Arthur Kelly, M.D.

President, N.C. Psychiatric Association

NORTH CAROLINA
Psychiatric
Association

North Carolina Psychiatric Association
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THE MISSION OF THE NCPA IS TO:
- Promote the highest quality care for North Carolina residents with mental illness, including substance use disorders
- Advance and represent the profession of psychiatry and medicine in North Carolina
- Serve the professional needs of its membership

February 17, 2016

Mr. Rick Brajer
Secretary's Office
NC Department of Health & Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Secretary Brajer:

As a follow up to the Governor's Task Force meeting on 1/19/16, the North Carolina Psychiatric Association (NCPA) was asked to provide solutions for addressing the ED Boarding problem facing North Carolina. NCPA's ED Boarding Task Force previously provided feedback in an email to John Santopietro, M.D. (enclosed); however, we want to provide additional thoughts on the issue.

Our association, and Burt Johnson, M.D. our ED Boarding Task Force Chair, have followed the proceedings of the Governor's Task Force meetings closely. We applaud the Task Force members for their candor and understanding of the issues facing North Carolina. In particular, we agree with those who say the mental health system is "broken" and is not really a system at all (*News & Observer* and *North Carolina Health News*). Nothing could be more illustrative of this assessment than the circumstances of psychiatric patients who are assessed in hospital emergency departments and found in need of psychiatric hospitalization. Currently, these patients are admitted into EDs on involuntary civil commitments—unable to leave until a private or community psychiatric bed opens up or the IVC is lifted. Adult patients typically stay for many days, while child or adolescent patients can languish for weeks in an ED that is ill-equipped to handle them. Recently, a Washington State Supreme Court decision deemed these ED detentions unconstitutional.

A rational system has competent clinicians skilled at evaluating behavioral health patients available at most or all hospital emergency departments (EDs) supported by case managers who can arrange appropriate follow-up outpatient dispositions for those patients who can be treated without hospital admission.

This system also has a total psychiatric inpatient capacity that meets the average demand so that the typical ED patient needing admission—rather than being held in an extended detention—waits less than a day before transfer to an inpatient unit. Furthermore, the psychiatric inpatient facilities are distributed geographically so that the typical patient routinely be placed in a psychiatric unit reasonably close to his/her home. North Carolina should create such a system.

Ideally, this system would be managed by NC DHHS Division of MH/DD/SAS. This would allow timely adaptation to changing circumstances and reduce the inefficiencies and quality deficits inherent in the current "non-system," described above.

This rational system is not idealistic. It is actually what prevails for virtually every other medical specialty in North Carolina—for both insured and uninsured—even without the presence of a case manager. Patients are evaluated by clinicians who are competent in their field. In contrast, for behavioral health patients in North Carolina, and particularly for those being evaluated in hospitals that lack their own psychiatric inpatient units, ED evaluations are often performed by general ED physicians who are not trained in the evaluation and treatment of behavioral health patients.

Psychiatric bed capacity in North Carolina is now too low. North Carolina state hospital psychiatric bed capacity has been reduced by 60% since 2000 for a variety of reasons, including a desire to reduce costs. Unfortunately this change was not accompanied by a planning process to ensure adequate inpatient capacity relative to the flow of psychiatric patients into EDs or the availability of adequate community services. Consequently, EDs bear the burden of this scarcity of psychiatric inpatient beds. EDs experience an ebb and flow of psychiatric patients but-are rarely free of psychiatric patients waiting for an inpatient bed elsewhere.

This overflow of psychiatric patients lingering for days and weeks (ED Boarding) has turned hospital EDs into de facto psychiatric units. The ED staff persistently call and recall their long list of hospital psychiatric units in an urgent attempt to find a bed—even if it is halfway across the state. We know from the state data that the farther from home the patient is sent, the longer the length of stay will be, presumably due to being cut off from family and outpatient providers.

This is a system begging for management, but this crisis has received little attention from state agencies even though the state has data that demonstrate the severity of the problem. The ED wait time for state hospital admissions steadily climbed from 3.0 days to 4.6 days between 2012 and 2015. A recent (2015) computer simulation research study of state hospital admissions and ED waits in the central region of NC demonstrated the need to almost double the number of state hospital beds in order to get the average ED wait time for state hospital-bound patients to 24 hours. At this point it is worth noting that JCAHO defines ED boarding as anything longer than 4 hours after a decision for inpatient care has been made.

Given the situation described above, the North Carolina Psychiatric Association recommends the following.

1. Increase psychiatric bed capacity in the private and public sectors. To do this, return the psychiatric inpatient Medicaid per diem to being equal to that of other specialties, and possible even higher to stimulate expansion of community general hospital psychiatric bed capacity. Twenty years ago they were the same, but the psychiatric per diem was decreased relative to the rest, and that was chronologically related to the closure of many general hospital psychiatric units—presumably because other specialties' patients became more lucrative. This change could lead to the expansion of community hospital and private psychiatric beds. Second, North Carolina should advocate for federal agencies to remove the "Institution of Mental Disease" or IMD designation for private psychiatric hospitals with more than 16 beds that currently prevents them from accepting adult psychiatric Medicaid patients. This could lead to expansion of private adult psychiatric bed capacity.

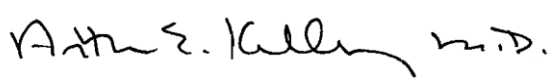
2. Designate a State official with the responsibility to manage the flow of patients between EDs and psychiatric hospitals with the mandate and the resources to reduce average ED wait times to below 24 hours for those admitted to a psychiatric facility.

3. Improve ED evaluation of psychiatric patients in the more than 100 hospitals across the state, preferably through on-site behavioral health clinicians. Telepsychiatry services are a good option when they can collaborate with on-site care managers familiar with local outpatient resources so as to aid in planning outpatient dispositions.

4. Improve coordination of care by transitioning case management back to providers.

We appreciate the opportunity to offer these recommendations for consideration by the Governor's Task Force on Mental Health and Substance Use.

Respectfully submitted,



Arthur E. Kelly
President

Enclosure

cc: Mr. Dale Armstrong
Mr. Dave Richard
John Santopietro, M.D.

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Richard O. Brajer
Secretary

February 24, 2016

Dr. Arthur Kelly
President
North Carolina Psychiatry Association
4917 Waters Edge Drive, Suite 250
Raleigh, NC 27606

Dear Dr. Kelly:

Thank you for your letter dated February 17, 2016. The challenges our community hospitals face on a daily basis across the State and those they serve facing acute behavioral health needs is without question daunting and requires a solution. Last year, I had the opportunity to visit the Emergency Department at the University of North Carolina. It was one of the most rewarding experiences I have had since assuming my role as Secretary of the Department of Health and Human Services.

As you are aware, the purpose of the Governor's Task Force on Mental Health and Substance Use is to reduce stigma and encourage people to seek help before their situation becomes a crisis – and they end up in an Emergency Department or jail. Appropriate treatment and early intervention can result in significant benefits for individuals, better utilization of limited resources in our communities, and ensure the State is an effect steward for our tax payers. The Task Force is currently in the process of prioritizing approximately 2 dozen recommendations. I can assure you that recommendations addressing Emergency Department boarding will be a key driver in the final report. I can also assure you that the recommendations in your letter will be shared with the Task Force Work Groups for inclusion in their discussions.

As a first step in transferring recommendations into action, on February 25, Chief Justice Martin, members from the Work Groups of the Task Force, and I will be presenting an initial draft of the Task Force recommendations to the Joint Study of Justice and Public Safety and Behavioral Health. This will be followed on March 10 with a full Task Force meeting to further discuss and refine the draft recommendations. This is meeting is open to the public. In addition Deputy Secretary Armstrong and Division of Mental Health Director Courtney Cantrell have been, and will continue to be, actively engaged in working with your association, the NCHA Behavioral Health Work Group, and other key stake holders.

Thank you again for sharing your association's thoughtful and systemic approach to address the critical Emergency Department boarding issue our state faces.

Very best regards,

Richard O. Brajer

Cc: Dale Armstrong, Deputy Secretary for Facility Based Behavioral Health and Developmental Disabilities Services, NC DHHS
Dave Richard, Deputy Secretary for Medical Assistance, NC DHHS
John Santopietro, M.D., Chief Clinical Officer of Behavioral Health, Carolinas HealthCare System

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Burt Johnson, M.D.

Chair, E.D. Boarding Task Force, N.C. Psychiatric Association

Solution-Oriented Approach to the ED Boarding Crisis

NCPA's ED Boarding Task Force appreciates the opportunity to offer solutions, but it must be stated that the actionable solutions with near-term potential for impact will all involve spending money from the public treasury.

The essence of the problem is that when it comes to hospitalizing its mentally ill, North Carolina is metaphorically trying to put 10 pounds of potatoes into a five-pound bag. In real life the overflow is not potatoes, but instead is comprised of suffering human beings, the majority being held under legal detention. NC has about 2,000 inpatient psychiatric beds. At any given time we estimate there are another 100-200 patients waiting to get in, and sometimes more than that. WakeMed hospital in Raleigh, alone, has had up to 60 psychiatric patients waiting in its ED on several recent occasions.

A recent research publication, using computer simulations to model the flow of adult (ages 18 to 65) patients from the EDs in North Carolina's central region to the 398 bed state psychiatric hospital for that region, Central Regional, estimated it would take another 356 beds to reduce average ED wait times for psychiatric patients to 24 hours. While that near doubling of current beds may seem dramatically unrealistic, it should be noted that a recent comparison found North Carolina ranked 44th in the nation in state psychiatric beds per 100,000 population, and increasing the available beds at the three state facilities in the same proportion as the research study projected for Central Regional would bring NC's number of state psychiatric beds to a shade over the national average of 14 beds per 100,000.

As noted, that bed gap estimate of 356 adult beds is for only one of the three NC state psychiatric hospitals. It does not include the child and adolescent population, who often spend prolonged detentions in EDs. Furthermore, the average statewide ED wait for a state hospital bed was 3.1 days in the 2011-2012 period of the study. It has increased almost 50% over the past three years to 4.59 days (Source: State Hospital Referral Database). It is likely that increase would have pushed the number of needed additional beds even higher if the computer simulation was rerun.

If one looks at the dynamics of patient flow through EDs to psych units and back out to the community, to attack the ED boarding problem there are basically five options:

1. Reduce the volume of ED admissions
2. Increase ED discharges to community or alternate specialty facilities after short ED stays
3. Decrease psychiatric hospital length of stays
4. Increase the number of hospital beds
5. Reduce recidivism and readmissions

1. Reduce ED Admissions

Reducing the volume of behavioral health ED admits in the public sector has been an ongoing effort in NC with a large proportion of MH/SA money going to fund crisis services, which some argue is to the detriment of funds for treatment. The DMH data presented at the

recent IOM meeting suggests there might have been a slight decrease in ED total admissions in 2014 from a previous four year plateau. Reduction efforts are ongoing and not pertinent to immediate solutions since the influences on ED admission rates are extremely complex.

2. Increase ED Discharges to Community or Alternate Specialty Facilities After Short ED Stays

If behavioral health patients admitted to EDs had access to prompt assessments by skilled behavioral health professionals, it is likely that ED durations could be shortened and higher percentages of patients could be sent home. Several programs already in place in NC have demonstrated that the availability of ED consultations by a Psychiatrist results in fewer patients going into hospitals and taking up bed space there, and shorter turnaround times in the ED, reducing the boarding there.

Regarding implementable solutions, there are two obvious ones:

1. Availability of telepsychiatry for the majority of NC hospitals that are without psychiatric staffing
2. Availability of experienced behavioral health clinicians to do on-site ED consultations 7 days a week

The goal is to have consistent experienced behavioral health staff making early decisions, preferably Psychiatrists, whose experience and training may make them less risk-averse to sending patients to an outpatient disposition when compared with other behavioral health disciplines, and whose psychopharmacology skills can aid in early stabilization of the patient.

Telepsychiatry is a potentially important intervention because of its availability through the state-funded NC-STeP program for hospitals without psychiatric staff. NC-STeP is going through a transition in vendors, and some hospitals will be without its services for a short time, but it reportedly will be back online within two months. One potential limitation it may face going forward, particularly if we want a 24/7 service, is that the contracted vendors are paid 90% of the Medicaid rate while Blue Cross Blue Shield reportedly pays 150% of Medicaid's rate. NC-STeP may need to pay higher rates to retain their vendors and particularly to provide around the clock coverage over time.

One critical component to the success of telepsychiatry clinicians' (who are working remotely far from the patients) ability to discharge these patients back to the community is assistance with identifying local behavioral health outpatient services. This requires an ED-based social worker or case worker who is knowledgeable about mental health resources in the community so as to facilitate the transition and reassure the telepsychiatrist that there is a competent local caregiver with reasonable access.

Widespread availability of on-site behavioral health consultations in EDs across the state that are currently without them would be a substantial step forward, but this would be a

costly, hospital-by-hospital project, and we will not try to recommend a specific solution here.

Another approach to expedite the transition of psychiatric patients out of the ED is to transfer them to another specialty facility staffed by behavioral health clinicians focusing on evaluation, treatment and management of behavioral health crises with a primary goal of returning patients to outpatient services. There are different examples of this in other states. The best known of these is referred to as the Alameda model in Oakland, California, which has demonstrated notable success in reducing use of the hospital. (This project reports being able to discharge around 70% of ED patients to outpatient care within 24 hours, compared to a previous 70% admission rate into inpatient care.) Urban areas are the logical locations for this approach due to population density, reduced transportation distances, and better availability of outpatient referral options.

3. **Decrease psychiatric hospital length of stays**
4. **Increase the number of hospital beds**
5. **Reduce recidivism and readmissions**

Decreasing hospital length of stay, increasing hospital beds, and decreasing readmissions can be considered as a group because of their interactive nature.

The bottleneck at the ED is frequently due to the limited availability of inpatient beds at the state hospitals. The rising average wait times in EDs over the past few years for patients being transferred to state hospitals indicate that the backup in the EDs is getting progressively worse. Along with the research analysis concluding that reducing average wait times to 24 hours for state hospital-bound patients in one region of NC would require almost doubling of the number of that region's state hospital beds, this provides testimony to the need for many more staffed acute state hospital beds.

The hospital acute care units are increasingly populated by long-stay forensic patients along with chronic patients who remain hospitalized because they are viewed as unable to function in the community and almost certain to be rapidly readmitted. This has led to a progressive reduction in available acute beds there are fewer and fewer available acute beds in the state hospitals. One solution offered by the Medical Director of a state hospital, with years of experience, is to reopen long-term care beds for patients who can be stabilized for up to 6 months in a less-intensely staffed long-term care unit, thus opening up acute beds for new admissions.

Increasing state hospital acute and long term beds are only part of the solution since there are many patients, including children and adolescents, boarding in EDs who are waiting for community hospital or private hospital beds. Because of their lack of availability, patients and particularly youth are frequently transferred to hospitals long distances away, far away from family and current clinical caregivers. A necessary solution is to increase the number of community hospital psychiatric units and the number of psychiatric beds in existing community hospital units, including funded 3-Way beds for the uninsured. Some of these community hospitals need to be subsidized to develop specialized units capable

of handling aggressive and violent patients. We particularly need more child and adolescent beds in NC since this group can be among the most difficult to place.

Reduction in hospital lengths of stay would make more acute beds available for admissions. This would be supported by availability of long term beds and diversion of the forensic patients to dispositions other than state hospitals.

Reduction in readmissions would also be supported by long term beds so that the severely ill would be better stabilized before discharge, but the essential solution would have to be a strengthened community outpatient behavioral health system for both the uninsured and those on Medicaid. That would require not only greater funding but a complex set of actions for which no direct solution will be attempted here.

Summary of Solutions

The following is a list from which North Carolina could pick one or more options that would aid in reducing or eliminating ED Boarding.

1. Increase the number of staffed acute beds at all three state hospitals. Beds are on no help if they are not staffed and available. This follows the conclusion of the research paper cited above**.** Substantially increasing available beds is an expensive but unavoidable action step if we are to make significant inroads in solving the psychiatric ED boarding problem.
2. Do whatever it takes to make NC-STeP an effective program including paying higher rates for the service in order to retain vendors and gain full 24/7 coverage, as well as mandating that hospitals utilizing telepsychiatry will have an ED-based case manager who is familiar with mental health resources in the community so as to support the telepsychiatry consultant in planning a safe and rapid return to outpatient treatment.
3. Expand the number of community hospital psychiatric units and the size of existing community psychiatric units to increase the likelihood that psychiatric inpatients, particularly children and adolescents, can be treated close to their homes. There is also a need for high acuity psychiatric units in community hospitals to serve the violent and aggressive patients who typically have long ED stays waiting for a state hospital bed.
4. Increase the number of 3-Way beds for the uninsured in community hospitals. If the uninsured can't get into one of these beds the only alternative is usually a state hospital.
5. At all three state hospitals, re-open long-term beds that once existed prior to the sweeping reduction of state hospital beds that began in the late 1990s.
6. Establish 5-10 Alameda model regional psychiatric emergency facilities in major urban locations, with crisis stabilization reimbursement rates that support the model.

David Rubinow, M.D.

Assad Meymandi Distinguished Professor and Chair
UNC-Chapel Hill School of Medicine

February 20, 2016

David Rubinow, MD
Assad Meymandi Distinguished Professor and Chair
University of North Carolina Chapel Hill School of Medicine

Dear Members of the Governor's Task Force on Mental Health and Substance Use,

I am happy to provide a letter in support of the activities of the task force on mental health. I would be less than candid if I failed to indicate my skepticism – based on the state's actions in the past – that anything will come of the recommendations.

To that point, I have attached one example of a series of recommendations that I provided years ago to two former Secretaries of HHS, to the former Governor, and to several legislators. I have also attached a copy of the Crisis Services Workgroup Report, one of three such documents created for former Secretary Dempsey Benton. Now as then, nothing will change unless the State makes the remediation of the travesty that is our mental health system a priority worthy of investment. My skepticism notwithstanding, I suggest the following:

1) Create more inpatient beds

2) Train more mental health professionals (psychiatrists, child psychiatrists, care managers, and advanced practice providers)

3) Create increased community capacity to prevent and manage mental health problems

4) Create increased capacity to treat substance abuse, a major cause of admissions to emergency rooms

5) Invest in telepsychiatry

6) Improve reimbursement model for community-based services such as supported employment, critical time intervention and supported housing

7) Standardize and assess community services

8) Reconstruct the MCO system to create uniform, system-wide policies (to avoid incredibly inefficient and prolonged negotiations with each entity) and to eliminate MCOs whose sole operational purpose appears to be obstructing the reimbursement of health care systems for services delivered. These MCOs do nothing to improve quality of care. Better yet, eliminate separate MCOs for mental health services to decrease stigma, facilitate integrated care, and streamline reimbursement.

Yours Sincerely,

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February 18, 2016

Members, Governor McCrory's Mental Health and Substance Use Commission

Dear Commission Members,

Thank you for the opportunity to present our ideas and suggestions about ways to improve mental health and substance abuse services in North Carolina. We have had the opportunity to review some of the recent recommendation of the adult work group and are very supportive of their recommendations. We hope to add a few points of emphasis and some additions to their excellent and comprehensive recommendations.

Many of our most troubled citizens with behavioral health conditions have very complex and co-occurring behavioral health and other medical conditions. They also often have a range of social problems associated with poverty and disability. As a result, it is difficult to separate many of their treatment needs from other critical support needs. These treatment and support needs include:

- Safe and affordable housing, including *supported housing programs* for those whose success in independent living requires treatment supports to be integrated into their housing.
- Opportunities for meaningful employment and recreation, including *supported employment,* an evidence-based model of that facilities competitive employment.
- Access to a range of intensities of *case management* from assertive community treatment to intensive case management to supportive/brokering case management.
- Appropriate access to *expanded state and local psychiatric hospitalization.*
- Access to a range of *crisis stabilization services,* including effective use of *psychiatric advance directives* whereby legally authorized family members and peers can serve as *crisis navigators.*
- Access to *integrated behavioral health and physical health care*. Along these lines –careful attention should be paid to Medicaid reform models that will enhance such integration.
- Access to *integrated mental health and substance abuse care.*
- Access to *trauma-informed treatment,* including comprehensive services for *veterans.*
- Access to *a robust range of criminal justice diversion programs* including crisis intervention training, specialized probation and problem-solving courts such as mental health and drug, veterans and family courts.
- Consideration should be given to making more effective use of existing statutes on *involuntary outpatient commitment*.

The Taskforce has commendably examined the need for improved behavioral payment mechanisms. We urge you to give additional attention to *state enforcement* of the *Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA).* Such enforcement would require private insurers to do their fair share to pay for treatment of behavioral health conditions and stop shifting the burden of these conditions to public payers.

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The Taskforce has also examined the problems of the behavioral health workforce. The shortage, maldistribution, non-representativeness and lack of appropriate training of the *behavioral health workforce is a national crisis* created by stigma, insurance discrimination in payment for behavioral health conditions and declining federal and state support. Several state and federal plans have focused on the unique problems of the behavioral health workforce (see SAMHSA's Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 24, 2013. http://store.samhsa.gov/product/Report-to-Congress-on-the-Nation-s-Substance-Abuse-and-Mental-Health-Workforce-Issues/PEP13-RTC-BHWORK) We recommend that DHHS renew efforts to develop and implement a comprehensive workforce development plan.

We recognize that there are many more detailed recommendations that the Taskforce has considered and we are in agreement with these recommendations.

We welcome further opportunities to collaborate with you on your important work.

Sincerely,

Richard Weiner, M.D., Ph.D.
Professor and Interim Chair
Department of Psychiatry
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Rahn K. Bailey MD, DFAPA
Executive Director, Behavioral Medicine
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February 22, 2016

Mr. Rick Brajer
Secretary's Office
NC Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Secretary Brajer,

Upon conclusion of the Governor's Task Force Meeting that took place on January 19, 2016, solutions were being sought to address the issues taking place with North Carolina ED Boarding. As the Chair of Psychiatry for the Wake Forest School of Medicine, I have been able to both conduct research and engage in medical practice within the mental health system. From these experiences, I can concur that the mental health system is indeed "broken" (News & Observer on North Carolina Health News).

The effects of a devalued mental health system impact all aspects of society. Our prisons are more occupied by individuals with severe mental health issues than our state mental hospitals. With the current health system, the society relies heavily on punitive methods in response to criminal behavior, as opposed to rehabilitation, which would require mental health assessments and in turn proper care which address these mental health issues. Mentally ill individuals in prisons cost the state of North Carolina more money than non-mentally ill patients. The cost of psychiatric medication exceeds the cost of feeding incarcerated individuals. Additionally, as a medical professional, the lack of holistic care (prescriptions without consistent medical attention) does not cure individuals of their illness. There are several evidenced-based practices in psychiatry and mental-health that must be utilized for the welfare of society. Additionally, individuals who have been incarcerated with mental illness tend to spend a longer amount of time in jail mostly due to facility violations. These individuals are held in prisons while they await availability for admittance to a psychiatric hospital. A devalued mental health system leaves an overwhelming number of people incarcerated without the proper care. Arguably, the most detrimental outcome of this is suicide. Mentally ill inmates are more likely to commit suicide. Approximately, half of all inmate suicides are committed by those who suffer from a mental illness. All of these reasons show how a broken mental health system leads to early death.

Mental health intersects with legal, medical, and social service aspects of society, leaving those with mental health illnesses arguably the most vulnerable group in society. The devaluing of the mental health system leads to stigma. Individuals with mental health issues are less likely to seek treatment or worse, do not know that they are mentally ill.

History will judge society based on humanity. They will view the attention given to protect and care for those who are ill and, therefore vulnerable. There is much reform needed in the mental health system to protect this group of individuals. All actions begin with a thought. Good mental health is ultimately the foundation for a healthy, productive society with intentions to progress. Without a valued mental health system the welfare of one's society is ultimately weakened.

It is my medical, ethical, and moral opinion that the recommendations for reform based on just a few of the issues that I have outlined be considered by the Governor's Task Force on Mental Health and Substance Use.

Sincerely,

R Bailey MD

Rahn Kennedy Bailey, MD
Chairman of Psychiatry & Behavioral Medicine
Executive Director of Behavioral Medicine
Wake Forest School of Medicine

Sy Saeed, M.D.

Chair, Department of Psychiatry and Behavioral Medicine
Brody School of Medicine at East Carolina University

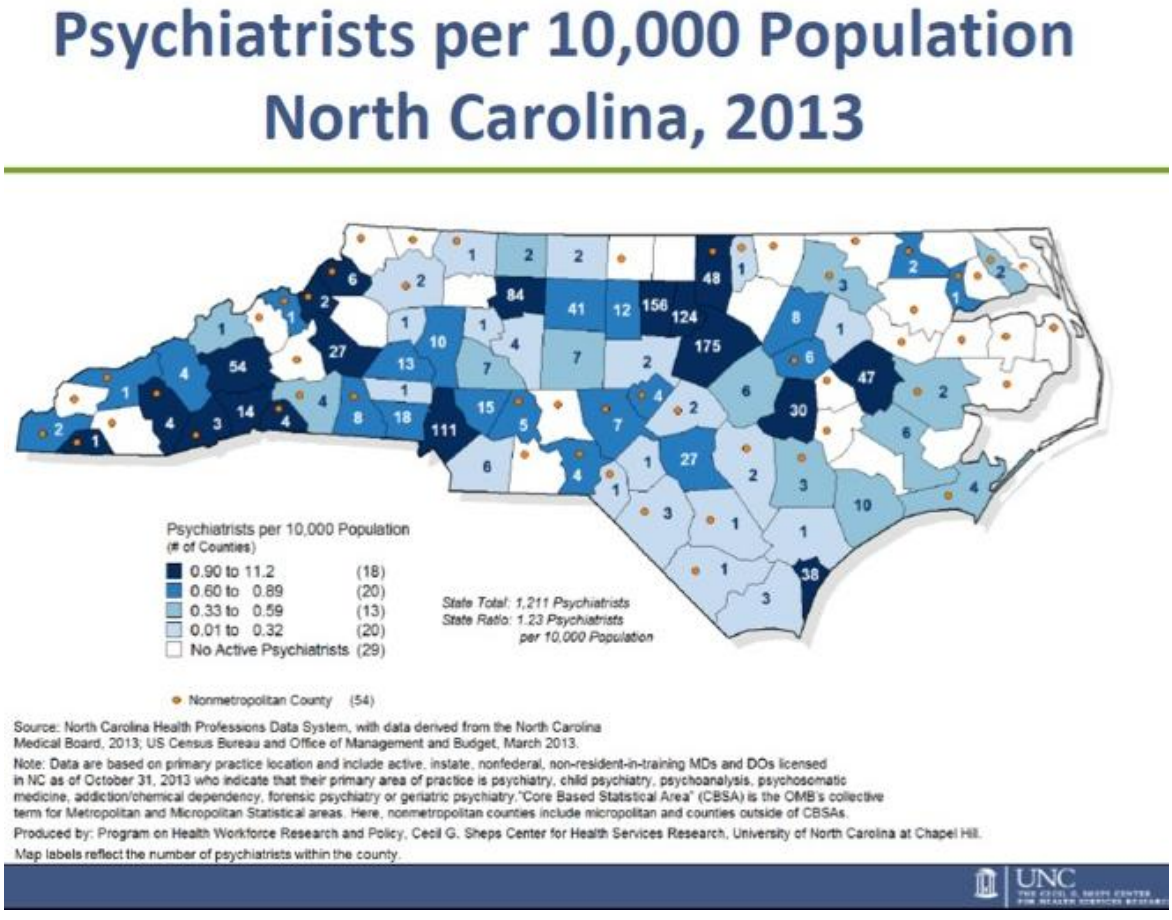
February 15, 2016

Sy Atezaz Saeed, MD
Chair, Department of Psychiatry and Behavioral Medicine
Brody School of Medicine at East Carolina University

[Email Communication]

TO: Members of the Governor's Task Force on Mental Health and Substance Use

Eastern NC has most of the 29 out of the 100 NC counties that have no psychiatrists. It also has a disproportionate share of counties where the number of psychiatrist are well below the 1.4/10,000 of NC average. The majority of our graduating residents have stayed in NC and investing in increasing the residency class size can help solve this problem.



Similarly, we lack the capacity to take care of our population with severe and persistent mental illness. This lack of capacity is in both inpatient and community-based settings.

In recent years we have launched a telepsychiatry program to care for patients who present to hospital EDs in crisis through our State wide Telepsychiatry Program (NC-STeP). This program has literally cut the length of stay in EDs to its half but this length of stay is still high.

NC has no fellowship programs in addiction psychiatry. When residents leave NC to pursue these fellowships in other states, the majority of them do not come back to NC to practice. Creating such a fellowship program in NC will be very helpful. ECU has a proposal for creating such a program but it continues to lack funding.

ECU psychiatry programs continue to be the safety net for the region. With the self-pay (no pay) staying around 33% of our payer mix, and without the Medicaid expansion on the horizon, sustainability of such programs remains a very high risk.

We have a workable model to solve these problem and would be happy to work with the Governor's Task Force in identifying and describing solutions. I'd also be happy to come to one of the Task Forces' meeting to present.

With regards,

Sy Atezaz Saeed, MD
Chair, Department of Psychiatry and Behavioral Medicine
Brody School of Medicine at East Carolina University

Sy Atezaz Saeed, M.D., M.S., FAC*Psych*
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Director
North Carolina Statewide Telepsychiatry Program (NC-STeP)

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The Department of Psychiatry and Behavioral Medicine is dedicated to providing excellence in education, patient care, research, and service in mental health. We strive to foster a collaborative environment committed to improving the health and well being of the people of eastern North Carolina and beyond. We support and advance evidence-based practice, sound scientific principles, and compassion in addressing the needs of our learners, our patients, our colleagues, and our community.

East Carolina University NC-STeP NORTH CAROLINA STATEWIDE TELEPSYCHIATRY PROGRAM VIDANT Medical Center

Jim Hartye, M.D.

Medical Director of Behavioral Health
Mission Health and Hospitals

February 20, 2016

Jim Hartye, M.D.
Medical Director of Behavioral Health, Mission Health and Hospitals

To the Members of the Governor's Task Force on Mental Health and Substance Use:

First, note the scope of the problem with acute psychiatric care at Mission. While numbers do not describe the suffering, they do present a problematic trend.

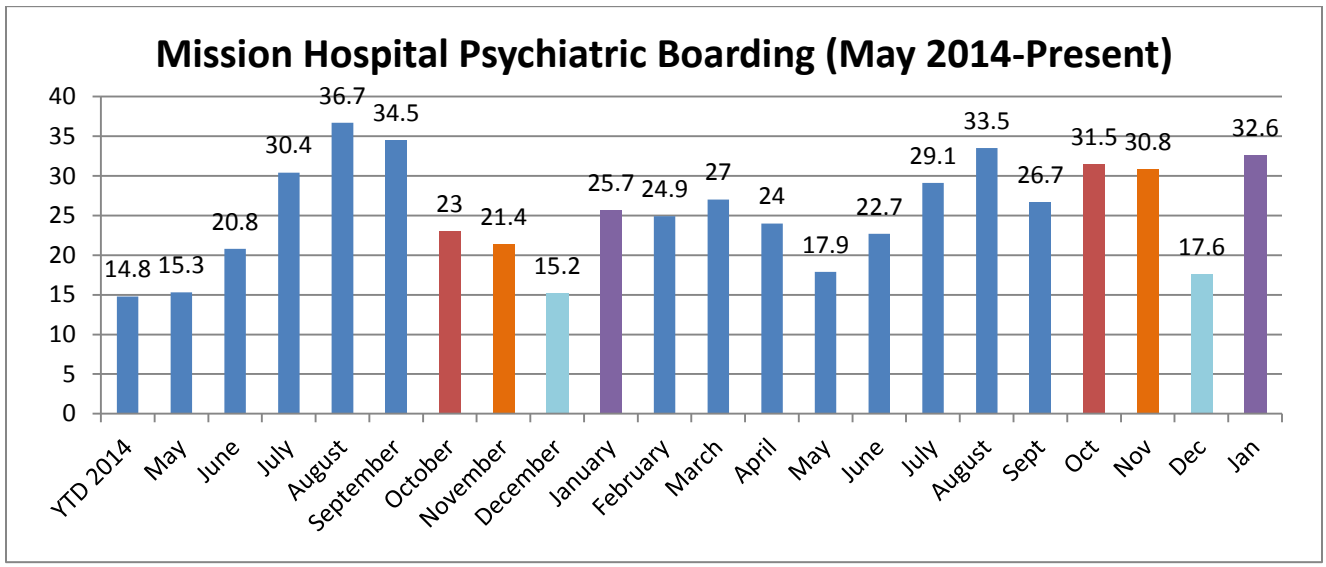

Figure 1: Mission Hospital Monthly Average Boarding per Day

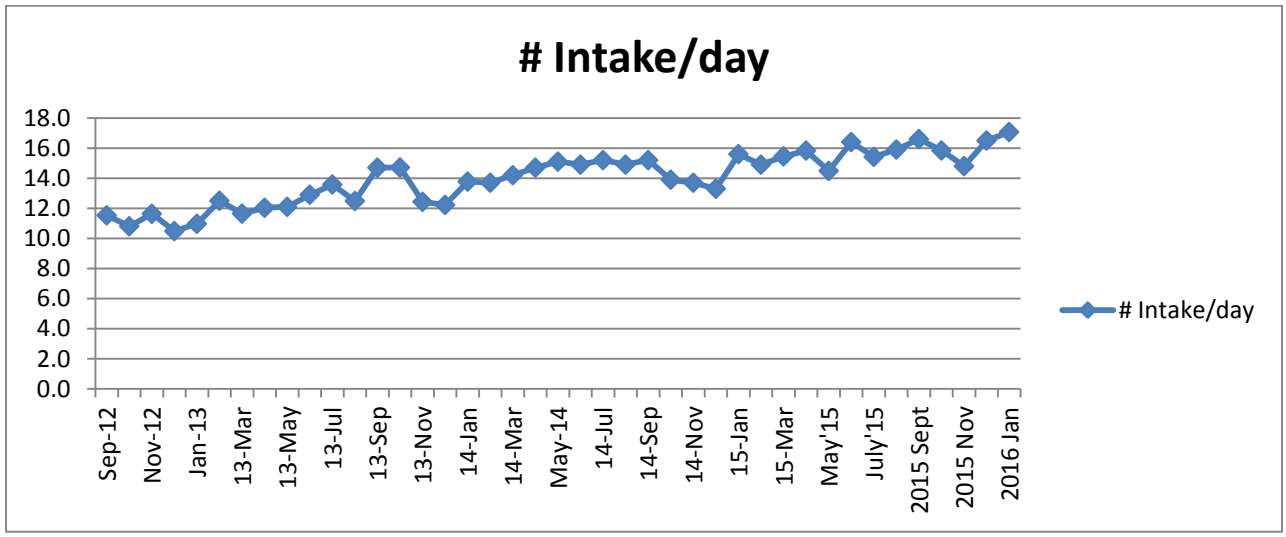

Figure 2: The Number of Mission ED Patients Triaged to Psychiatry per Day by Month

Even in the slow months October through January the boarding has increased by 33% from FY2015 to 2016 (Figure 1). The pattern of increased presentation of BH patients has continued relentlessly for the last four years (Figure 2). What these numbers do not portray is that those who sit for days not being picked by other psychiatric facilities are the sickest of our patients. The state facilities used to take these patients with high acuity and who have assaulted staff. The state facilities are now clogged with forensic patients with little remaining access for civilians. The net effect is that the most violent patients suffering with mental illness are the most likely to be in community hospital emergency departments for extended stays cared for by ED staff whose comfort or expertise in caring for behavioral health patients is variable.

A second issue is lack of resources and appropriate housing for patients suffering with severe mental illness. Patients with a history of violence are difficult to find placement for. Those facilities who do try to care for these patients get blamed and sanctioned when the patient acts out. One gentleman has been in Mission ED holding since last July. Apparently the state facilities that would normally take him as an adult IDD patient are restricted from taking patients on the sex offender registry despite having locked units. The supply of permanent supported housing for those who might live semi-independently is inadequate.

We decided 18 months ago to provide individual and group therapy in our holding units. It was the right thing to do, despite the fact that the system does not pay us for providing any care for boarding patients except the emergency visit on the first day. So the third issue is the warped incentive for the system and payers who have no incentive to fix the problem because the worse the boarding, the less they pay.

A fourth issue involves the CMS regulations that thwart delivery of care to the underserved. They will not pay for services provided by LPC's and LMFT's who are licensed providers and comprise a significant proportion of the work force in underserved areas. CMS also does not pay for tele-psychiatric visits to urban areas such as Asheville. With limited psychiatric manpower resources, like many urban areas, we depend on supplementing our resources with tele-psychiatrists to provide emergency psychiatric assessment, but are not allowed to bill CMS for those services.

Sincerely,

Jim Hartye, M.D.
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Allan Chrisman, M.D.

Chair, Disaster Committee, N.C. Psychiatric Association
Associate Professor Psychiatry-Emeritus, Duke Child and Family Study Center

February 24, 2016

Allan Chrisman, M.D.
Chair, Disaster Committee, N.C. Psychiatric Association
Associate Professor Psychiatry-Emeritus, Duke Child & Family Study Center

To the Members of the Governor's Task Force on Mental Health and Substance Use:

It is a well understood fact that our view of Disaster Planning has changed in recent years due to events like Newtown, the Boston Marathon and the Paris attacks in 2015. Many entities involved in the planning from a Federal level (DHHS, the CDC, Homeland Security, etc.) fund multiple high level grants which now incorporate behavioral health planning and response into the larger framework of "healthcare".

In collaborative systems where Public Health and Behavioral Health are in the same department or agency this model seems to work well (examples include New York, Maryland, Nevada, etc.). In systems where the Public Health agency and the Mental Health agency are separated there seems to be much less cohesion. Many of these systems include hospital networks, EMT's and other emergency medical professionals into the overall planning. In North Carolina we have at least 3 autonomous divisions (DPH, DMH, OEMS) where multiple planning for disaster health response (whether natural or manmade) occurs.

Two of these divisions receive federal grant money annually which have distinct mental and behavioral health deliverables (the HPP grant through OEMS and the PHEP grant through DPH). Neither of these entities have the mental health resources to effectively plan and respond to a large scale event needs, and DMH has only a single staff member dedicated to Disaster planning. Local planning efforts are further stymied by the convoluted county health department system (autonomous from the state) and the MCO system which has only the most minimal disaster planning and capabilities (further limited by the fact that the response would necessarily be provided by private providers contracted to do so). This combination of factors (only minimal state oversight at the local level and the silo effect of individual agencies) could lead to critical system failures should a disaster of the nature of San Bernardino or Aurora occur in our state.

These factors, added to the growing concern of "sob target" attacks (schools, government buildings, shopping centers, entertainment venues) being the primary outlet for manmade disasters (and the large military industrial complex scattered across the state of NC) has led to the conclusion of many in the Disaster Preparedness community that greater collaboration and cohesion needs to occur within the overall healthcare system in North Carolina to address these needs. Critical partners might

include: Mental Health, Public Health, The Office of Emergency Medical Services, Veterans Administration, the RAC system (hospital preparedness), as well as smaller agencies supporting the response (Aging and Adult Services, DSS, DRN, etc.). Having all these agencies work together in a substantive way to meet the challenges of our ever evolving world seems to the only real solution to a problem that is growing, not shrinking.

At this point, it might do well to encourage a task force or executive leaders meeting where the idea of cross pollination and collaboration in a more formalized and less laisse faire way occur.

Looking forward to hearing you about your willingness to join this effort.

Best,

Allan Chrisman, M.D., DLFAACAP
Associate Professor Psychiatry-Emeritus
Duke Child & Family Study Center
Division of Child & Adolescent Psychiatry
Department of Psychiatry & Behavioral Sciences

Andrew Farah, M.D., D.F.A.P.A.

Chief of Psychiatry and Medical Director
High Point Division of UNC Healthcare

March 9, 2016

Andrew Farah, MD, DFAPA
Chief of Psychiatry and Medical Director, High Point Division of UNC Healthcare

Summary of Issues for The Governor's Task Force on Mental Health and Substance Abuse

The main issues we face in daily practice, all of which result in lack of access, poor outcomes, financial strain, and dangerousness towards patients, providers, and our communities include:

1. The shortage of State psychiatric beds, resulting in long E R waits (often weeks), lack of treatment in the E R settings, and resultant danger to patients and staff.
2. The lack of payment from designated LME's, which is essentially theft of our services. Our facility receives at most only 20% of amounts due from LME's each quarter.
3. Lack of long-term/residential State beds and facilities for the intractably violent or psychotic, resulting in homelessness, jail/prison sentences, and "revolving door" admissions in communities.
4. Restrictive formularies for those who have a payer source, limiting our treatment options, and specifically excluding our most advanced options.

If our 28 beds are full, as they often are, there is no back-up system we can rely on for the safety of our patients. I am appreciative that the Task Force is exploring options and hope that many issues may be resolved through your efforts, and I authorize Dr. Weisler to speak on my behalf as he is well aware of the specific concerns in our community.

Sincerely,

Andrew Farah, MD, DFAPA
Chief of Psychiatry and Medical Director
High Point Division of UNC Healthcare

Hans Stelmach, M.D.

Medical Director, Behavioral Health Services
New Hanover Regional Medical Center

March 7th, 2016

This letter is written to spell out the mental health crisis in Southeastern North Carolina. As Medical Director of the Behavioral Health Hospital for the past four years, I am kept informed of the crisis on a daily basis. Additionally, we have a sixty-two bed inpatient mental health unit, yet our Emergency Department typically has three times the allotted beds for mental health patients in the Emergency Department as "boarders." Our Emergency Department is now so overwhelmed with psychiatric patients, that New Hanover Regional Medical Center has created 24-hour psychiatric services in the Emergency Department, and we are constantly adding more staff positions.

I had the opportunity to visit the New Hanover County Detention Center last week, as the jail is also overwhelmed with mental health patients. The Inmate Medical Data indicates that from 2010 to 2015, the number of inmates on psychiatric medications has increased by over 230%.

As of February 2016, our Emergency Department is on pace for 88,800 total boarding hours for psychiatric patients for fiscal year 2016. Experts estimate that a psychiatric boarding hour costs the System $100/hour. That is, just in New Hanover County at our Regional Medical Center, we will spend an estimated $8.8 million this year. The boarding time and hours is more than double all of the other total boarding hours for non-psychiatric patients.

The number of Psychiatric Providers at our hospital has stayed the same from 2010 through 2014. Yet the number of psychiatric consults annually has increased from 1800 in 2011 to 2950 in 2014. In 2011, our psychiatric nurses screened 2286 patients. In 2014, we screened 3410.

Our inpatient mental health unit has been over staffing capacity for the past couple of months. In February 2016, we typically had a waitlist averaging 5 patients per day in the Emergency Department that had orders written and were waiting for a bed. Last week, our number of patients boarding in the ED averaged over 20 per day, while our discharges averaged 7 per day. Our inpatient unit used to average less than one restraint per month. In February 2016, we had over 30 restraints in that month alone. We have virtually no ability for a male between the ages of 18—65 to be referred to Cherry State Hospital without waiting greater than 3 weeks on average, in the Emergency Department. This necessitates us to admit higher acuity patients to our inpatient mental health unit, resulting in more restraints on the unit and longer length of stays.

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This morning, we have had 10 outside hospitals calling us requesting a psychiatric bed, but they already know that we will not have one today for their patient. Due to our overburdened waiting list of patients, it has been months since we have been able to accept patients from outside facilities.

Our MCO has decided to cut enhanced services for anyone receiving supplemental insurance (including Medicare) other than Medicaid in the community. Our successful ACT Teams are seeing their sickest patients forced out of these enhanced services because of these decisions. There is a grave disjointedness in the efficiency of delivering mental health care that has grown proportionally with the consolidation of these LME's.

Respectfully,

Hans Stelmach, M.D.
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