the following program measures:

- short-term admissions to state psychiatric hospitals,
- the number of persons in crisis seen in local hospital emergency departments, and
- the average waiting time in the emergency departments for mental health patients transferring to hospitals with three-way bed contracts and state psychiatric hospitals.

Stakeholders also suggested the following patient outcomes:

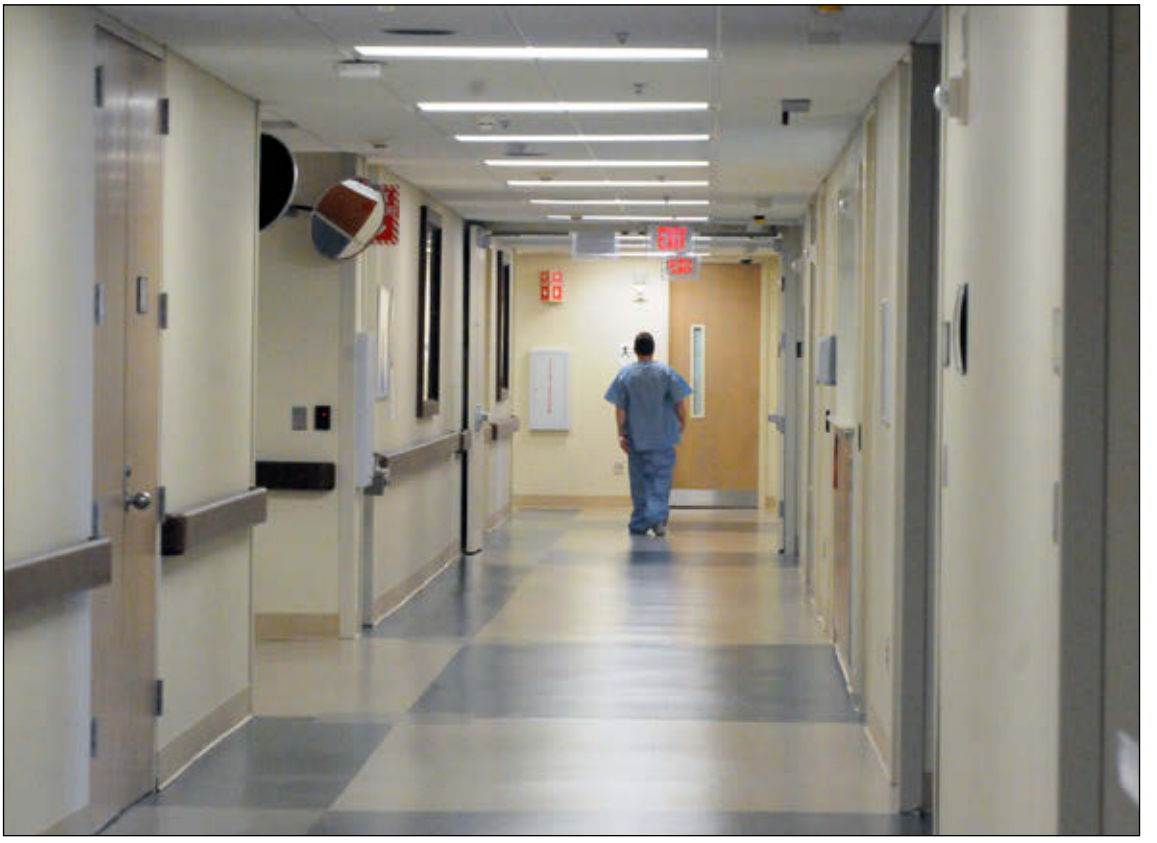
- number of persons served;
- number of bed days purchased;
- average length of stay;
- re-admission rates after 30 days, 180 days, and one year;
- percent of those served from home LMEs;
- percent of those served from outside the hospital's region;
- total admissions; and

- most importantly, comparing patient outcomes under the three-way contracts with the outcomes of patients served by other community hospitals providing this type of treatment, as well as comparing with outcomes of patients served in state psychiatric hospitals.

Some of this data is already captured by current reporting, but all data pertaining to the three-way contracts needs to be reported annually so that the public and policymakers can more easily evaluate how well this program is working. For some of the outcomes suggested by stakeholders, cooperation from the N.C. Hospital Association also may be required.

The U.S. Supreme Court decision in Olmstead requires states, including North Carolina, to treat mental health patients in the least restrictive setting possible. To its credit, the state has invested almost $125 million, purchasing bed space at community hospitals across the North Carolina to serve those in crisis since 2008. These beds keep patients out of the state psychiatric hospitals and provide care for them close to home—near family and friends and treatment providers, in communities where they belong. The state has chosen a strategy to address this critical need, implemented the strategy, and funded the strategy. Often the state's biggest problem with mental health reform has been its ability to stay the course. While the Center's research suggests some changes to the three-way contracts and evaluation of the program going forward, the state should stay the course with this strategy and continue to fund the three-way contracts. It's better for the patients, the local hospitals, and the state.

A three-way contract patient at Catawba Hospital.



Karen Tam

Endnotes

[1] Mike Vicario, "The 'Crisis' Crisis: Emergency Department Use and Community Resources in North Carolina's Behavioral Health Crisis System," *North Carolina Medical Journal*, Vol. 73, No. 3, North Carolina Institute of Medicine and The Duke Endowment, Morrisville, NC, May/June 2012, p. 216.

[2] Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2009 and 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2010 and Jan. 2012, Table 1, p. 3. The reduction in the number of persons served by state psychiatric hospitals is a function of both reduced capacity and the increasing number of state hospitals admissions that require a longer length of stay.

[3] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Report on the Provision of Behavioral Health Crisis Services by Hospital Emergency Departments," March 1, 2011, p. 3.

[4] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 1.1.a, p. 15.

[5] The populations served by the three-way contracts and the state psychiatric hospitals are now intentionally different. State hospitals treat more complex patients requiring longer lengths of stay. To a large degree, the reduced number of unique patients served in the state facilities reflects the longer lengths of stay of the more complex patients and demonstrates some success of the state initiative to serve short-term patients in the community.

[6] Local management entities (LMEs) replaced the state's old area mental health authorities as part of state mental health reform. LMEs are the agencies responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disability, and substance abuse services in the area served. LME responsibilities include offering consumers access to services 24 hours a day, seven days a week, 365 days a year, as well as developing and overseeing providers, and handling consumer complaints and grievances. On the Internet at *http://www.ncdhhs.gov/mhddsas/lmedirectory.htm#lmelist*, accessed on Feb. 6, 2010. See also N.C. Gen. Stat. § 122C-115.4.

[7] This provides funding for up to 186 beds. However, "[f}unds may not be expended prior to January 1, 2013 and only after OSBM [Office of State Budget and Management] certification that the funding is not needed for the Medicaid Program."

[8] See Alison Gray, "The History of Mental Health Reform in North Carolina," *North Carolina Insight*, Special Report, N.C. Center for Public Policy Research, Raleigh, NC, March 2009. See also N.C. Session Law 2001–437 (H.B. 381).

[9] N.C. Department of Health and Human Services, *Transformation of North Carolina's System of Services for Mental Health, Development Disabilities, and Substance Abuse: The State Strategic Plan, 2007–2010*, Raleigh, NC, July 1, 2007, p. 19.

[10] For an evaluation of the three-way contract in Durham County, see The Durham Center, "A Study of the Three-Way Contract in Durham County. On the Internet at *http://www.durhamcenter.org/uploads/docs/area_board/reports/ Area_Board_Report_March_2010.pdf*, accessed May 22, 2012.

[11] N.C. Department of Health and Human Services , N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2009–10, Spring Report, Raleigh, NC, April 1, 2010.

[12] The contract is limited to inpatient adult psychiatric services and inpatient medical detox services. Children with mental illnesses also may require short-term inpatient care, but low-income children are more likely than adults to have public insurance through Medicaid.

[13] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 1.1.a, p. 6. Based on N.C. Office of State Budget and Management (OSBM) State Demographics Unit, July 2011, population projection data. These numbers are calculated by the Division using *national estimates of prevalence*—the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population—and then applying them to North Carolina's population. To assess the percent of the state's population, see also the N.C. Office of State Budget and Management (OSBM), Annual Population Totals, July 2011, when the state's total population was estimated to be 9,735,890.

[14] *Ibid*., Table 1.1.b, p. 7.

[15] Mental Health Association–NC, "Mental Health, Developmental Disabilities, and Substance Abuse Services System Reform in North Carolina," May 2006.

[16] N.C. Department of Health and Human Services , N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, p. 14. However, this trend may be changing. In 2012, 21 percent of the discharges from the state's psychiatric hospitals involved stays of seven or fewer days, down from 32 percent in 2011, 39 percent in 2010, and 51 percent in 2009. N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Reports, Spring Reports, Raleigh, NC, April 1, 2009–12, Table 3.2.a.

[17] *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L.E.2d 540 (1999). The Court held, "States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

[18] Gerald G. Akland, *Involuntary Commitments: NC Sheriff's Office Impact (Including Observations on the Outcomes for People with Mental Illness)*, 2009 Update, NAMI–Wake County, Jan. 4, 2010, pp.7–8.

[19] Ruth Sheehan, "Shuttling Patients Burdens Deputies," *The News & Observer*, Raleigh, NC, Jan. 15, 2010.

[20] In April and May of 2012, *The News & Observer* published a series of articles on hospitals in North Carolina, finding "that while North Carolina hospitals get tax breaks worth hundreds of millions, some are doing little to help the poor. Instead, many hospitals are pursuing uninsured patients with lawsuits or collections agencies that can destroy their credit." The articles are available online at *http://www.newsobserver.com/2012/04/22/2016905/north-carolinas-urban-hospitals.html*

[21] Gray, see note 8 above, pp. 62–63.

[22] North Carolina Department of Health and Human Services, note 9 above, p. 19.

[23] See also Monte Mitchell, "Psychiatric Unit Ready to Reopen at Hospital," *The Winston-Salem Journal*, Winston-Salem, NC, Sept. 28, 2008. On the Internet at *http://www2.journalnow.com/content/2008/sep/28/psychiatric-unit-ready-to-reopen-at-hospital/news-regional/,* accessed on Aug. 7, 2010.

[24] Kent Woodson, program manager of the three-way contracts for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, says, "The abrupt termination referenced happened when the budget crisis hit. The Division of State-Operated Healthcare Facilities and state regional hospitals abruptly suspended or terminated all of their community contracts. This sent a shockwave throughout the three-way contract community. So in working with the North Carolina Hospital Association and as a backup measure for reassurance, we contracted with Brynn Marr and Frye Regional as temporary support and backup if needed during the initial stages of the three-way contract development where the state hospitals could use them for overflow. Both hospitals are free standing psychiatric hospitals and the contracts were eventually terminated because they were not deemed to be community hospitals."

[25] For budget information online, see *http://www.ncga.state.nc.us/fiscalresearch/Budget_Legislation/ budget_legislation.shtml.* Because Mecklenburg County needs to cut its budget by $95 million, it ended a relationship with a provider of outpatient mental health services for about 750 children that had existed since 1984. According to *The Charlotte Observer*, "The programs primarily serve low-income families with children who suffer from issues that include anxiety, depression and bipolar disorder." Brett Loftis, the executive director of the Council for Children's Rights, says, 'People are going to go without.'" Peter St. Onge, "County's cuts disrupt youth mental health programs," *The Charlotte Observer*, Charlotte, NC, April 2, 2010. On the Internet at *http://www.charlotteobserver.com/201%4/02/v-print/1350960/mecklenburg-cuts-mental-health.html*, accessed on Aug. 7, 2010.

[26] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2009," Division of MH/DD/SAS, Raleigh, NC, Jan. 2010, Figure 1, p. 1, and Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Figure 1, p. 1.

[27] *Olmstead v. L.C.,* see note 17 above.

[28] Susan Saik, the medical director for the Division of State Operated Healthcare Facilities, notes, "A large portion of individuals served in state facilities are or at some time have been Medicaid eligible." However, Medicaid does not cover inpatient care for people aged 21–65 treated at a state psychiatric hospital. 42 U.S.C. § 1396(d)(a)(1). This exception was meant to keep states from funding their state institutions with Medicaid dollars. This has created incentives for states to find other Medicaid-funded facilities where they can treat those individuals and capture federal funding. Regarding the different costs of care at state hospitals as compared to community hospitals, Saik says, "There is a more intensive level of care being provided to patients with more complex needs in the state facilities. Community hospitals and state hospitals have different populations, and that factors into the cost of providing care."

[29] Inpatient psychiatric services, in either general acute care hospitals or specialized inpatient psychiatric care hospitals, are regulated by the state's Certificate of Need law. A general hospital seeking to add beds on its own would need to go through the Certificate of Need process if it intended to create a new inpatient unit or if it wanted to reallocate existing beds to new psychiatric ones. See N.C. General Statutes § 131E-176(13), § 131E-176(16)c, § 131E-176(5), and § 131E-176(9c). According to the website of the N.C. Department of Health and Human Services, "The North Carolina Certificate of Need (CON) law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services…. The fundamental premise of the CON law is that increasing health care costs may be controlled by governmental restrictions on the unnecessary duplication of medical facilities." Beds at *state* hospitals are not subject to Certificate of Need laws. The statutory provisions also do not apply to beds being converted to mental health use pursuant to a contract with the state Department of Health and Human Services or a local management entity. N.C. General Statute § 131E-184 (c) states, "The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric beds provided: (1) The hospital proposing the conversion has executed a contract with the Department's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and (2) The total number of beds to be converted shall not be more than twice the number of beds for which the contract pursuant to subdivision (1) of this subsection shall provide." See also Chapter 15 of the 2010 State Medical Facilities Plan. On the Internet at *http://www.dhhs.state.nc.us/dhsr/ncsmfp/2010/2010smfp.pdf*, accessed on Aug. 7, 2010.

[30] These are the duties outlined in the standard contract provided by North Carolina Department of Health and Human Services, Dec. 2009, pp. 5–6.

[31] *Ibid*., p. 6.

[32] *Ibid*., pp. 5 and 17.

[33] *Ibid*., p. 1. The cap is set at different amounts for different contracts.

[34] North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Uniform System for Beds or Bed Days Purchased: with Local Funds, from Existing State Appropriations, under the Hospital Utilization Pilot, and from Funds Appropriated under Session Law 2011–145, Section 10.8.(b), Raleigh, NC, May 25, 2012.

[35] N.C. Session Law 2008–107, N.C. Session Law 2009–451, N.C. Session Law 2010–31, and N.C. Session Law 2011–145. In fiscal years 2009–10 and 2010–11, contracts were not signed until partway through the fiscal year, and spending during those partial years did not exceed budgeted amounts. On an annualized basis, however, the state overcommitted the funds, and there was approximately a $3.5 million ongoing obligation that needed to be closed. The Division of Mental Health knew it was over-committing funds and did so with the consent of the Secretary of the Department of Health and Human Services and the Governor's office.

Michael Watson of Division of Medical Assistance says the additional $9 million appropriated by the legislature in 2010 allowed the Department to address the issue of over-committed funds in several ways. "One was to annualize the cost of existing contracts, and in doing that, what we did was look at the actual utilization of those contracts. The good news is that we spent all the money, and for those contracts that used all of their money, we annualized them at 100 percent. For those that stayed around the 75 percent utilization that we initially budgeted for, we kept them there. For those that we phased in, we annualized those. So, we solved the problem of over-committing funds. Then, the money that was left over then went into either new contracts or expanding existing ones."

[36] For budget information online, see *http://www.ncga.state.nc.us/fiscalresearch/Budget_Legislation/ budget_legislation.shtml.*

[37] Kent Woodson, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

[38] E. Fuller Torrey, M.D., *et al.,* "The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy, The Treatment Advocacy Center," Arlington, VA, p. 8. On the Internet at *http://www.treatmentadvocacycenter.org/storage/tac/documents/the_shortage_of_publichospital_beds.pdf,* accessed on Aug. 7, 2010. To estimate the minimum number of psychiatric beds needed for children and adults with serious psychiatric disorders, including forensic patients, "we solicited opinions from 15 experts on psychiatric care in the United States. They included individuals who have run private and state psychiatric hospitals, county mental health programs, and experts on serious psychiatric disorders. We asked them to assume the existence of good outpatient programs and the availability of outpatient commitment and told them that they would not be publicly identified…. The replies received were surprisingly consistent. Almost all 15 experts estimated a need for 50 (range 40 to 60) public psychiatric beds per 100,000 population for hospitalization for individuals with serious psychiatric disorders. Since it assumes the availability of good outpatient programs and outpatient commitment, this is a minimum number." The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illnesses.

[39] This calculation is based on a financial report provided by the N.C. Division of Mental Health, Development Disabilities, and Substance Abuse Services on Dec. 10, 2009, and data contained Torrey, note 38 above, Table 1: Degree of Deinstitutionalization: Public Psychiatric Beds Per Population, 1955 and 2004–2005. On the Internet at *http://www.treatmentadvocacycenter.org/documents/Table1—PublicPsychBedsperpop1955and 2004–2005_5_.pdf,* accessed on Aug. 8, 2010. North Carolina's population in July 2011 was 9,735,890. The population of 9,735,890 divided by 100,000 persons equals 97.4 multiplied by 50 beds equals 4,868 beds needed in North Carolina using this methodology.

[40] Marvin Swartz and Joseph Morrissey, "Public Behavioral Health Care Reform in North Carolina: Will We Get It Right This Time Around?," *North Carolina Medical Journal*, Vol. 73, No. 3, North Carolina Institute of Medicine and The Duke Endowment, Morrisville, NC, May/June 2012, p. 181.

[41] Report on Emergency Departments, note 3 above, pp. 3–5. The transfer times to community hospitals apply to all transfers to community hospitals, not just those operating with three-way contracts.

[42] N.C. Session Law 2011–145, § 10.8.(b). See Ran Coble, "Special Provisions in Budget Bills: A Pandora's Box for North Carolina Citizens," N.C. Center for Public Policy Research, Raleigh, NC, June 1986.

[43] In May 2012, UNC announced it will build a $30 million, 28-bed psychiatric facility in Wake County. Mandy Locke and John Frank, "WakeMed and Rex Hospital reach settlement, ending public feud," *The News & Observer*, Raleigh, NC, May 23, 2012, p. 1A.

[44] Furthermore, the standard three-way contract restricts the use of funds for "the purchase of 'new or expanded capacity' of local inpatient psychiatric beds or bed days." There also is no financial incentive for hospitals to swap patients from Medicaid to the three-way contract stream. Medicaid is a better deal for the hospitals and for patients, provided they are eligible. Finally, overall bed capacity has increased.

[45] See also Gerald and Ann Akland, "State Psychiatric Hospital Admission Delays in North Carolina," National Alliance on Mental Illness—Wake County, January–June 2010 (released Aug. 6, 2010) and July–September 2010 (released Jan. 17, 2011).

[46] Cristy Williams is a board certified registered nurse with a Bachelor of Science in Nursing.

[47] N.C. Session Law 2011–145, § 10.8.(b).

[48] *Ibid*.

[49] The number of LMEs is in flux as they merge to form LME-MCOs as required by the federal waiver of Medicaid regulations to provide mental health care in North Carolina. For instance, Alamance-Caswell and Five County are now with Piedmont Behavioral Healthcare.

[50] See note 20 above and Table 3 on pp. 78–81.

[51] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

[52] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2008–09, Spring Report, Raleigh, NC, April 1, 2009, Table 3.2.a, p. 19; Statewide System Performance Report, FY 2009–10, Spring Report, Raleigh, NC, April 1, 2010, Table 3.2.a, p. 16; Statewide System Performance Report, FY 2010–11, Spring Report, Raleigh, NC, April 1, 2011, Table 3.2.a, p. 15; Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

[53] Program Evaluation Division, *Caring for Previously Hospitalized Consumers: Progress and Challenges in Mental Health System Reform*, Raleigh, NC, Dec. 10, 2008, p. 11.

[54] *Ibid*., pp. 14–15.

[55] Susan Saik with the Division of State Operated Healthcare Facilities cautions, "The etiology of readmissions to the state facilities is multi-factorial because different populations are being served."

[56] Michael Watson, "DHHS Report on Local Inpatient Community Hospital Contracts (3 Way Contracts) Update, Presented to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, April 14, 2010, Slide 14.

[57] Data provided by Kent Woodson, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

[58] See 10A N.C. Administrative Code 27G .6002 and 10A N.C. Administrative Code 13B .5203.

[59] Program Evaluation Division, note 53 above, p. 11.

[60] North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Chapel Hill, NC, with data derived from the North Carolina Medical Board and North Carolina Medical Society, Aug. 19, 2011. On the Internet at *http://www.shepscenter.unc.edu/hp/prof 2010.htm*, accessed on April 20, 2012. With the implementation of Critical Access Behavioral Health Agencies (CABHAs) statewide, it is likely that psychiatrists will become more available in rural regions. CABHAs are large providers of mental health and substance abuse services, and the state requires certain staffing, including having a medical director if more than 750 consumers are served