March 10, 2016

To: NC Governor's Task Force on Mental Health and Substance Use

We have gathered the concerns of some of North Carolina's exemplary leaders in mental health who can speak first-hand about the needs in their regions and in the State. You will find each of their powerful letters attached below in this document. We strongly encourage each of you to read the each Chairman's letter for full recommendations. What follows is a summary of some of their major concerns and recommendations:

Emergency Department Overflow

- Patients wait an average of 4.6 days in the Emergency Department (ED) for a hospital bed and the situation is worsening (it was 3 days in 2012). JCAHO considers a wait greater than 4 hours to be *ED boarding*.
- Sicker patients and those with a history of violence have longer ED waits because they are more difficult to place in any clinical setting.
- Many EDs lack clinical staff trained in behavioral health, and almost all are ill equipped to care for extremely violent patients. An extreme example was a patient in Raleigh who physically assaulted and threatened to kill multiple ED staff at Rex Hospital in 2015 shortly after his release from jail for threatening to kill his father. Issues that arose from the hospital's ED attempts to stabilize that situation led to significant fines for the hospital and endangered the staff involved in that prolonged ED stay due to lack of an available psychiatric bed. The care dilemmas that arose from this very high-risk case briefly exposed the entire Rex hospital system to the potential loss of future Medicare and Medicaid funding.

Ideas for improvement:

- Staff EDs with behavioral health specialists, supported by case managers. Allow expansion of telepsychiatry consultations and coverage in psychiatrically underserved areas.
- If possible distribute EDs psychiatric coverage geographically as well as by population centers to allow evaluations and hospitalization closer to home. Involuntary committed patients require law enforcement officers to accompany them to the ED or psychiatric hospital for evaluations. Traveling greater distances to the EDs or the few remaining psychiatric hospitals can be very demanding both time wise and monetarily for law enforcement currently.
- Develop crisis-stabilization units, which can triage appropriate ED patients to outpatient care (e.g. Alameda model article as noted in the NC Psychiatric

Association response letter). This strategy has been found to reduce psychiatric inpatient utilization by over 50% in some places.

Shortages of Hospital Beds

- Public psychiatric beds in NC have been reduced by 60% since 2000 even as our population grew significantly. In our opinion this has negatively impacted the care of the seriously mentally ill in our state. A significant number of private psychiatric beds in some areas have also closed during this period. Moreover, outpatient psychiatric resources have shrunk in most areas across NC even as the population has grown.
- Completed suicide rates have increased significantly in NC during this same time from an age-adjusted rate of 15.6/100,000 people in 2004 to 16.7/100,000 people in 2014. Suicide rates are highest in the counties (e.g. Ashe) where resources are most scarce, and rural counties have been particularly impacted. Suicides alone have passed motor vehicle accidents and even breast cancer as a cause of death. Suicide is also a serious health problem nationally as can be seen in the attached Center for Disease Control and Prevention 2015 Suicide Facts at a Glance. There are only 371 psychiatric beds in NC for children and adolescents yet an estimated 10.6 percent of high school girls alone attempt suicide each year according to the CDC report and that is fairly similar to the NC rate. Many hospital admissions and emergency room visits are related to suicide attempts in NC and elsewhere.
- Separate of suicides, there has been an epidemic increase in the rate of death from unintentional overdose with opioids, heroin, and benzodiazepines. These deaths have more than tripled in North Carolina from 3/100,000 in 1999 to 11/100,000 people in 2009. Many of these same people also have other psychiatric problems including mood, anxiety, and psychotic disorders, among others.
- Although the suicide rate among military veterans is almost triple that in the general population, North Carolina's veterans face a disproportionate shortage of mental health services in many areas of the state. There are only 124 psychiatric beds specifically for the 800,000 military veterans living in our state. The elevated rate of suicide among our returning soldiers may for some be linked to this lack of care resources.
- This clear lack of adequate psychiatric beds in NC often leads directly to ED overflow secondary to the need for longer ER waits for the limited bed openings for these higher risk patients.
- Hospitals in NC are generally not being reimbursed for ED stays longer than 1-2 days, so these prolonged stays occur at great cost to these institutions and threaten their sustainability. There have been many cases of patients staying in the ED weeks to months while awaiting a psychiatric hospital bed in NC. Mission Hospital in Asheville has a patient in their ER eight months awaiting hospital placement as noted in their attached letter. Such care is costing many millions of

dollars for each health system in uncompensated care as can be seen in the letters from the Mission Hospital, New Hanover Hospital, and High Point Regional Psychiatric chair letters that are attached. This problem was also noted to be a significant problem in conversations with other psychiatry chairs we spoke to as well.

Ideas for improvement:

- Doubling the number of psychiatric hospital beds is likely to reduce ED wait time to less than 24 hours according a recent study in *Psychiatric Services* ("Increasing Access to State Psychiatric Hospital Beds: Exploring Supply-Side Solutions" by Elizabeth M. La, Ph.D., M.S.E., Kristen Hassmiller Lich, Ph.D., M.H.S.A., Rebecca Wells, Ph.D., M.H.S.A., Alan R. Ellis, Ph.D., M.S.W., Marvin S. Swartz, M.D., Ruoqing Zhu, Ph.D., Joseph P. Morrissey, Ph.D.)

- If available beds are <u>not</u> doubled then other large but somewhat smaller increases in psychiatric beds in the near future could be a wise and caring first step for NC.

- Distributing beds geographically will allow patients to stay closer to home. This may reduce length of stay because family involvement and other outpatient supports are nearby. Additionally, some smaller community hospitals already may have available unused beds, which could with financial support be converted to psychiatric units for patients requiring hospitalizations.

- Increase the Medicaid inpatient per diem for psychiatric patients to be on par with other medical specialties to take away the potential hospital disincentive for providing such resources.
- Remove the "Institution of Mental Disease" (IMD) designation, which prevents many private psychiatric hospitals from accepting any Medicaid patients.
- North Carolina should revisit their earlier decision of electing <u>not</u> to expand Medicaid. Expanding Medicaid would bring in Federal financial resources, which could help cover the cost of the suggestions in this document. It has been estimated by some that NC has lost greater than $400,000,000 a year by not expanding Medicaid.
- Expand financial support to our educational institutions and hospitals for the training of new mental health professionals/staff to better provide for treatment for the growing numbers of NC citizens. NC needs to supplement the already understaffed mental health work force, which is growing increasingly older on average with many nearing retirement age.
- Dr. Rubinow and others suggested revisiting and potentially restructuring the current MCO model, which could perhaps benefit by a study/audit. The state needs to analyze the money provided to and by MCO's for psychiatric services in the entire state and examine effective end user treatment measures and outcomes related to funding. Currently many of the Chairman feel that the current reimbursement model is not working effectively.

Access to Outpatient Care

- Medicaid's billing requirements have grown in complexity over the past five years, which has led many providers of outpatient mental health services to move away from serving this population. This has limited the available options for patients on Medicaid, and further shifted the burden of care to the public sector.
- Many psychiatrists in NC continued to offer a safety net for these patients by treating them at a reduced rate, as that was less burdensome on their practice than billing Medicaid. In 2014 that practice ended when NC Medicaid stopped covering prescriptions written by psychiatrists who were not enrolled in Medicaid.
- Most therapists who want to serve these populations that are most in need are not able to do so because the credentialing requirements are more restricted under Medicare, and sometimes Medicaid, than they are for private sector insurers.
- Without adequate outpatient resources, Medicaid patients are more likely to turn to the ED for psychiatric care, placing an undue burden on the resources of the state and the hospital system.

Ideas for improvement:

- Consider changing Medicaid's policies for billing and documentation so they are more in line with private sector insurers.
- Revisit the current MCO model to allow for statewide negotiations and contracts for larger systems and others.
- Consider expanding CMS credentialing of master's level therapists (e.g. LPC, LMFT).
- Expand CMS coverage of telepsychiatry in underserved areas and for underserved groups.

Closure

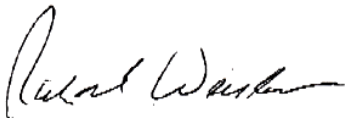
Nearly 1 in 5 of our residents have a diagnosable mental illness, and for 1 in 25 the illness is severe. Those with serious mental illness die 10-25 years earlier than expected, and this death rate is largely due to physical illnesses rather than suicide according to large multi-state and other studies. In economic terms, untreated mental illness reduces work productivity at a cost of at least $105 billion annually in the U.S. For those unable to work, psychiatric disorders occupy six of the top ten causes of disability in working age adults. The economic effects of mental illness are magnified by its impact on education: 46% of those with psychiatric disorders drop out of college. Low educational

attainment has also been linked to early death. These problems extend into future generations as untreated or poorly treated mental illness impairs parenting skills and elevates divorce rates. Untreated mental illness poses a serious threat to public safety, and the penal system has become one of the largest providers of mental health services – at great cost to the NC as well as our local county and city jails. Up to 45% of state prison inmates in the United States have a severe mental illness in the large Bureau of Justice Statistics 2006 study, which is attached to our report.

Working together, we believe North Carolina can leverage the collective resources of our hospitals, MCO's/LME's, Medicare/Tricare/Medicaid and other insurance companies as well as the Department of Health and Human Services to improve access to care. Expanding education and training through our great educational institutions can increase the professionals necessary to provide this mental health care. The considerable knowledge, compassion and skill of our North Carolina psychiatrists, psychologists, psychiatric mental health practitioners, therapists, doctors, physician assistants, addiction counselors, pharmacists, nurses, and vocational rehabilitation specialists can ease the patient, family, and community suffering and allow fuller achievement for our state's residents. Moreover, effective psychiatric treatment combined in many cases with improved adherence to medication therapy can effectively reduce overall costs of medical care. For example, one study that I helped conduct as a site in NC and later co-authored in 1999 with Revicki, et al demonstrated that bipolar patients who took their mood stabilizing medications after their psychiatric hospitalization had improved care outcomes. Additionally, we concluded that "Patients continuing mood stabilizer therapy at 3 months had slightly better health outcomes and substantially lower total medical costs than those who discontinued therapy ($10,091 versus $34,432, respectively). We believe the cost savings would be even greater in 2016 given inflation and could occur for many of the other psychiatric disorders like schizophrenia, depression, anxiety disorders, and substance abuse among others.

In closing, we all agree there must be further expansion of collaborative health care so that mental health and primary care providers, including pediatricians, internists, and family physicians as well as nurse practitioners and physician assistants, directly share patient care and consult with each other to improve health outcomes.

Sincerely,



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