Funds for Local Inpatient Psychiatric Beds or Bed Days Purchased in State Fiscal Year 2016-2017 and Other Department Initiatives to Reduce State Psychiatric Hospital Use

Session Law 2015-241, Section 12F.1.(f)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

Fiscal Research Division

By

North Carolina Department of Health and Human Services

December 1, 2017


Reporting Requirements

Session Law 2015-241, Section 12F.1.(f) Reporting by Department. – By no later than December 1, 2016, and by no later than December 1, 2017, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on all of the following:
(1) A uniform system for beds or bed days purchased during the preceding fiscal year from (i) funds appropriated in this act that are designated for this purpose in subsection (a) of this section, (ii) existing State appropriations, and (iii) local funds.
(2) Other Department initiatives funded by State appropriations to reduce State psychiatric hospital use.

Session Law 2016 – 94, Section 12F.9. Subsection (a) of Section 12F.1 of S.L. 2015-241 reads as rewritten:

"SECTION 12F.1.(a) Use of Funds. – Of the funds appropriated in Section 2.1 of this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for crisis services, the sum of forty million five hundred eighty-three thousand three hundred ninety-four dollars ($40,583,394) for the 2015-2016 fiscal year and the sum of forty million five hundred eighty-three thousand three hundred ninety-four dollars ($40,583,394) for the 2016-2017 fiscal year shall be used to purchase additional new or existing local inpatient psychiatric beds or bed days not currently funded by or though LME/MCOs. The Department shall continue to implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department. The enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels shall not exceed the lowest average cost per patient bed day among the State psychiatric hospitals. In addition, at the discretion of the Secretary of Health and Human Services, existing funds allocated to LME/MCOs for community-based mental health, developmental disabilities, and substance abuse services may be used to purchase additional local inpatient psychiatric beds or bed days. Funds designated in this subsection for the purchase of local inpatient psychiatric beds or bed days shall not be used to supplant other funds appropriated or otherwise available to the Department for the purchase of inpatient psychiatric services through contracts with local hospitals.

The Department may use up to ten percent (10%) of the funds allocated in this subsection for the 2016-2017 fiscal year for the State’s three-way contracts to pay for facility-based crisis services and non-hospital detoxification services for individuals in need of these services, regardless if the individuals are medically indigent, as defined in subsection (b) of this section."
Executive Summary

Session Law 2015-241, Section 12F.1.(f), requires the North Carolina Department of Health and Human Services (DHHS) to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the use of and expenditures for hospital beds for state-and locally-funded psychiatric and substance use inpatient care for persons who were medically indigent, and on other state-funded Department initiatives to reduce State psychiatric hospital use. In Session Law 2016-94, House Bill 1030, Section 12F.9. Subsection 12F.1 of S.L. 2015.241 was rewritten to allow DHHS to use up to 10% of the appropriation to pay for Facility-Based Crisis and Non-Hospital Medical Detoxification services.

Three-Way Contract Inpatient, Facility-Based Crisis (FBC) and Non-Hospital Medical Detoxification (NHMD): Uniform System for Beds or Bed Days

The “expanded use of funds for inpatient psychiatric beds or bed days,” as directed by Session Law 2016-94, House Bill 1030, Section 12F.9, (http://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2015-2016/SL2016-94.html) was executed through Three-Way Psychiatric Inpatient contracts between the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS), the Local Management Entity/Managed Care Organizations (LME/MCOs), and 29 community hospitals. In addition, Session Law 2016-94 allowed for up to 10 percent of the total appropriation to be used “to pay for facility-based crisis services and non-hospital detoxification services” and DMHDDSAS allocated a total of 8 percent to the LME/MCOs for these purposes.

Three-Way Contract Inpatient, Facility-Based Crisis and Non-Hospital Medical Detoxification: Actual Paid Amounts by End of SFY 2017

The total amount of funds that were paid through the end of June 2017 for Three-Way Contract inpatient services, Facility Based Crisis, and Non-Hospital Medical Detoxification was $38,522,407.

Other State-Funded and Locally-Funded Inpatient Care: Paid Amounts for Services in SFY 2017

In addition to the financial aspects of the Three-Way Contract psychiatric and substance use inpatient services summarized above, this report provides information about other state-funded and locally-funded psychiatric and substance use inpatient services that were delivered during SFY 2017.

Single-stream state-funds that were allocated to the LME/MCOs were also used to purchase psychiatric and substance use inpatient care in SFY 2017 for persons who were indigent. Single-stream funds and some local funds, in the amount of $11,987,397, were paid to community hospitals for psychiatric and substance use inpatient service (procedure code YP 820).
Local funding was reported by the LME/MCOs in the amount of $8,979,823 (e.g., county contributions) to have been used to pay for psychiatric inpatient care. However, much of those local dollars paid for the YP 820 psychiatric and substance use inpatient care; thus, reflecting the bulk of the funding for that service.

**Three-Way Contract, Other State & Locally-Funded Inpatient: Persons Served**

During SFY 2017, 6,255 persons who were indigent were served in Three-Way Contract psychiatric inpatient beds and 2,458 additional persons who were indigent were served in psychiatric inpatient beds paid for by other state funds, for a total of 8,713 persons served.

It should be noted that, beyond the scope of this report, LME/MCOs also paid hospitals to serve Medicaid recipients in inpatient care funded by Medicaid dollars.

**Three-Way Contract Inpatient: Expected Impact and Findings**

By strengthening and expanding community psychiatric inpatient beds, three-way contract funding was expected to have substantial impacts in several areas:

1. to reduce the need for short-term lengths of stay (7 days and less) at state psychiatric hospitals;
2. to decrease emergency department (ED) wait times and impact on law enforcement; and
3. to stop trend toward closure of community inpatient beds.

Regarding these three areas of expected impact, the report explains that the following:

1. short-term lengths of stay at state hospitals continues a downward trend; and that multiple reasons, including the increase in three-way contract beds in the community, may account for that desired decrease;
2. DMHDDSAS does not have recent ED wait time data for three-way contract beds. However, with the upcoming implementation (December 2017 – January 2018) of the Behavioral Health Crisis Referral System (BH-CR Sys), DMHDDSAS will attain the resource and capability of tracking and monitoring ED wait times for those EDs that participate in the BH-CR Sys.
3. since 2007, the number of licensed psychiatric beds for adults has risen each year, from 1,232 beds in 2007 to 1,720 in 2017; while this increase (40%) of 488 beds includes some of the 180 three-way beds, a larger number of beds have become licensed in addition to those funded by three-way contracts.

**Three-Way Contract Inpatient: Improvements & Other Initiatives**

After receiving input from LME/MCOs, community hospitals, and the DHHS General Counsel on a proposed revision to the three-way contract, DMHDDSAS implemented a revised contract on February 1, 2017. The revised contract substantially improved upon the foundation of the original contract with respect to the service description:
1. identified service eligibility and medical necessity criteria,
2. clarified requirements for initial authorization and continued stays,
3. and modified some of the monitoring requirements.

DMHDDSAS has also reduced the reporting requirements of the hospitals, as DMHDDSAS has the capacity to access most of the needed monitoring data from claims in NCTracks.

Other funded initiatives are discussed in Section V, that are designed to reduce psychiatric and substance use admissions to EDs (i.e., 24-hour Behavioral Health Urgent Care centers) and another initiative that serve as an alternative to the psychiatric and substance use inpatient level of care (i.e., 24-hour Facility-Based Crisis beds).

**Suggestions to Sustain the Success of Three-Way Contract Inpatient and Alternative Crisis Response Initiatives**

Hospital Emergency Departments and inpatient services should be reserved for and used to treat persons with acute behavioral health crises that cannot be treated at a lower level of care. The needs of individuals that are appropriate for hospital Emergency Departments include the need for acute medical stabilization (e.g., injuries, emergent medical illness) along with behavioral health crisis stabilization. Persons who need only behavioral health crisis response and stabilization can be appropriately served at lower levels of care, including FBCs, NHMDs, BHUCs, Assertive Community Treatment, Community Support Team, and other intensive outpatient services.

1. To ensure the sustainability of effective community hospital psychiatric and substance abuse inpatient care, and other crisis response services, Behavioral Health Urgent Care Centers (BHUCs), FBCs, and NHMDs, it is essential that these services are supported by a fully-functioning foundation of lower level, integrated community services for North Carolinians who have mental illness, substance use disorders, and intellectual and developmental disabilities.

2. In order to have a state-wide impact on unnecessary visits to hospital EDs and admission to behavioral health inpatient level of care, the number of Tier IV BHUCs, FBCs (for both adults and children/adolescents), and NHMDs should be increased, especially in locations having close proximity to hospitals with EDs and behavioral health inpatient beds.
Funds for Local Inpatient Psychiatric Beds or Bed Days Purchased in State Fiscal Year 2016-2017 and Other Department Initiatives to Reduce State Psychiatric Hospital Use

December 1, 2017

I. Introduction

In 2008, NC DHHS convened a task force comprised of hospital administrators, psychiatrists, other clinicians and providers, Local Management Entity (LME) leaders, and advocates to develop a comprehensive plan for community crisis services for individuals with mental health, developmental disabilities, and substance abuse service needs. The task force focused on the problem of the decreasing availability of community psychiatric inpatient beds. Between 2001 and 2006, 200 community psychiatric inpatient beds were reportedly closed.

During that same period, admissions to state psychiatric hospitals for inpatient care had steadily risen resulting in a length of stay of seven days or less representing more than fifty percent (50%) of all admissions in State Fiscal Year (SFY) 2006–2007. In catchment areas when LMEs used county funds and/or state appropriations to purchase indigent care in the community, those trends were not as severe. The task force identified the lack of funding for community psychiatric inpatient care for indigent people as one of the main obstacles to building a full crisis service continuum in the community and developed a plan to request funding for the purchase of this care. The NC General Assembly appropriated $8,121,644 for community psychiatric inpatient care in SFY 2008-2009, although the funding was limited to new beds only.

In response to the closure of Dorothea Dix Hospital and the reduction of state psychiatric beds over the past two decades, the NC General Assembly (NCGA) has appropriated state funds to increase access to psychiatric inpatient care in community hospitals beyond the state and local funds that had been already made available. The newly funded inpatient beds became known as Three-Way Contract psychiatric and substance use inpatient beds, reflecting the three partners involved in the contracted service: DMHDDSAS, LME/MCOs, and community hospitals.

The NCGA initially funded this initiative in 2008 (Session Law 2008-107), and subsequently expanded in 2009 (Session Law 2009-451), in 2013 (Session Law 2013-360), in 2017 (Session Law 2017-57). With the increases in the appropriations since SFY 2008, DMHDDSAS has been able to increase and fund community hospital inpatient psychiatric beds or bed days that were not already funded by or through LME/MCOs. The approximate number of available three-way contract inpatient beds has increased since SFY 2008 from 77 to 180 in SFY 2017. See Attachment 1 for a map showing all of the three-way contract hospital locations with the number of available beds at each facility.

The overall purpose of the funds for community hospital psychiatric inpatient care is to strengthen and expand community capacity to ensure individuals, who experience crises related to their mental illness, substance use disorder or developmental disability, receive appropriate...
inpatient level of care, when necessary, in the communities in which they live. Historically, individuals in crisis situations requiring short-term inpatient hospitalization have been served at the state’s three psychiatric hospitals – Broughton Hospital in Morganton in Burke County, Central Regional Hospital in Butner in Granville County, and Cherry Hospital in Goldsboro in Wayne County. By serving an individual in the community, the hospital provides care closer to home, family, friends, and community service providers; thus, reserving the state hospitals’ resources for individuals whose needs require more intensive and/or longer-term hospitalization or specialty services that only state hospitals can provide.

By strengthening and expanding community psychiatric inpatient beds, the funding was expected to have substantial impacts in several areas:

1. to reduce the need for short-term lengths of stay (7 days and less) at state psychiatric hospitals;
2. decrease emergency room wait times and impact on law enforcement; and
3. stop trend toward closure of community inpatient beds.

Discussion of the above expectations and additional measures is included within the body of this report.

All beds created through this initiative must also be available for involuntarily committed individuals who would otherwise qualify for admission to a state psychiatric hospital. Community hospitals may create new beds in several ways: 1) by increasing the number of beds actually in operation if their current license for psychiatric beds is greater than the number being operated; 2) by designating inpatient units for involuntarily committed persons if they had not previously held that designation; or 3) by increasing the number of licensed psychiatric inpatient beds in the hospital, either through a transfer of beds from a state hospital or a transfer of acute beds within the hospitals.

The beds contracted through the three-way contracts serve as a regional resource. Although three-way contracts are awarded to each LME/MCO and the community hospitals in the LME/MCO’s catchment area, the hospital beds are available to any indigent individual from any county in North Carolina, who requires inpatient hospitalization. For this reason, DMHDDSAS worked to locate the beds strategically throughout the state and to target areas where there have historically been a high number of admissions for short-term lengths of stay in state hospitals. The LME/MCOs managing the contracts are responsible for participating in discharge planning designed to connect individuals to community-based services upon discharge from the hospital.

In 2013, per directive of Session Law 2013-360, Section 12F.2.(a), the Department shall develop and implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level, with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department...

With the SFY 2013-2014 appropriation, the General Assembly established the two-tiered (i.e., two rates) system of payment for the provision of inpatient care based on the acuity level of the
individual needing psychiatric inpatient care. Of the $38,121,644 in funding, $2 million were used to contract with three LME/MCOs and three hospitals for the enhanced three-way inpatient care.

The standard rate for the lower level of three-way contract care is $750 per day (service code YP 821), and the enhanced three-way contract level of care was established at $900 per day (service code YP 822). The higher rate was intended to purchase a higher level (enhanced three-way psychiatric inpatient) of care in community hospitals for eligible patients who met a higher level of behavioral and/or medical acuity, similar to the level of care provided in the regional State Psychiatric Hospitals. DMHDDSAS convened a workgroup, consisting of community hospitals, LME/MCOs, and DHHS representatives, which developed the eligibility criteria for admission to enhanced three-way inpatient care. These rates are inclusive of all professional and ancillary charges (laboratory tests, medications, physician’s fees, etc.) and a week of psychotropic medication upon the individual’s discharge.

**Three-Way Contracts: Basic Agreement**

The Three-Way Psychiatric Inpatient Contract is an agreement among three partners, DMHDDSAS, LME/MCOs, and community hospitals, to provide medically necessary psychiatric and/or substance use inpatient treatment to persons who are deemed to be indigent. In accord with the contract agreement, the community hospitals make beds available to admit persons who are eligible for and whose care is authorized by the LME/MCOs. The community hospitals deliver the inpatient treatment and then submit claims to the LME/MCOs. The LME/MCOs adjudicate the claims, and pay the hospitals for the episodes of care that were authorized and adjudicated for payment. The LME/MCOs then submit claims to DMHDDSAS via NC TRACKS for adjudication and reimbursement.

On February 1, 2017, DMHDDSAS implemented a revision to the three-way contract. The revised contract substantially improved upon the foundation of the original contract with respect to the service description, identifying service eligibility and medical necessity criteria, authorization for admissions and continued stays, and monitoring of the contract requirements. DMHDDSAS has also reduced the reporting requirements of the hospitals, with the current capacity of accessing most of the needed monitoring data from NCTracks.

**Three-Way Contracts: Dates of Service and Dates of Payment**

The appropriated funds for each state fiscal year (SFY) for Three-Way Psychiatric and Substance Use Inpatient services do not carry forward beyond the end of the SFY for which they are appropriated. As such, the data used to determine bed utilization/bed days is based on the date of service (DOS) and the data used to determine the expenditure of funds is based on the date of payment (DOP). In most cases, there is a lag in the time between the DOS and the DOP which results in some claims being paid out of the following SFY’s budget.

Table 1, on the next page, reflects the pertinent S.L. 2016-94 appropriation, the pertinent Authorized Budget amounts (Fund # 1464) and the Actual amounts paid (period ending June 29,
2017), as reported in the State of North Carolina General Ledger System’s Authorized Monthly Budget Report, (accessed on August 11, 2017) for the following:

1. Three-Way Contract psychiatric and substance use inpatient services provided in SFY 2016 (accounted by lagged billing and payment delayed until beginning of SFY 2017); and
2. Three-Way Contract psychiatric and substance use inpatient services provided in SFY 2017; and
3. Facility Based Crisis (FBC) and Non-Hospital Medical Detoxification (NHMD) services provided in SFY 2017.

Table 1. Total Funds Paid for Three-Way Contract Inpatient and FBC/NHMD from S.L. 2016-94 Appropriation

<table>
<thead>
<tr>
<th>S.L. 2016-94 Appropriation: $40,583,394</th>
<th>SERVICES</th>
<th>ACTUAL AMOUNT PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three-Way Inpatient</td>
<td></td>
<td>$35,171,149</td>
</tr>
<tr>
<td>FBC/NHMD</td>
<td></td>
<td>$3,351,258</td>
</tr>
<tr>
<td>Total paid from S.L. 2016-94 Appropriation</td>
<td></td>
<td>$38,522,407</td>
</tr>
</tbody>
</table>

Three-Way Contracts: LME/MCOs, Hospitals, Beds, and Amounts for SFY 2017

The following table (Table 2) provides an overview of the three-way contracts for SFY 2017. With DMHDDSAS as the state contracting partner, the LME/MCO contractors and community hospital contractors are identified, along with the number of beds and expected number of bed days to be used, and the dollar amount of each contract. Totals for the contracts within each LME/MCO catchment area are provided. Additionally, the state-wide totals are shown: 29 hospitals and contracts; 180 available beds, 49,591 bed days; and an overall amount of $37,233,098.

Table 2. Three-Way Contract Hospitals, Beds, and Contract Amounts in SFY17 from S.L. 2016-94 State Appropriation

<table>
<thead>
<tr>
<th>LME/MCO</th>
<th>3-Way Contract Hospitals</th>
<th>Number of Beds (Bed Days) Per Contract SFY17</th>
<th>SFY 17 Contract Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Behavioral Healthcare</td>
<td>Cape Fear Valley Hosp.</td>
<td>10 (950 bed days)</td>
<td>$ 712,603</td>
</tr>
<tr>
<td>Duke University Health</td>
<td>4 (1,081 bed days)</td>
<td></td>
<td>$ 810,541</td>
</tr>
<tr>
<td>Johnston Health System</td>
<td>5 (1,551 bed days)</td>
<td></td>
<td>$ 1,163,177</td>
</tr>
<tr>
<td>UNC Hosp.-Wake Brook</td>
<td>7 (1,547 bed days)</td>
<td></td>
<td>$ 1,159,971</td>
</tr>
<tr>
<td>Alliance Total</td>
<td>4 contracts</td>
<td>26</td>
<td>$ 3,846,292</td>
</tr>
<tr>
<td>LME/MCO</td>
<td>3-Way Contract Hospitals</td>
<td>Number of Beds (Bed Days) Per Contract SFY17</td>
<td>SFY 17 Contract Amounts</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>*Cardinal Innovations Healthcare Solutions</td>
<td>Cone Health Alamance Regional</td>
<td>5 (817 bed days)</td>
<td>$ 613,104</td>
</tr>
<tr>
<td></td>
<td>Carolinas Healthcare: Charlotte &amp; Davidson</td>
<td>5 (2,224 bed days)</td>
<td>$ 1,667,816</td>
</tr>
<tr>
<td></td>
<td>Halifax Regional Medical Center</td>
<td>5 (1,153 bed days)</td>
<td>$ 864,495</td>
</tr>
<tr>
<td></td>
<td>*Novant Health Presbyterian Medical</td>
<td>11 (2,472 bed days)</td>
<td>$ 1,856,081</td>
</tr>
<tr>
<td></td>
<td>Novant Health Forsyth Medical Center</td>
<td>11 (3,498 bed days)</td>
<td>$ 2,623,240</td>
</tr>
<tr>
<td><strong>Cardinal Total</strong></td>
<td></td>
<td></td>
<td>$ 7,624,736</td>
</tr>
<tr>
<td>Eastpointe Human Services</td>
<td>Nash Hospitals (Coastal Plain Hospital)</td>
<td>11 (3,807 bed days)</td>
<td>$ 2,855,200</td>
</tr>
<tr>
<td></td>
<td>Southeastern Health</td>
<td>2 (1,023 bed days)</td>
<td>$ 766,922</td>
</tr>
<tr>
<td></td>
<td>Vidant Duplin Hospital</td>
<td>5 (1,340 bed days)</td>
<td>$ 1,005,364</td>
</tr>
<tr>
<td><strong>Eastpointe Total</strong></td>
<td></td>
<td></td>
<td>$ 4,627,486</td>
</tr>
<tr>
<td>*Partners Behavioral Health Management</td>
<td>*Catawba Valley Medical</td>
<td>14 (4,231 bed days)</td>
<td>$ 3,206,405</td>
</tr>
<tr>
<td></td>
<td>Davis Regional Med. Center</td>
<td>5 (1,429 bed days)</td>
<td>$ 1,071,971</td>
</tr>
<tr>
<td></td>
<td>DLP Frye Regional</td>
<td>5 (1,555 bed days)</td>
<td>$ 1,166,464</td>
</tr>
<tr>
<td></td>
<td>Carolinas Healthcare Sys, Kings Mountain</td>
<td>7 (2,160 bed days)</td>
<td>$ 1,619,884</td>
</tr>
<tr>
<td><strong>Partners Total</strong></td>
<td></td>
<td></td>
<td>$ 7,064,724</td>
</tr>
<tr>
<td>Sandhills Center for MH/DD/SA Services</td>
<td>FirstHealth Moore Regional</td>
<td>9 (1,584 bed days)</td>
<td>$ 1,187,718</td>
</tr>
<tr>
<td></td>
<td>Good Hope Hospital</td>
<td>5 (1,495 bed days)</td>
<td>$ 1,121,467</td>
</tr>
<tr>
<td></td>
<td>Moses H. Cone Hospital</td>
<td>6 (2,448 bed days)</td>
<td>$ 1,836,312</td>
</tr>
<tr>
<td><strong>Sandhills Center Total</strong></td>
<td></td>
<td></td>
<td>$ 4,145,497</td>
</tr>
<tr>
<td>Vaya Health (formerly Smoky Mountain Center)</td>
<td>Charles A. Cannon Memorial Hospital</td>
<td>3 (1,023 bed days)</td>
<td>$ 767,109</td>
</tr>
<tr>
<td></td>
<td>DLP Haywood Regional</td>
<td>4 (1,213 bed days)</td>
<td>$ 909,533</td>
</tr>
<tr>
<td></td>
<td>Margaret R. Pardee Hosp.</td>
<td>5 (1,481 bed days)</td>
<td>$ 1,110,541</td>
</tr>
<tr>
<td></td>
<td>Mission Hospital System</td>
<td>7 (2,061 bed days)</td>
<td>$ 1,545,750</td>
</tr>
<tr>
<td></td>
<td>DLP Rutherford Regional</td>
<td>3 (679 bed days)</td>
<td>$ 509,353</td>
</tr>
<tr>
<td><strong>Vaya Health Total</strong></td>
<td></td>
<td></td>
<td>$ 4,842,286</td>
</tr>
<tr>
<td>*Trillium Health Resources</td>
<td>CarolinaEast Health Sys.</td>
<td>2 (815 bed days)</td>
<td>$ 611,438</td>
</tr>
<tr>
<td></td>
<td>New Hanover Regional</td>
<td>10 (3,031 bed days)</td>
<td>$ 2,273,134</td>
</tr>
<tr>
<td></td>
<td>Vidant Beaufort Hospital</td>
<td>4 (1,295 bed days)</td>
<td>$ 971,250</td>
</tr>
<tr>
<td></td>
<td>*Vidant Medical Center</td>
<td>5 (921 bed days)</td>
<td>$ 426,014</td>
</tr>
<tr>
<td></td>
<td>Vidant Roanoke-Chowan Hospital</td>
<td>5 (1,067 bed days)</td>
<td>$ 800,242</td>
</tr>
<tr>
<td><strong>Trillium Total</strong></td>
<td></td>
<td></td>
<td>$ 5,082,078</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td>$37,233,098</td>
</tr>
</tbody>
</table>
*Only three hospitals, with their LME/MCO partners, have service code YP 822 beds (enhanced three-way). The three hospitals each have two beds available for enhanced three-way care.

### Three-Way Contracts by LME/MCO & Hospital: Utilization and Expenditures

DMHDDSAS has paid the LME/MCOs, which in turn, paid the community hospitals, for three-way contract inpatient care provided from July 1, 2016 through June 30, 2017 (dates of service during SFY 2017) in the amount of $34,678,106. A total of 46,428 bed days were purchased, 6,255 persons were served, with an overall average of 7.4 units per person (i.e., bed days per person, which ranged from 4.6 to 13.5 days). Table 3 provides persons served, bed days, and units per person, while Table 4 shows the expenditures by LME/MCO for both SFY 2017 and SFY 2016 to ascertain any substantial changes in the data across the two years.

#### Table 3. Three-Way Contract Inpatient Persons Served, Bed Days, and Units Per Person Purchased (service codes YP 821 & YP 822) with State Appropriations by LME/MCOs and Community Hospitals for Services During SFY 2017 (as of 9/6/17) and SFY 2016 (as of 9/27/16)

<table>
<thead>
<tr>
<th>LME/MCO</th>
<th>Hospital</th>
<th>Persons Served – SFY16</th>
<th>Persons Served – SFY17</th>
<th>Bed Days – SFY16</th>
<th>Bed Days – SFY17</th>
<th>Units Per Person – SFY16</th>
<th>Units Per Person – SFY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>Cape Fear Valley</td>
<td>293</td>
<td>140</td>
<td>1,750</td>
<td>922</td>
<td>6.0</td>
<td>6.6</td>
</tr>
<tr>
<td>Alliance</td>
<td>Duke Univ. Health</td>
<td>95</td>
<td>110</td>
<td>979</td>
<td>930</td>
<td>10.3</td>
<td>8.5</td>
</tr>
<tr>
<td>Alliance</td>
<td>Johnston Health</td>
<td>222</td>
<td>213</td>
<td>1,460</td>
<td>1,561</td>
<td>6.6</td>
<td>7.3</td>
</tr>
<tr>
<td>Alliance</td>
<td>UNC-Wakebrook</td>
<td>101</td>
<td>122</td>
<td>1,233</td>
<td>1,649</td>
<td>12.2</td>
<td>13.5</td>
</tr>
<tr>
<td><strong>Alliance</strong></td>
<td><strong>Total</strong></td>
<td><strong>711</strong></td>
<td><strong>585</strong></td>
<td><strong>5,422</strong></td>
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<tr>
<td>Cardinal</td>
<td>Cone Health Alamance Regional</td>
<td>162</td>
<td>170</td>
<td>772</td>
<td>774</td>
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<td>4.6</td>
</tr>
<tr>
<td>Cardinal</td>
<td>Carolinas Healthcare: Charlotte &amp; Davidson</td>
<td>249</td>
<td>255</td>
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<td>2,164</td>
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</table>

Table 3
<table>
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<tr>
<th>LME/MCO</th>
<th>Hospital</th>
<th>Persons Served – SFY16</th>
<th>Persons Served – SFY17</th>
<th>Bed Days – SFY16</th>
<th>Bed Days – SFY17</th>
<th>Units Per Person – SFY16</th>
<th>Units Per Person – SFY17</th>
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<tbody>
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<td>Cardinal</td>
<td>Halifax Regional Medical Center</td>
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<td>127</td>
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<tr>
<td>*Cardinal</td>
<td>*Novant Health Presbyterian Medical</td>
<td>301</td>
<td>309</td>
<td>2161</td>
<td>2,353</td>
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<tr>
<td>Cardinal</td>
<td>Novant Health Forsyth Medical Center</td>
<td>499</td>
<td>465</td>
<td>3156</td>
<td>3,276</td>
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<td>Cardinal</td>
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<td>1,326</td>
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<td>9,703</td>
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<td>7.3</td>
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<tr>
<td>Eastpointe</td>
<td>Nash Hospitals (Coastal Plain Hospital)</td>
<td>522</td>
<td>545</td>
<td>3865</td>
<td>3,807</td>
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<td>7.0</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>Southeastern Health</td>
<td>123</td>
<td>150</td>
<td>670</td>
<td>987</td>
<td>7.4</td>
<td>6.6</td>
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<tr>
<td>Eastpointe</td>
<td>Vidant Duplin Hospital</td>
<td>143</td>
<td>133</td>
<td>1229</td>
<td>1,014</td>
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<td>7.6</td>
</tr>
<tr>
<td>Eastpointe</td>
<td><strong>Total</strong></td>
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<td>828</td>
<td>5,764</td>
<td>5,808</td>
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<tr>
<td>*Partners</td>
<td>*Catawba Valley Medical</td>
<td>726</td>
<td>635</td>
<td>4116</td>
<td>3,666</td>
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<td>5.8</td>
</tr>
<tr>
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<td>Davis Regional Med. Center</td>
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<td>202</td>
<td>1601</td>
<td>1,444</td>
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<td>Partners</td>
<td>DLP Frye Regional</td>
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<td>333</td>
<td>1115</td>
<td>1,827</td>
<td>5.5</td>
<td>5.5</td>
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<tr>
<td>Partners</td>
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<td>403</td>
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<td>2193</td>
<td>1,561</td>
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<td>5.5</td>
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<td><strong>Total</strong></td>
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<td>1,454</td>
<td>9,025</td>
<td>8,498</td>
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<td>5.8</td>
</tr>
<tr>
<td>LME/MCO</td>
<td>Hospital</td>
<td>Persons Served – SFY16</td>
<td>Persons Served – SFY17</td>
<td>Bed Days – SFY16</td>
<td>Bed Days – SFY17</td>
<td>Units Per Person – SFY16</td>
<td>Units Per Person – SFY17</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Sandhills</td>
<td>FirstHealth Moore Regional</td>
<td>321</td>
<td>273</td>
<td>1484</td>
<td>1,255</td>
<td>4.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Sandhills</td>
<td>Good Hope Hospital</td>
<td>168</td>
<td>121</td>
<td>1602</td>
<td>1,281</td>
<td>9.5</td>
<td>10.6</td>
</tr>
<tr>
<td>Sandhills</td>
<td>Moses H. Cone Hospital</td>
<td>418</td>
<td>385</td>
<td>2398</td>
<td>2,363</td>
<td>5.7</td>
<td>6.1</td>
</tr>
<tr>
<td>Sandhills</td>
<td><strong>Total</strong></td>
<td><strong>907</strong></td>
<td><strong>779</strong></td>
<td><strong>5,484</strong></td>
<td><strong>4,899</strong></td>
<td><strong>6.1</strong></td>
<td><strong>6.3</strong></td>
</tr>
<tr>
<td>Trillium</td>
<td>CarolinaEast Health Sys.</td>
<td>28</td>
<td>119</td>
<td>175</td>
<td>746</td>
<td><strong>6.3</strong></td>
<td><strong>6.3</strong></td>
</tr>
<tr>
<td>Trillium</td>
<td>New Hanover Regional</td>
<td>363</td>
<td>331</td>
<td>2665</td>
<td>2,933</td>
<td><strong>7.3</strong></td>
<td><strong>8.9</strong></td>
</tr>
<tr>
<td>Trillium</td>
<td>Vidant Beaufort Hospital</td>
<td>210</td>
<td>182</td>
<td>1296</td>
<td>1,234</td>
<td><strong>6.2</strong></td>
<td><strong>6.8</strong></td>
</tr>
<tr>
<td>*Trillium</td>
<td>*Vidant Medical Center</td>
<td>79</td>
<td>89</td>
<td>613</td>
<td>514</td>
<td><strong>7.8</strong></td>
<td><strong>5.8</strong></td>
</tr>
<tr>
<td>Trillium</td>
<td>Vidant Roanoke-Chowan Hospital</td>
<td>129</td>
<td>160</td>
<td>824</td>
<td>979</td>
<td><strong>6.4</strong></td>
<td><strong>6.1</strong></td>
</tr>
<tr>
<td>Trillium</td>
<td><strong>Total</strong></td>
<td><strong>809</strong></td>
<td><strong>881</strong></td>
<td><strong>5,573</strong></td>
<td><strong>6,406</strong></td>
<td><strong>7.1</strong></td>
<td><strong>7.3</strong></td>
</tr>
<tr>
<td>Vaya</td>
<td>Charles A. Cannon Memorial Hospital</td>
<td>70</td>
<td>157</td>
<td>416</td>
<td>992</td>
<td><strong>5.9</strong></td>
<td><strong>6.3</strong></td>
</tr>
<tr>
<td>Vaya</td>
<td>DLP Haywood Regional</td>
<td>114</td>
<td>133</td>
<td>814</td>
<td>957</td>
<td><strong>7.1</strong></td>
<td><strong>7.2</strong></td>
</tr>
<tr>
<td>Vaya</td>
<td>Margaret R. Pardee Hosp.</td>
<td>255</td>
<td>243</td>
<td>1386</td>
<td>1,484</td>
<td><strong>5.4</strong></td>
<td><strong>6.1</strong></td>
</tr>
</tbody>
</table>
Overall, Table 3 illustrates the following changes from SFY 2016 to SFY 2017:

- A decrease of 724 persons served;
- An increase of 564 adjudicated bed days, corresponding with,
- an increase of .4 units per person.

**Table 4. Three-Way Contract Inpatient Service Purchased (service codes YP 821 & YP 822) with State Appropriations by LME/MCOs and Community Hospitals for Services During SFY 2017 (as of 9/6/17) and SFY 2016 (as of 9/27/16)**

<table>
<thead>
<tr>
<th>LME/MCO</th>
<th>Hospital</th>
<th>Dollars Paid – SFY16</th>
<th>Dollars Paid – SFY17</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>Cape Fear Valley</td>
<td>$1,308,475</td>
<td>$687,000</td>
<td>($621,475)</td>
</tr>
<tr>
<td>Alliance</td>
<td>Duke Univ. Health</td>
<td>$731,250</td>
<td>$697,500</td>
<td>($33,750)</td>
</tr>
<tr>
<td>Alliance</td>
<td>Johnston Health</td>
<td>$1,084,821</td>
<td>$1,165,427</td>
<td>$80,606</td>
</tr>
<tr>
<td>Alliance</td>
<td>UNC-Wakebrook</td>
<td>$924,750</td>
<td>$1,201,971</td>
<td>$277,221</td>
</tr>
<tr>
<td><strong>Alliance</strong></td>
<td>Total</td>
<td><strong>$4,049,296</strong></td>
<td><strong>$3,751,898</strong></td>
<td><strong>($297,398)</strong></td>
</tr>
<tr>
<td>Cardinal</td>
<td>Cone Health Alamance Regional</td>
<td>$579,000</td>
<td>$580,104</td>
<td>$1,104</td>
</tr>
<tr>
<td>LME/MCO</td>
<td>Hospital</td>
<td>Dollars Paid – SFY16</td>
<td>Dollars Paid – SFY17</td>
<td>Difference</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Cardinal</td>
<td>Carolinas Healthcare: Charlotte &amp; Davidson</td>
<td>$1,510,500</td>
<td>$1,622,066</td>
<td>$111,566</td>
</tr>
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<td>Cardinal</td>
<td>Halifax Regional Medical Center</td>
<td>$797,849</td>
<td>$851,745</td>
<td>$53,896</td>
</tr>
<tr>
<td>*Cardinal</td>
<td>*Novant Health Presbyterian Medical</td>
<td>$1,640,100</td>
<td>$1,764,415</td>
<td>$124,315</td>
</tr>
<tr>
<td>Cardinal</td>
<td>Novant Health Forsyth Medical Center</td>
<td>$2,367,000</td>
<td>$2,457,000</td>
<td>$90,000</td>
</tr>
<tr>
<td>Cardinal</td>
<td><strong>Total</strong></td>
<td><strong>$6,894,449</strong></td>
<td><strong>$7,275,330</strong></td>
<td><strong>$380,881</strong></td>
</tr>
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<td>Eastpointe</td>
<td>Nash Hospitals (Coastal Plain Hospital)</td>
<td>$2,897,800</td>
<td>$2,855,200</td>
<td>($42,600)</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>Southeastern Health</td>
<td>$502,500</td>
<td>$736,922</td>
<td>$234,422</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>Vidant Duplin Hospital</td>
<td>$905,550</td>
<td>$760,500</td>
<td>($145,050)</td>
</tr>
<tr>
<td><strong>Eastpointe</strong></td>
<td><strong>Total</strong></td>
<td><strong>$4,305,850</strong></td>
<td><strong>$4,352,622</strong></td>
<td><strong>$46,772</strong></td>
</tr>
<tr>
<td>*Partners</td>
<td>*Catawba Valley Medical</td>
<td>$3,101,100</td>
<td>$2,731,985</td>
<td>($369,115)</td>
</tr>
<tr>
<td>Partners</td>
<td>Davis Regional Med. Center</td>
<td>$1,191,558</td>
<td>$1,065,971</td>
<td>($125,587)</td>
</tr>
<tr>
<td>Partners</td>
<td>DLP Frye Regional</td>
<td>$836,250</td>
<td>$1,369,714</td>
<td>$533,464</td>
</tr>
<tr>
<td>LME/MCO</td>
<td>Hospital</td>
<td>Dollars Paid – SFY16</td>
<td>Dollars Paid – SFY17</td>
<td>Difference</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Partners</td>
<td>Carolinas Healthcare Sys. Kings Mountain</td>
<td>$1,644,750</td>
<td>$1,168,050</td>
<td>($476,700)</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$6,773,658</strong></td>
<td><strong>$6,335,720</strong></td>
<td><strong>($437,938)</strong></td>
</tr>
<tr>
<td>Sandhills</td>
<td>FirstHealth Moore Regional</td>
<td>$1,107,750</td>
<td>$909,750</td>
<td>($198,000)</td>
</tr>
<tr>
<td>Sandhills</td>
<td>Good Hope Hospital</td>
<td>$1,197,023</td>
<td>$960,750</td>
<td>($236,273)</td>
</tr>
<tr>
<td>Sandhills</td>
<td>Moses H. Cone Hospital</td>
<td>$1,797,835</td>
<td>$1,772,250</td>
<td>($25,585)</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$4,102,608</strong></td>
<td><strong>$3,642,750</strong></td>
<td><strong>($459,858)</strong></td>
</tr>
<tr>
<td>Trillium</td>
<td>CarolinaEast Health Sys.</td>
<td>$131,250</td>
<td>$559,206</td>
<td>$427,956</td>
</tr>
<tr>
<td>Trillium</td>
<td>New Hanover Regional</td>
<td>$1,998,000</td>
<td>$2,199,634</td>
<td>$201,634</td>
</tr>
<tr>
<td>Trillium</td>
<td>Vidant Beaufort Hospital</td>
<td>$972,000</td>
<td>$925,500</td>
<td>($46,500)</td>
</tr>
<tr>
<td>*Trillium</td>
<td>*Vidant Medical Center</td>
<td>$478,300</td>
<td>$388,564</td>
<td>($89,736)</td>
</tr>
<tr>
<td>Trillium</td>
<td>Vidant Roanoke-Chowan Hospital</td>
<td>$617,850</td>
<td>$733,614</td>
<td>$115,764</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$4,197,400</strong></td>
<td><strong>$4,806,518</strong></td>
<td><strong>$609,118</strong></td>
</tr>
<tr>
<td>Vaya</td>
<td>Charles A. Cannon Memorial Hospital</td>
<td>$312,000</td>
<td>$735,536</td>
<td>$423,536</td>
</tr>
<tr>
<td>Vaya</td>
<td>DLP Haywood Regional</td>
<td>$610,500</td>
<td>$710,338</td>
<td>$99,838</td>
</tr>
<tr>
<td>Vaya</td>
<td>Margaret R. Pardee Hosp.</td>
<td>$1,039,500</td>
<td>$1,110,541</td>
<td>$71,041</td>
</tr>
<tr>
<td>LME/MCO</td>
<td>Hospital</td>
<td>Dollars Paid – SFY16</td>
<td>Dollars Paid – SFY17</td>
<td>Difference</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Vaya</td>
<td>Mission Hospital System</td>
<td>$1,691,250</td>
<td>$1,443,000</td>
<td>($248,250)</td>
</tr>
<tr>
<td>Vaya</td>
<td>DLP Rutherford Regional</td>
<td>$418,104</td>
<td>$513,853</td>
<td>$95,749</td>
</tr>
<tr>
<td>Vaya</td>
<td>Total</td>
<td>$4,071,354</td>
<td>$4,513,268</td>
<td>$441,914</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$34,394,614</td>
<td>$34,678,106</td>
<td>$283,492</td>
</tr>
</tbody>
</table>

*Three LME/MCOs/hospitals have enhanced (YP 822, $900/day) three-way beds, as well as the lower rate tier (YP 821, $750/day) three-way beds. The YP 822 beds have had very little utilization, and thus were combined on this table with the more frequently used lower tier three-way beds (YP 821).

Table 4 shows an overall increase (1%) of $283,492 in the dollar value of claims that was adjudicated for payment from SFY 2016 to SFY 2017. However, there was much variability across some of hospitals in changes from year to year. Three hospitals had reductions of 20%, 29%, and 47%, while four hospitals had increases of 23%, 30%, 64%, 136% in claims amounts adjudicated for payment. Two hospitals’ contracts, Southeastern Regional Medical Center and Carolina East Health System, were in effect for just part of SFY 2016; thus, making comparisons from one SFY to another not meaningful.

Due to utilization trends of individual hospitals prior to and during SFY 2017, four hospitals had two contract amendment reductions, and one had three reductions during the SFY; while eight hospitals each had two contract amendment increases.

II. **Other Hospital Beds/Bed Days Purchased from Generic State Appropriations**

In addition to the funds specifically appropriated by the NC General Assembly for community hospital psychiatric inpatient beds/bed days purchased through three-way contracts, all of the LME/MCOs used a portion of their generic allocation of state funding, known as Single Stream funding, to purchase hospital inpatient services (service code, YP 820). Further, it is known that Alliance Behavioral Health LME/MCO paid for this YP 820 psychiatric inpatient care with local funding. This YP 820 psychiatric inpatient service differed from the three-way funding (service codes, YP 821 and YP 822) in a notable way. The YP 820 inpatient payment rate, which varies across the LME/MCOs, only pays the hospital for the bed fee, not for the professional services provided by the psychiatrists and other caregivers, which may be separately billed. As described above, the three-way contract rates are inclusive of the bed fee, all professional and ancillary charges, plus seven days of psychotropic medication upon the individual’s discharge.

Table 5 depicts the expenditures, bed days purchased, persons served, and units per person in State Fiscal Year 2015–2016 per LME/MCO. Seven (7) LME/MCOs paid for psychiatric inpatient services for 2,458 individuals in community hospitals at a cost of $11,987,397, paying
for 20,313 bed days. The state-wide average was 8.3 units per persons (i.e., bed days), with a range across the identified hospitals from an average of 3.0 to 11.2 units per person.

Table 5. Inpatient Bed Days Purchased (service code YP 820) with LME/MCO Allocations of State Appropriations for Services in SFY 2017 in Community Hospitals (as of 9/6/17)

<table>
<thead>
<tr>
<th>LME/MCO</th>
<th>Hospital</th>
<th>Persons Served</th>
<th>YP 820 Dollars Paid</th>
<th>Bed Days</th>
<th>Units Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>Holly Hill Hospital</td>
<td>834</td>
<td>$6,084,068</td>
<td>9,366</td>
<td>11.2</td>
</tr>
<tr>
<td>Alliance Total</td>
<td></td>
<td>834</td>
<td>$6,084,068</td>
<td>9,366</td>
<td>11.2</td>
</tr>
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<td>Cardinal</td>
<td>High Point Regional Health</td>
<td>73</td>
<td>$101,508</td>
<td>219</td>
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</tr>
<tr>
<td></td>
<td>Old Vineyard Behavioral Health</td>
<td>507</td>
<td>$2,448,713</td>
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</tr>
<tr>
<td></td>
<td>Holly Hill Hospital</td>
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<td>$955,799</td>
<td>2,143</td>
<td>9.0</td>
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<td></td>
<td>Rowan Regional Medical Center</td>
<td>155</td>
<td>$324,299</td>
<td>699</td>
<td>4.5</td>
</tr>
<tr>
<td>Cardinal Total</td>
<td></td>
<td>900</td>
<td>$3,728,811</td>
<td>7,717</td>
<td>8.6</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>Southeastern Regional Medical Center</td>
<td>105</td>
<td>$521,474</td>
<td>600</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>Brynn Marr Behavioral Healthcare</td>
<td>1</td>
<td>$2,700</td>
<td>6</td>
<td>6.0</td>
</tr>
<tr>
<td>Eastpointe Total</td>
<td></td>
<td>106</td>
<td>$524,174</td>
<td>606</td>
<td>5.7</td>
</tr>
<tr>
<td>Partners</td>
<td>Gaston Memorial Hospital</td>
<td>57</td>
<td>$128,625</td>
<td>277</td>
<td>4.9</td>
</tr>
<tr>
<td>Partners Total</td>
<td></td>
<td>57</td>
<td>$128,625</td>
<td>277</td>
<td>4.9</td>
</tr>
<tr>
<td>Sandhills</td>
<td>High Point Regional Health</td>
<td>391</td>
<td>$901,413</td>
<td>1,252</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>Moses H. Cone Memorial Hospital</td>
<td>7</td>
<td>$26,645</td>
<td>37</td>
<td>5.3</td>
</tr>
<tr>
<td></td>
<td>Old Vineyard Behavioral Health</td>
<td>17</td>
<td>$65,520</td>
<td>96</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td>Sandhills Regional Medical Center</td>
<td>42</td>
<td>$82,134</td>
<td>180</td>
<td>4.3</td>
</tr>
<tr>
<td>Sandhills Total</td>
<td></td>
<td>457</td>
<td>$1,075,711</td>
<td>1,565</td>
<td>3.4</td>
</tr>
<tr>
<td>Vaya (formerly Smoky Mountain)</td>
<td>Charles A. Cannon, Jr. Memorial Hospital</td>
<td>50</td>
<td>$151,036</td>
<td>289</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>DLP Haywood Regional</td>
<td>39</td>
<td>$183,849</td>
<td>259</td>
<td>6.6</td>
</tr>
<tr>
<td>Vaya Total</td>
<td></td>
<td>89</td>
<td>$334,885</td>
<td>548</td>
<td>6.2</td>
</tr>
<tr>
<td>Trillium</td>
<td>Brynn Marr Behavioral Healthcare</td>
<td>1</td>
<td>$5,200</td>
<td>8</td>
<td>8.0</td>
</tr>
<tr>
<td></td>
<td>Holly Hill Hospital</td>
<td>1</td>
<td>$4,414</td>
<td>7</td>
<td>7.0</td>
</tr>
<tr>
<td>Trillium Total</td>
<td></td>
<td>2</td>
<td>$9,614</td>
<td>15</td>
<td>7.5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,458</td>
<td>$11,987,397</td>
<td>20,313</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Source: NCTracks

Data retrieved for claims adjudicated for payment through September 6, 2017 for service dates in SFY 2017.
III. Beds/Bed Days Purchased with Local Funds

Four LME/MCOs reported to DMHDDSAS that they were able to access local funding to purchase or supplement additional psychiatric inpatient services in community hospitals. A total of $8,979,823 was paid to community hospitals for inpatient care. These local funds were reported to have purchased 12,212 bed days and served 1,052 people, with an overall average units per person of 11.6, as reflected in Table 6. However, as previously noted, Alliance Behavioral Health LME/MCO used much, if not all, of its local funding to pay for YP 820 inpatient care. Hence, there is significant overlap between the data in Tables 5 and 6.

Table 6. Inpatient Bed Days Purchased by Local Management Entities-Managed Care Organizations with Local Funds for Services During SFY 2017 in Community Hospitals

<table>
<thead>
<tr>
<th>LME/MCO</th>
<th>Hospital</th>
<th>Persons Served</th>
<th>Local Dollars Paid</th>
<th>Bed Days</th>
<th>Units Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>Holly Hill Hospital</td>
<td>899</td>
<td>$7,984,583</td>
<td>11,156</td>
<td>12.4</td>
</tr>
<tr>
<td>Alliance Total</td>
<td></td>
<td>899</td>
<td>$7,984,583</td>
<td>11,156</td>
<td>12.4</td>
</tr>
<tr>
<td>Cardinal *</td>
<td>UNC Hospital *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardinal Total</td>
<td></td>
<td></td>
<td>$214,200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partners</td>
<td>Carolinas Health Blue Ridge</td>
<td>21</td>
<td>$15,858</td>
<td>36</td>
<td>1.7</td>
</tr>
<tr>
<td>Partners Total</td>
<td></td>
<td>21</td>
<td>$15,858</td>
<td>36</td>
<td>1.7</td>
</tr>
<tr>
<td>VAYA Health</td>
<td>Charles A. Cannon Memorial</td>
<td>18</td>
<td>$91,714</td>
<td>122</td>
<td>6.7</td>
</tr>
<tr>
<td>VAYA Health</td>
<td>DLP Haywood Regional</td>
<td>49</td>
<td>$267,178</td>
<td>356</td>
<td>7.3</td>
</tr>
<tr>
<td>VAYA Health</td>
<td>DLP Rutherford Hospital</td>
<td>9</td>
<td>$65,250</td>
<td>87</td>
<td>9.9</td>
</tr>
<tr>
<td>VAYA Health</td>
<td>Mission Hospital</td>
<td>41</td>
<td>$276,000</td>
<td>368</td>
<td>8.9</td>
</tr>
<tr>
<td>VAYA Health</td>
<td>Margaret Pardee Memorial</td>
<td>15</td>
<td>$64,500</td>
<td>86</td>
<td>5.7</td>
</tr>
<tr>
<td>VAYA Health Total</td>
<td></td>
<td>132</td>
<td>$764,642</td>
<td>1,020</td>
<td>7.7</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,052</td>
<td>$8,979,283</td>
<td>12,212</td>
<td>11.6</td>
</tr>
</tbody>
</table>

Source: LME/MCOs reports on local funds used for inpatient care

*The annual amount Cardinal Innovations pays to one community hospital using local funds is $214,200. These funds do not pay for actual bed days, but are used to offset the costs of indigent inpatient care.

IV. Selected Measures of Performance for Three-Way Contract Psychiatric Inpatient Care

Claims submitted by the LME/MCOs into NCTracks for three-way contract psychiatric and substance use inpatient services contain valuable information that enables DMHDDSAS to monitor some of the basic aspects the contract. This section of the report focuses on several aspects that are being monitored on an ongoing basis.
Discharges and Average Length of Stay by Disability

Table 7 depicts two main measures by hospital for SFY 2017: number of discharges of persons with a principle mental health (MH) or substance use disorder (SUD) disability; and average length of stay (Avg LOS) of persons with a principle mental health or substance use disorder disability.

Table 7. Three-Way Contract Discharges & Average Lengths of Stay by Principal Diagnostic Category in SFY 2017

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Count of Discharges</th>
<th>Avg LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Principal disability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MH</td>
<td>SUD</td>
</tr>
<tr>
<td>Alamance Regional Medical Center</td>
<td>170</td>
<td>23</td>
</tr>
<tr>
<td>Beaufort Regional Medical Center</td>
<td>125</td>
<td>83</td>
</tr>
<tr>
<td>Cape Fear Valley Hospital</td>
<td>148</td>
<td>3</td>
</tr>
<tr>
<td>Carolina East Medical Center</td>
<td>168</td>
<td></td>
</tr>
<tr>
<td>Carolinas Medical Center</td>
<td>296</td>
<td>2</td>
</tr>
<tr>
<td>Catawba Valley Medical Center</td>
<td>432</td>
<td>299</td>
</tr>
<tr>
<td>Charles A. Cannon, Jr. Memorial Hosp</td>
<td>159</td>
<td>7</td>
</tr>
<tr>
<td>Davis Regional Medical Center</td>
<td>233</td>
<td></td>
</tr>
<tr>
<td>Duke University Health System</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>Duplin General</td>
<td>121</td>
<td></td>
</tr>
<tr>
<td>First Health/Moore Regional Hospital</td>
<td>204</td>
<td>112</td>
</tr>
<tr>
<td>Forsyth Memorial Hospital</td>
<td>442</td>
<td>106</td>
</tr>
<tr>
<td>Frye Regional</td>
<td>185</td>
<td>172</td>
</tr>
<tr>
<td>Good Hope</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Halifax Regional</td>
<td>160</td>
<td>1</td>
</tr>
<tr>
<td>Haywood Regional Medical Center</td>
<td>138</td>
<td>8</td>
</tr>
<tr>
<td>Johnston Memorial</td>
<td>237</td>
<td>5</td>
</tr>
<tr>
<td>Kings Mountain Hospital</td>
<td>286</td>
<td>9</td>
</tr>
<tr>
<td>Margaret Pardee Memorial</td>
<td>152</td>
<td>173</td>
</tr>
<tr>
<td>Mission</td>
<td>216</td>
<td>19</td>
</tr>
<tr>
<td>Moses Cone</td>
<td>351</td>
<td>100</td>
</tr>
<tr>
<td>Nash Hospitals, Inc.</td>
<td>359</td>
<td>330</td>
</tr>
<tr>
<td>New Hanover Regional Medical Center</td>
<td>394</td>
<td>8</td>
</tr>
<tr>
<td>Northside</td>
<td>192</td>
<td></td>
</tr>
<tr>
<td>Pitt Memorial</td>
<td>135</td>
<td>1</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>349</td>
<td>12</td>
</tr>
<tr>
<td>Rutherford</td>
<td>81</td>
<td></td>
</tr>
</tbody>
</table>
The total number of discharges was 7,743 with 81% of the discharges of persons having a principle MH disability and 19% having a principle SUD disability. The average LOS for persons having a principle MH disability was 6.8 days, while persons having a principle SUD disability was 5.6 days. The overall average LOS was 6.6 days, with a range across the hospitals of 3.5 to 12.9 days.

Clearly, the predominant overall principle disability at discharge was MH. The data also indicate seven of the hospitals submitted claims that did not reflect any principle SUD disability among the persons discharged from their care, while six other hospitals had a range of 35% to 53% of persons discharged with principle SUD disabilities. Moreover, it is well known that many individuals have co-occurring behavioral health needs that include both MH and SUD treatment.

As noted above, the average LOS among the 29 hospitals had a fairly wide range; though 21 of the hospitals had average LOS between 5 and 9 days. Three hospitals had average LOS below 5 days, and five were above 9 days. As in previous years, the state-wide or overall average LOS continued to remain under seven days (6.6 days) in SFY 2017.

Differences across the 29 hospitals in LOS likely has a variety of possible explanations. Higher LOS would be expected for hospitals that have the following:

- Staffing with the willingness, expertise, and resources to serve a higher proportion of the persons who have more complex psychiatric or substance use needs, and/or behavioral challenges;
- Location in areas with few community services that could prevent crises from occurring or escalating to a level requiring psychiatric or substance use inpatient care, for medically indigent people;
- Difficulty working with LME/MCOs or providers in developing proactive discharge plans and finding appropriate community services, thus delaying discharge;
- Combinations of the aforementioned factors (e.g., scarce community resources and hospital staff with the willingness, expertise, and resources to admit and treat persons with more complex psychiatric or substance use needs and/or behavioral challenges).

Lower LOS would be expected for hospitals that have the following:

- Staff who were more reluctant, have insufficient expertise, or inadequate resources to serve a higher proportion of the persons presenting with more complex psychiatric or substance use needs, and/or behavioral challenges;

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Count of Discharges</th>
<th>Avg LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Principal disability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MH</td>
<td>SUD</td>
</tr>
<tr>
<td>Southeastern Regional Medical Center</td>
<td>166</td>
<td>11</td>
</tr>
<tr>
<td>UNC-Wakebrook</td>
<td>111</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,243</strong></td>
<td><strong>1,500</strong></td>
</tr>
</tbody>
</table>
• Locations in areas with few community services for medically indigent people, thus persons with less complex needs and challenging behaviors may be referred to inpatient care for short stays, in the absence of other non-hospital alternatives (e.g., Facility Based Crisis, Non-Hospital Medical Detox);
• Combinations of the aforementioned factors (e.g., scarce community resources and hospital staffing who may be more reluctant, have insufficient expertise, or inadequate resources to serve a higher proportion of the persons presenting with more complex psychiatric or substance use needs, and/or behavioral challenges).

Re-admissions to Inpatient Care

The National Committee for Quality Assurance includes follow-up care after hospitalization for mental illness among its numerous measures in the Healthcare Effectiveness Data and Information Set (HEDIS), which are applicable to the provision of care funded by commercial, Medicaid, and Medicare health insurers. This HEDIS measure considers re-admissions to inpatient hospitals when evaluating effectiveness of care. [http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf](http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf)

Likewise, DMHDDSAS tracks hospital re-admissions within 30 days of discharge as one way to assess performance of the publicly-funded system of care. It must be noted, however, that multiple factors can affect re-admission to inpatient care, such as:

• Incomplete stabilization/treatment: individuals may be discharged before stabilization occurred or treatment was completed during inpatient care;
• Lack of availability of more intensive recovery services and supports following inpatient: without higher levels of recovery care after discharge from hospitalization, persons with severe mental illness and substance use disorders often experience relapses and additional crisis events; more intensive step-down services include but are not limited to Partial Hospitalization, Assertive Community Treatment; Critical Time Intervention; Substance Abuse Non-Medical Community Residential Treatment; and Substance Abuse Medically Monitored Community Residential Treatment;
• Insufficient access to or availability of outpatient (e.g., prescribers), community services or support system;
• Inadequate care coordination or linkage to follow-up care; and
• Untimely follow-up care.

For persons discharged from three-way contract inpatient care during SFY 2017, the overall re-admission rate to any community hospital for psychiatric/substance use inpatient care was 10% (see Table 8). Across LME/MCÖs the range varied from 6% to 15%, while across hospitals the range was broader, 1% to 34%.
Table 8. Re-admission (Post Discharge from Three-Way Contract Hospital) within 30 Days to Any Community Hospital Psychiatric/Substance Abuse Inpatient Bed in SFY 2017

<table>
<thead>
<tr>
<th>LME/MCO</th>
<th>Hospital</th>
<th>Total Discharges</th>
<th>Readmit within 30 Days</th>
<th>Readmit as % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLIANCE</td>
<td>Cape Fear Valley Hospital</td>
<td>151</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Duke University Health System</td>
<td>113</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Johnston Memorial</td>
<td>242</td>
<td>21</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>UNC-Wakebrook</td>
<td>127</td>
<td>8</td>
<td>6%</td>
</tr>
<tr>
<td>ALLIANCE Total</td>
<td></td>
<td>633</td>
<td>40</td>
<td>6%</td>
</tr>
<tr>
<td>CARDINAL</td>
<td>Alamance Regional Medical Center</td>
<td>193</td>
<td>12</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Carolinas Medical Center</td>
<td>298</td>
<td>50</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Forsyth Memorial Hospital</td>
<td>548</td>
<td>61</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Halifax Regional</td>
<td>161</td>
<td>18</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Presbyterian</td>
<td>361</td>
<td>47</td>
<td>13%</td>
</tr>
<tr>
<td>CARDINAL Total</td>
<td></td>
<td>1,561</td>
<td>188</td>
<td>12%</td>
</tr>
<tr>
<td>EASTPOINTE</td>
<td>Duplin General</td>
<td>121</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Nash Hospitals, Inc.</td>
<td>689</td>
<td>67</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Southeastern Regional Medical Center</td>
<td>177</td>
<td>18</td>
<td>10%</td>
</tr>
<tr>
<td>EASTPOINTE Total</td>
<td></td>
<td>987</td>
<td>89</td>
<td>9%</td>
</tr>
<tr>
<td>PARTNERS</td>
<td>Catawba Valley Medical Center</td>
<td>731</td>
<td>65</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Davis Regional Medical Center</td>
<td>233</td>
<td>23</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Frye Regional</td>
<td>357</td>
<td>28</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Kings Mountain Hospital</td>
<td>295</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>PARTNERS Total</td>
<td></td>
<td>1,616</td>
<td>127</td>
<td>8%</td>
</tr>
<tr>
<td>SANDHILLS</td>
<td>First Health/Moore Regional Hospital</td>
<td>316</td>
<td>19</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Good Hope</td>
<td>120</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Moses Cone</td>
<td>451</td>
<td>34</td>
<td>8%</td>
</tr>
<tr>
<td>SANDHILLS Total</td>
<td></td>
<td>887</td>
<td>54</td>
<td>6%</td>
</tr>
<tr>
<td>TRILLIUM</td>
<td>Beaufort Regional Medical Center</td>
<td>208</td>
<td>18</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Carolina East Medical Center</td>
<td>168</td>
<td>36</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>New Hanover Regional Medical Center</td>
<td>402</td>
<td>39</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Northside</td>
<td>192</td>
<td>29</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Pitt Memorial</td>
<td>136</td>
<td>46</td>
<td>34%</td>
</tr>
<tr>
<td>TRILLIUM Total</td>
<td></td>
<td>1,106</td>
<td>168</td>
<td>15%</td>
</tr>
<tr>
<td>VAYA</td>
<td>Charles A. Cannon, Jr. Memorial Hosp</td>
<td>166</td>
<td>12</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Haywood Regional Medical Center</td>
<td>146</td>
<td>11</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Margaret Pardee Memorial</td>
<td>325</td>
<td>44</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Mission</td>
<td>235</td>
<td>28</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Rutherford</td>
<td>81</td>
<td>7</td>
<td>9%</td>
</tr>
<tr>
<td>VAYA Total</td>
<td></td>
<td>953</td>
<td>102</td>
<td>11%</td>
</tr>
<tr>
<td>Total Discharges</td>
<td></td>
<td>7,743</td>
<td>768</td>
<td>10%</td>
</tr>
</tbody>
</table>
In order to impact the overall rate of re-admissions to three-way contract inpatient care and consequently the effectiveness of care, it is important to consider that funding to restore community services is needed at multiple levels of the service continuum and within the systems that fund and manage care.

**State Psychiatric Hospitals’ Lengths of Stay**

With respect to one expected impact of the increased number of psychiatric inpatient beds in the community hospitals, that is, a reduction of short-term stays in the state psychiatric hospitals, Figure 1, on the next page, illustrates the downward trend of lengths of stay of seven days or less in the state hospitals since calendar year 2008.

The data below are presented as the percentage of state hospital discharges by quarter over the last 10 years. As indicated in the note beneath Figure 1, the source for this data is inclusive of only those persons discharged for whom the LME/MCOs are responsible for serving in the community service system.
At the beginning of State Fiscal Year 2008, more than half (57%) of the discharges from the state hospitals had a length of stay of seven days or less. By the end of State Fiscal Year 2017, only 14% of discharges had a length of stay of seven days or less. During that same period, reflected in Figure 2, on the next page, the number of discharges significantly decreased from 3,381 to 382, while the average length of stay (ALOS), depicted in Figure 3 for persons treated at the state psychiatric hospitals increased from 22.6 days to 91.4 days.
While the increase of available community hospital beds, through three-way contracts, likely was a considerable reason for the reduced percentage of short-term stays in the state hospitals, other factors likely have shared contribution to this desired outcome. These factors include:

- Decrease in operational beds in the state hospitals between SFY 2008 and SFY 2010, making fewer beds available for short term admissions;
- State hospitals having a higher percentage of admission diagnoses of schizophrenia and other major psychiatric disorders (i.e., longer-term inpatient treatment needs) and lower percentage of substance use diagnoses, which occurred primarily due to the state operated Alcohol and Drug Abuse Treatment Centers beginning to admit individuals who involuntarily committed for substance use treatment;
- Admission delays at the state hospitals resulting in individuals with less significant needs being admitted to local inpatient units (including three-way contract beds) or discharged from the ED; only those with the most significant needs remain in the ED until a bed is
available in the State hospital; thus, the lengths of stay increases as the higher proportion of admitted individuals have more severe and chronic impairments; and

- Fewer community discharge options for individuals with high-support needs tends to increase lengths of stay in the state hospitals.

It should also be noted that the downward trend, depicted in Figure 1, began a few quarters before the inception of three-way contract inpatient care in community hospitals.

**Emergency Department Wait Times**

The Division of State Operated Health Facilities has been able to perform ongoing monitoring of the wait times in EDs for persons who are admitted to state psychiatric hospitals, as the tracking is performed by a collaborative and standardized effort between the LME/MCOs and the state hospitals. DMHDDSAS, in collaboration with the North Carolina Hospital Association and numerous community hospitals, reported to the North Carolina General Assembly on ED wait times for state hospitals and community hospitals (North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services March 2011) [https://www2.ncdhhs.gov/mhddas/statspublications/Reports/reports-generalassembly/generalreports/edreport-3-11.pdf](https://www2.ncdhhs.gov/mhddas/statspublications/Reports/reports-generalassembly/generalreports/edreport-3-11.pdf).

In that March 2011 report of a one month (November 2010) period, the average wait times for state hospital beds (26 hours, 38 minutes) were found to be higher than the wait times for community hospital beds (14 hours, 7 minutes). DMHDDSAS does not have recent ED wait time data for three-way contract beds. However, with the upcoming implementation (December 2017 – January 2018) of the Behavioral Health Crisis Referral System (BH-CRSys), DMHDDSAS will attain the resource and capability of tracking and monitoring ED wait times for those EDs that participate in the BH-CR Sys.

**Trend of Closure of Community Inpatient Beds**

In order to track the number of community hospital psychiatric beds for this report, data from the North Carolina State Medical Facilities Plans (SMFPs) were accessed from 2007 through 2017. [https://www2.ncdhhs.gov/dhsr/ncsmfp/index.html](https://www2.ncdhhs.gov/dhsr/ncsmfp/index.html) and [https://www2.ncdhhs.gov/dhsr/ncsmfp/archive.html](https://www2.ncdhhs.gov/dhsr/ncsmfp/archive.html).

The 2007 SMFP reported that there were 1,232 licensed psychiatric beds for adults in the community hospitals. By 2017, the number of licensed psychiatric beds for adults had increased by 488 (40%) to 1,720 (North Carolina Department of Health and Human Services Division of Health Service Regulation, 2007-2017). This data suggests that community hospitals were motivated to apply for Certificates of Need and psychiatric bed licensure since 2007, which indicated a reversal of any downward trend that may have existed prior to 2007. However, the reasons for the increased number of beds are unclear; and because the increase of 488 beds substantially exceeds the number of beds that were identified for three-way contract funding (i.e., 180), the creation of the 488 beds cannot be solely attributed to the three-way contracts.
V. Other Department Initiatives Funded by State Appropriations to reduce State psychiatric hospital use.

S.L. 2014-100 SECTION 12F.5.(b) From funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for community services for the 2014-2015 fiscal year, the Division shall use two million two hundred thousand dollars ($2,200,000) in recurring funds to accomplish the following:

(1) To increase the number of co-located or operationally linked behavioral health urgent care centers and facility-based crisis centers.
(2) To increase the number of facility-based crisis centers designated by the Secretary as facilities for the custody and treatment of involuntary clients pursuant to G.S.122C-252 and 10A NCAC 26C .0101. The Department shall give priority to areas of the State experiencing a shortage of these types of facilities.
(3) To provide reimbursement for services provided by facility-based crisis centers.
(4) To establish facility-based crisis centers for children and adolescents.

The initiatives described below are intended to divert individuals who experience behavioral health crises from seeking psychiatric or substance use crisis response from EDs. Rather, these initiatives function as alternative crisis responders, diverting people from ED visits and are intended to reduce the need for psychiatric and substance use inpatient hospital care. It is anticipated that these alternative community resources will reduce the need for State Psychiatric Hospital admissions.

Behavioral Health Urgent Care and Facility Based Crisis

In SFY 2013, the NC General Assembly appropriated funding for Facility Based Crisis (FBC) centers and Behavioral Health Urgent Care (BHUC) centers to serve as alternatives to EDs and inpatient hospitalization for persons who experience crises related to mental health, substance use, or intellectual/developmental disabilities diagnoses. Several BHUCs (i.e., Tier IV BHUCs) and all of the FBCs operate on a 24-hour, seven days per week basis. The FBCs are licensed residential facilities, under Rule 10A NCAC 27G .5000, and provide facility-based crisis service as described in Rule 10A NCAC 27G .5001. The state currently has 22 adult FBC Service sites, 12 of those are designated for the treatment of persons who are under involuntary commitment (IVC). The 22 FBC’s have 303 beds to offer alternative treatment to inpatient hospitalization.

The Session Law 2014-100 definition of Behavioral Health Urgent Care (BHUC) was as follows:

*Behavioral Health Urgent Care Center. – An outpatient facility that provides walk-in crisis assessment, referral, and treatment by licensed behavioral health professionals*
with prescriptive authority to individuals with an urgent or emergent need for mental health, intellectual or developmental disabilities, or substance abuse services

Some of the Tier IV BHUC sites are equipped with additional resources to help stabilize individuals in crisis. These resources are 23-hour crisis stabilization/observation beds, which provide supervised care to deescalate the behavioral health crises and reduce the need for emergent care. This service provides prompt assessments, stabilization and linking to the appropriate level of care. The intended outcome is to avoid unnecessary hospitalizations for people experiencing crises that may resolve with time and observation.

Together, Tier IV BHUCs and FBCs provide alternative routes for crisis stabilization that allow individuals in crisis to completely avoid an ED visit. The BHUCs function as effective alternatives to EDs for persons in behavioral health crisis who are not experiencing any significant medical distress. Like EDs, BHUCs are capable of providing first evaluations for involuntary commitment (IVC), and are able to refer persons needing crisis stabilization to either a hospital inpatient level of care, an FBC level of care, or an intensive outpatient level of care, depending on an individual’s needs. FBCs function as local alternatives to an inpatient level of care, and typically provide three to five days of behavioral health crisis stabilization in a unit of 16 beds or less, including treatment of persons who are under involuntary commitment. The above appropriation has helped with the development of some of these facilities:

- Vaya Health LME/MCO and RHA a provider agency, have opened a 24 hour BHUC in Buncombe County, and have moved an existing adult FBC to the same location, and will re-apply to be an IVC designated facility. This one location also encompasses RHA’s outpatient services, a peer living room, a pharmacy and community resources. Of interest here is that Mission Hospital assisted with funding this project due to the expectation that ED diversion will be successful.
- Eastpointe LME/MCO and Monarch a provider agency in Robeson County renovated its existing adult FBC to add 5 additional beds making it a 16-bed facility. The facility opened on August 28, 2017, has applied for designation as an IVC treatment facility, and also added a co-located BHUC component with two 23-hour crisis stabilization/observation chairs. The provider has developed working partnership with Southeast Regional Medical Center to ensure a broader continuum of crisis care is available nearby.
- Former CenterPoint, now Cardinal Innovations Healthcare Solutions LME/MCO and Daymark a provider agency, in Forsyth County is in the construction phase for a new BHUC with co-located outpatient services and medical clinic. On August 31, 2017 Daymark had an opening for a new FBC in neighboring Davidson County which will service the Forsyth BHUC. The FBC plans to apply to be an IVC designated facility.
- Cardinal Innovations Healthcare Solutions, LME/MCO, and Monarch, a provider agency, in Mecklenburg County is constructing a child/adolescent FBC (no BHUC). The FBC functions as a viable alternative to behavioral health inpatient, when it has received designation as an IVC facility.
With respect to the main intent of the appropriation, that is, to reduce ED visits for persons who experience behavioral health crises, DMHDDSAS was able to report last year (December 1, 2016) to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division that EDs in counties, in which BHUCs that were open 24 hours/seven days a week, had 25% fewer ED visits in SFY 2015. [https://ncdhhs.s3.amazonaws.com/s3fs-public/SL%202015-24112F%20Uniform%20System%20Beds-Bed%20Day%20Report.pdf](https://ncdhhs.s3.amazonaws.com/s3fs-public/SL%202015-24112F%20Uniform%20System%20Beds-Bed%20Day%20Report.pdf)

The following projection was included in the December 2016 report:

> If similar BHUC and FBC centers could be made available statewide as an alternative to EDs and inpatient hospitalization, NC could see up to 30,000 fewer ED visits for this population per year and fewer subsequent inpatient admissions.

The NC Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT) is the primary data source used to evaluate ED usage for this population. While DHHS access to these data for this purpose has been blocked, we are working closely with the North Carolina Hospital Association and other stakeholders to address.

**VI.  Summary and Recommendations to Sustain Success of Behavioral Health Crisis Alternatives and Hospital Inpatient**

In response to the closure of Dorothea Dix state psychiatric hospital and the reduction of state psychiatric beds over the past two decades, the NC General Assembly has appropriated state funds to increase access to psychiatric inpatient care in community hospitals. The number of available three-way contract psychiatric beds has increased since SFY 2008 from 77 to 180 in SFY 2017. For three-way contract inpatient services provided between July 1, 2016 and June 30, 2017, DMHDDSAS has expended approximately $34.7 million, with another $12.0 million for state-funded psychiatric inpatient care paid through Single Stream allocation funds.

Local funding was reported by the LME/MCOs in the amount of $9.0 million (e.g., county contributions) to have been used to pay for psychiatric inpatient care. However, much of those local dollars paid for the YP 820 psychiatric and substance use inpatient care; reflecting the bulk of the funding for that service.

**Need to Prevent Unnecessary Hospital ED Visits and Behavioral Health Inpatient Admissions**

All stakeholders have acknowledged that, in many communities, hospital Emergency Departments have become the default resource for many people without health insurance who experience behavioral health crises. Over-crowding of many Emergency Departments as well as lengthy wait times for persons in EDs who are referred for behavioral health inpatient care have been repeatedly reported by the media.
Fortunately, the NC General Assembly has provided some funding for BHUCs and FBCs to reduce the burden on hospitals, and to facilitate access for persons without health insurance to obtain effective behavioral health resources that divert individuals from unnecessary hospital admissions.

While hospital inpatient care offers the most intensive level of behavioral health crisis stabilization in the continuum of services for persons with mental illness, substance use disorders, and intellectual/developmental disabilities, it is the most restrictive and expensive care within our array of services; and may not be the most appropriate level of care to address some crisis situations. In order to access this level of care, individuals, especially those who have no health insurance and who often have received no behavioral health services, experience behavioral health crises, and do not receive intervention at a lower level of care; and thus, the crises escalate until the most intensive, restrictive, and expensive intervention is determined necessary.

Hospital Emergency Departments and inpatient services should be reserved for and used to treat persons with acute behavioral health crises that cannot be treated at a lower level of care. The needs of individuals that are appropriate for hospital Emergency Departments include the need for acute medical stabilization (e.g., injuries, emergent medical illness) along with behavioral health crisis stabilization. Persons who need only behavioral health crisis response and stabilization can be appropriately served at lower levels of care, including FBCs, NHMD, BHUCs, Assertive Community Treatment, Community Support Team, and other intensive outpatient services.

As most would agree, it is better to prevent crises than to have to intervene after crises have escalated. To avoid the over-crowding of and unnecessary visits to Emergency Departments and to prevent some of the need for inpatient admissions for persons without health insurance, planning and funding should focus on developing and implementing a strategy that strives to serve people in their communities within a comprehensive continuum of care.

Two reports that were previously submitted to the North Carolina legislature include a broad array of recommendations about the integration of crisis services into a robust continuum of services that offer accessible and multiple levels of care within local communities that are intended to prevent crises and intervene earlier in a crisis episode, which will reduce some of the need for Emergency Department visits and psychiatric inpatient admissions. Links to two of these reports are provided here:

- Report Joint Legislative Oversight Committee on health and Human Services and Fiscal Research Division on Strategies for Improving Mental Health, Developmental Disabilities and Substance Abuse Services
  
  https://www2.ncdhhs.gov/mhddsas/statspublications/Reports/reports-generalassembly/generalreports/Strategies%20for%20Improving%20MHDDSAS.pdf
• Report to Joint Legislative Oversight Committee on health and Human Services and Fiscal Research Division on Strategies to Increase Child and Adolescent Behavioral Health Inpatient Beds


Recommendations in both reports cited above emphasize the need for integrated care, health promotion and wellness, prevention, early intervention, alternative crisis services and diversion programs.

To ensure the sustainability of effective community hospital psychiatric and substance abuse inpatient care, and other crisis response services, BHUCs, FBCs, and NHMDs, it is essential that these services are supported by a fully-functioning foundation of lower level, integrated community services for North Carolinians who have mental illness, substance use disorders, and intellectual and developmental disabilities.

In order to have a state-wide impact on unnecessary visits to hospital EDs and admission to behavioral health inpatient level of care, the number of Tier IV BHUCs, FBCs (for both adults and children/adolescents), and NHMDs should be increased, especially in locations having close proximity to hospitals with EDs and behavioral health inpatient beds.

**Need to Improve Management of Three-Way Contract Psychiatric Inpatient Care**

With respect to the two-tier system of payment for three-way contract inpatient services, it has become evident that the upper tier (enhanced three-way), intended to serve individuals with higher levels of acuity (e.g., violence, medical fragility), has been infrequently utilized. DMHDDSAS will continue to review the need for this enhanced three-way level of care with the LME/MCOs and community hospitals.

**Monitoring Impact of Efforts to Reduce ED Visits**

DHHS is working closely with the North Carolina Hospital Association and other stakeholders to address regaining access to NC DETECT data to track ED utilization trends.

**References**


* Please note that contract totals for Vidant (Pitt), Catawba Valley Medical Center, and Presbyterian Hospitals contain 2 enhanced beds each.