# REPORT TO

# JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

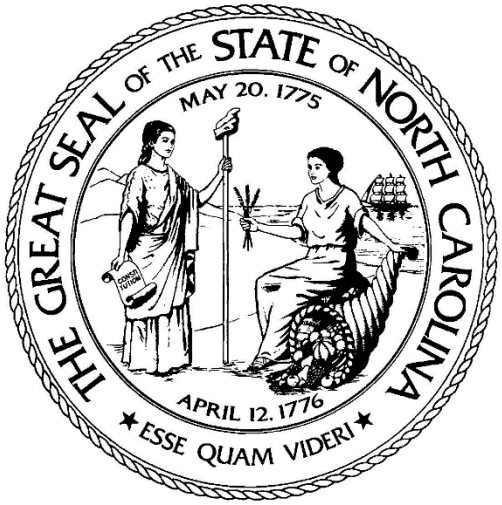
# AND

# FISCAL RESEARCH DIVISION

# ON

# STRATEGIES TO INCREASE CHILD AND ADOLESCENT BEHAVIORAL HEALTH INPATIENT BEDS

Session Law 2014-100, Section 12F.3.(b)(1)




**North Carolina Department of Health and Human Services**
**Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

**March 1, 2015**

## Executive Summary

Session Law 2014-100, *The Current Operations and Capital Improvements Appropriations Act of 2014,* required the Department of Health and Human Services (Department) to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on *Strategies for Improving Mental Health, Developmental Disabilities, and Substance Abuse Services* by March 1, 2015. This report addresses the following requirements:

**SECTION 12F.3.(b)**

*The Department shall submit a report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by March 1, 2015, that includes all of the following components:*
*(1) A comprehensive strategy, developed in collaboration with stakeholders deemed relevant by the Department, to address the dearth of licensed child and adolescent inpatient psychiatric beds in facilities throughout the State. The strategy shall do all of the following:*

- *a) Ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area.*
- *b) Include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed and non-licensed facility in the State.*
- *c) Include recommendations as to any regulatory changes necessary to ensure safety and quality in Facility-Based Crisis Programs for Children and Adolescents.*

In addition, information referenced in the legislative report from the North Carolina Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) report submitted on November 1, 2014 to the 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 as required by Session Law 2014-100, Section 12F.3.(a). is provided. This information is in reference to the following requirement:

*SECTION 12F.3.(a)(3) A plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO catchment area. The plan shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO catchment area. The plan shall include specific strategies for increasing the number of Facility-Based Crisis Programs for Children and Adolescents in high-need areas of the State and the availability of Professional*

*Treatment Services in Facility-Based Crisis Programs for Children and Adolescents as defined in section 4.b.(8)(k) of the current Medicaid State Plan. The plan shall further describe in detail all actions necessary to implement those strategies, including a description of how the Department's funds will be utilized.*

This report addresses each requirement in a separate section. Section one of the report addresses the requirements of SECTION 12F.3.(a)(3) by providing a vision for a continuum of comprehensive services array for children, adolescents, and transition age youth. These services are viewed as necessary to treat the behavioral health and substance use disorder needs of this population. As required, section one also includes recommendations and action steps necessary to ensure that Facility-Based Crisis programs for children and adolescents are available to high-need areas of the state, and that these services include the professional treatment services needed to meet the needs of those who access this service.

Section two of the report addresses SECTION 12F.3(b)(1)(a-c) of the legislation. This section reflects and builds on the recommendations of the November 1, 2014 report. The recommendations for 12F.3(b)(1)(a) are taken directly from the November 1, 2014 report as these recommendations continue to be applicable strategies for addressing the dearth of child and adolescent inpatient psychiatric beds in facilities throughout the state. Every state facility, community hospital, substance abuse treatment facility, and private psychiatric providers licensed by the NC DHHS shall participate in the bed registry, and shall designate an employee to submit information for the bed board system.

As in the November 1, 2014 report, information in this report was compiled from a variety of sources including:

1. Secretary's bi-monthly Local Management Entity-Managed Care Organization (LME/MCO) leadership meeting;
2. Division of Medical Assistance (DMA) and DMH/DD/SAS bi-monthly leadership meeting;
3. Monthly LME-MCO Chief Executive Officer leadership forum that includes the Deputy Secretary and leadership of DMH/DD/SAS, DMA, and the Division of State Operated Healthcare Facilities (DSOHF);
4. Quarterly Intra-Departmental Monitoring Team (IMT) meetings with LME/MCO, DMH/DD/SAS, and DMA staff;
5. Weekly leadership meetings between DMH/DD/SAS and DSOHF and the Deputy Secretary; and
6. Transitions to Community Living Initiative Leadership Team that includes staff of the DMH/DD/SAS, DMA, Division of Aging and Adult Services (DAAS), Division of Social Services (DSS), and DSOHF, with the Deputy Secretary and Special Advisor on the Americans with Disabilities Act.

Stakeholder engagement occurred via the:

1. Crisis Solutions Initiative;
2. Formal Stakeholder Input groups such as DHHS Waiver Advisory Committee (DWAC), External Advisory Team (EAT), the Coalition, the Consortium, the Mental Health Coalition, and the Substance Abuse Federation; and
3. Informal or time limited opportunities such as DD listening sessions, Home and Community Based Services (HCBS) Stakeholder group, and Innovations Waiver Stakeholder group.

In conclusion, the recommendations set forth in this report are based on a number of premises. First, the behavioral health, intellectual and developmental disabilities, and substance use disorder treatment system must continue to develop new and innovative services designed to meet the needs of those we serve. These services should be flexible to provide the needed intensity, and provided in the most inclusive, community-based environment possible. For children and adolescents, services should be delivered in the context of a system of care philosophy that respects family and youth voice and cultural competencies. Effective services should also be available to meet the changing needs of children, adolescents, and transition age youth throughout their developmental stages.

The second premise is that an effective continuum includes services from prevention through inpatient care. Services should be trauma and evidence informed. Timely access to this continuum is necessary to meet the varied needs of our State's children, adolescents, and transition age youth. Services should be available and accessible as close to the child and adolescent's home and family as possible to facilitate their involvement in all aspects of services and discharge planning.

The third premise is that services must be managed effectively utilizing the tools and resources available. Changes must be thoughtfully implemented and monitored for desired outcomes. Recommendations for new services or increased capacity should be the result of an in depth and on-going analysis of the current patterns of service usage. Collaborating with the LME/MCOs and other stakeholders will provide the opportunity to examine more closely the gaps, needs, and service utilization patterns. Ongoing analysis will provide valuable information on how to achieve the necessary balance between inpatient and community services referenced this report.

Lastly, the fourth premise is that new services and mandates often require regulatory changes requiring stakeholder support if they are to be implemented and successfully utilized. Recommendations for regulatory changes are provided in section two for both the proposed psychiatric bed registry and for facility based crisis services for children and adolescents.

In conclusion, DHHS would like to thank the Joint Legislative Oversight Committee on Health and Human Services for the opportunity to set forth a collaborative and united vision for community-based and inpatient mental health and substance use disorder services for the state of North Carolina.

**Legislative Directive**

The North Carolina Governor and the General Assembly directed the Department of Health and Human Services (DHHS) to report to the Joint Legislative Oversight Committee on Health and Human Services (LOC) and the Fiscal Research Division on how to improve the state's mental health, developmental disabilities, and substance abuse (MH/DD/SA) services. The legislation, Session Law (SL) 2014-100, Section 12F.3.(b) (1)(a)(b)(c), requires that:

**The Department shall submit a report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by March 1, 2015, that includes all of the following components:**

A comprehensive strategy, developed in collaboration with stakeholders deemed relevant by the Department, to address the dearth of licensed child and adolescent inpatient psychiatric beds in facilities throughout the State. The strategy shall do all of the following:

a. Ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area.
b. Include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed and non-licensed facility in the State.
c. Include recommendations as to any regulatory changes necessary to ensure safety and quality in Facility-Based Crisis Programs for Children and Adolescents.

The recommendations in this report build on the recommendations provided in the November 1, 2014 report to the 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.

Section one of this report contains the additional information on child and adolescent services referenced in Section 12F.3.(a)(3) of the November report. Section two of the report contains the response to SL 2014-100, Section 12F.3 (b) (1).

Please note that recommendations in this report are not necessarily for immediate funding or implementation. We are setting out a vision for the future of our services by establishing goals for our system. Any changes must be made incrementally and resulting outcomes must be closely monitored to ensure effectiveness. Thus far, we have prioritized crisis services as an initiative that will move us closer to our vision of a well balanced, effective and efficient mental health system.

**Section One:**

**SECTION 12F.3.(a)(3) A plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO catchment area. The plan shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO catchment area. The plan shall include specific strategies for increasing the number of Facility- Based Crisis Programs for Children and Adolescents in high-need areas of the State and the availability of Professional Treatment Services in Facility-Based Crisis Programs for Children and Adolescents as defined in Section 4.b.(8)(k) of the current Medicaid State Plan. The plan shall further describe in detail all actions necessary to implement those strategies, including a description of how the Department's funds will be utilized.**

**Recommended plan:**

1. Continue to work with LME/MCOs and other stakeholders to develop a comprehensive continuum of services for children, adolescents and transition-aged youth that includes the following components:

   Prevention/Health Promotion/Wellness: Develop an array of trauma-informed wellness planning, screening, crisis/suicide prevention, and early intervention approaches in the places where children and families are found, this includes day care centers, preschools, k-12 schools, primary care, and parks/recreation centers. Staff in these settings can be trained and supported in identifying families in need and connecting those families to behavioral health supports and services.

   Integrated Care/Prevention: Promote screening and access to behavioral health services within primary care practices. Most child behavioral health care needs could be identified and addressed early and effectively in primary care. Youth with more complex needs could be referred to specialty mental health with improved coordination between primary care and community providers.

   Outpatient Services: Increase access to evidence- and trauma-informed practices in clinics and schools.

   Home and Community Based Services: Increase timely access to home and community services to allow children with complex needs to stay safely and successfully in their homes and communities. These services need to be evidence and trauma-informed services and build on the strengths and needs of their families.

   Supported Transitions: Increase access to care coordination for children with complex needs who need transition assistance between services and levels of need. Children with the most complex needs and high use of crisis and residential services should have access to intensive care coordination with low family to staff ratios. Test models such as

Critical Time Intervention for emerging adults as they make the transition between child and adult service systems.

Supportive Housing: Emerging adults (ages 18-21) with significant behavioral health challenges need flexible housing supports to maximize housing stability and community integration.

Acute/Crisis Services: Improve crisis supports so children, adolescents, and emerging adults are identified and connected to crisis services quickly and easily. A range of crisis services including crisis respite programs, mobile crisis, facility-based crisis programs, and inpatient services are needed. In addition, these services must be staffed by well-trained workforce who understands child development, practices trauma-informed care, and who can de-escalate crises and assist children and families in regaining their functioning. Crisis services initiatives should:

a) Create diversion programs for young people with I/DD, Traumatic Brain Injury (TBI) and other complex special needs requiring longer treatment. This should include altering community-based crisis services available for young people with IDD to meet their individual needs.
b) Enable, through policy and regulatory changes, efficient transfer of individuals experiencing crisis from emergency departments (EDs) to Behavioral Health Urgent Care/Facility-Based Crisis Centers with appropriate medical clearance.
c) Provide training to Emergency Medical Service paramedics to assist with crisis situations.

Recovery Supports: Family and youth peer support provide information, support, and mentorship to families from prevention through crisis services.

Residential Treatment: When children need residential care, this care should be available as close to their home communities as possible so their families are fully involved in their recovery. Residential care should last only as long as needed to restore the young person to a level of functioning to where they can make use of community treatments. Residential care should offer evidence- and trauma-informed care.

2. Develop performance incentives to keep individuals at the lowest level of care needed and ensure person-centered outcomes, including community-based stability and recovery.
3. Address the lack of balance in the current system by providing more emphasis on prevention, early intervention, care coordination, and family and youth peer support services through outcome expectations.
4. Ensure the existing treatment system is based in local Systems of Care, which are coordinated networks of services that partner with parents to help youth with behavioral needs to function better at home, school, and in communities. Access to these coordinated services must be available in all local communities and monitored by LME/MCOs.
5. Allow, through amendment of rules, State Plan, and policies, added flexibility for LME/MCOs and providers to implement evidence-based practices and monitor outcomes.

6. As new services or funds are added to the system in the future, ensure a balance of any new funding between prevention and primary care as well as enhance outpatient treatment levels. This includes transition support to a graduated array of services in the community to prevent more expensive inpatient care when possible. Savings from efforts to reduce unnecessary ED visits, inpatient hospitalizations and readmissions should be reinvested into preventive community services.
7. Encourage LME/MCOs to continue the implementation of alternative payment systems and encourage attention to the "whole person" through collaboration with medical providers.
8. Increase access and availability of services for those with substance use disorders.
9. Work with the LME/MCOs to support additional facility based crisis programs for children and adolescents. Requests for startup or other funds should be evaluated based upon the severity of need for crisis services for children and adolescents in a particular area.

**Plan for Facility-Based Crisis:**

1. Continue working with the Division of Medical Assistance and other stakeholders on the revision of the Facility-Based Crisis for Children and Adolescents clinical policy/service definition. The revised clinical policy includes professional staffing requirements and provides a rate for 24/7 services. The proposed revisions are currently under review and promulgation is expected in early 2015.
2. DMH/DD/SAS issued an invitation to apply for funds based upon the legislation **(**Session Law 2014-100, 12F.5. (b)**)** and the allocation of 2.2 million dollars (of state appropriation) supplemented by federal block grant funds. The invitation was issued in November of 2014.
3. Eleven applications were submitted by LME/MCOs and their partners. Applicants will be chosen based on adherence to the legislative language, the presentation of a viable plan, and merits of the proposal.
4. Session Law 2014-100, 12F.5. (b) allowed funding to develop behavioral health urgent care, and adult or child/adolescent Facility-Based Crisis programs. All proposals from the LME/MCOs were required to show the level of need for crisis services for the population served in their respective catchment areas. DMH/DD/SAS will continue to assess for unmet needs and work towards the development of additional facility based programs, including those for children and adolescents as necessary.

**<u>Section Two:</u>**

**12F.3(b)(1)**

**A comprehensive strategy, developed in collaboration with stakeholders deemed relevant by the Department, to address the dearth of licensed child and adolescent inpatient psychiatric beds in facilities throughout the State. The strategy shall do all of the following:**

- **a. Ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area.**
- **b. Include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed and non-licensed facility in the State.**

**c. Include recommendations as to any regulatory changes necessary to ensure safety and quality in Facility-Based Crisis Programs for Children and Adolescents.**

**12F.3(b)(1)(a)**

**Ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area.**

Many of the findings and recommendations in this section remain the same as those included in the November 1, 2014, report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on *Strategies for Improving Mental Health, Developmental Disabilities, and Substance Abuse Services.* These recommendations continue to be applicable strategies for addressing the dearth of inpatient psychiatric beds in facilities throughout the state.

Upon review of these recommendations, it is important to note that inpatient beds are one part of the continuum of behavioral health services, specifically, the crisis services continuum. Ultimately, the need for inpatient beds is dependent upon access to a full continuum of services and supports, including natural community supports, prevention and primary care outpatient services; enhanced services; and long-term, residential supports such as those outlined in section one of this report. Adding new services such as behavioral health urgent care and facility based crisis will continue to reduce the strain on the inpatient bed capacity while providing treatment to children and adolescents in crisis closer to their homes and their families.

As stated in the November report, achieving the desired balance between the community and inpatient services continuum requires a thorough assessment of the adequacy of the behavioral health system, especially inpatient services. The state will consider the full array of services and supports, from natural community supports through prevention and primary care outpatient services; enhanced services; long-term, residential supports; and inpatient psychiatric services. Funding higher level services at the expense of lower levels of services, results in higher levels of services becoming the default level of care, and subsequently, changes to one component of the continuum affects other areas. With this in mind, factors that impact inpatient bed recommendations are provided in this report.

**Factors Affecting Inpatient Bed Recommendations:**

Recommendations for inpatient beds cannot be made in the absence of considering the whole system. Further, recommendations cannot be implemented without careful evaluation. The following were considered in developing recommendations:

- Inpatient beds are the most intensive, restrictive, and expensive part of the service array. These should be reserved for consumers whose situations cannot be addressed in a less restrictive environment.
- Need must be determined locally through LME/MCO gap analyses, community needs assessments, and periodic re-assessments. Analyses must include the factors that are

keeping the state facilities full and factors that influence the demand for inpatient beds. These factors may differ in different regions of the state.
- Need for inpatient beds is impacted by resources in the rest of the service continuum.

The problems that exacerbate long lengths of stay in local emergency departments; wait times for admission to inpatient care; and difficulty finding appropriate placements for individuals needing to be discharged include the following:

- Uneven geographic distribution of community inpatient psychiatric beds.
- Lack of beds for persons with specialized needs, specifically:
    - Children ages 6-12 years old and adolescents 13 years and older, especially those who present with substance abuse disorders, co-occurring disorders, and sexually aggressive behaviors.
- Private insurance does not support the full array of needed services.
- Need for diversion sites for children and adolescents with IDD who have aggressive behavior or other serious, behavioral issues.
- Need for coordination with law enforcement and crisis providers to reduce transports to emergency departments, which is not the most effective level of care and may result in overuse of inpatient services.
- Make community hospitals reluctant to admit persons they will have difficulty discharging.
- Need for community-based step-down services.
- Need for consistent coordinated transitions between community hospitals, state facilities, and community-based treatment settings.
- Need for synchronization of treatment models throughout the continuum of care.
- Historical focus on treatment rather than prevention and early intervention for chronic conditions.

**Considerations for Recommending Adequate Quantity of Publicly Funded[1] Inpatient Beds**

- **There is no single right answer in terms of the right service to add or the right ratio of inpatient beds.** Instead, the state must agree and commit to how the system will be funded-what proportions of services and what funding priorities will attain the sought-after outcomes. This process is continuous, requiring interventions and shifts in the system, followed by evaluations of the effect of those changes across the system.
- **Inpatient psychiatric beds are not all created equal.** One must look at the system in detail to determine what is causing long ED wait times, overutilization, and waitlists for psychiatric beds. The identified barriers, such as highly complex specialty care needs, should lead to a more targeted solution.
- All recommendations in this section could improve the system but we must choose only a few at a time to test.

[1] There are psychiatric beds in community hospitals that are also paid for by Medicare and private insurance. It may be noted that people who have private insurance may be treated in a State psychiatric facility and their insurance is billed. If the insurance will not pay, the person is funded via the State Hospital allocation.

**Recommendations:**

1. Generally, our recommendation is not that new hospitals must be built, but that we should continue to capitalize on the specialization of our safety net state psychiatric facilities' ability to serve highly complex populations while maximizing federal contribution for inpatient psychiatric utilization by individuals with Medicaid. For uninsured and underinsured children the state facilities offer one of the few options, so for these individuals, broader reforms may be required, including increasing funding for downstream (enhanced, outpatient) services that prevent hospitalization and investigating the potential for obtaining federal match for these individuals.
2. Support flexibility in staffing for state hospital beds and focus on community hospital bed use to leverage maximum federal funding.
3. Add community inpatient beds in rural areas to keep people closer to potential community supports.
4. Analyze data requiring 45 child- and adolescent-specific community beds, taking into account available services and geographical distribution.
5. Implement hospital bed registry for children, adolescents and adults.
6. Continue to follow Session Law 1995-739 (Senate Bill 859 in 1995-1996 Session) legislation, by developing multiple inpatient diversion sites across North Carolina for children and adolescents who have Intellectual/Developmental Disabilities and Mental Illness. This will allow treatment in the appropriate setting and may improve discharge back to the community, as providers will have the assurance that there are reasonable options available in times of crisis. Timely assessment and treatment will also help people with Intellectual/Developmental Disabilities and Mental Illness remain in community.
7. Dedicate funding to community hospitals and 24-hour crisis centers specifically for people who have IDD and mental illness, this could accomplish diversion.
8. Investigate the development of geographically dispersed residential placements to serve as step-up/step-down treatment before and after inpatient admission.
9. Increase capacity to serve children and adolescents with Traumatic Brain Injury (TBI) and IDD, and other special populations, in the state facility safety net system.
10. Continue to work with the LME/MCOs to analyze utilization trends to determine where community beds will be most effective.
11. Collaborate with the LME/MCOs to analyze utilization trends for the purpose of targeting unmet need, acknowledging that the number of inpatient beds needed directly relates to the make-up and capacity of the community-based system.
12. Require the management of inpatient bed utilization by LME/MCOs while ensuring that protections are in place to preserve an adequate safety net for consumers.
13. Utilize the Federal System of Care Implementation grant to develop a pilot for High Fidelity Wraparound that includes intensive care coordination and family peer support for youth with high use of residential and/or crisis services.
14. Review the effects of Critical Time Interventions (CTI) for emerging adults and other LME/MCO care coordination models in order to determine best practices for ensuring continuity of care for individuals transitioning to and from inpatient services.

**SECTION 12F.3.(1)(b)(1)(b)**

**Include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed and non-licensed facility in the State.**

**Purpose:**

To establish and implement a comprehensive and accessible web-based bed registry to collect, aggregate, and display information about available beds in public and private psychiatric and substance use inpatient treatment and residential treatment facilities throughout North Carolina. The registry would include community psychiatric hospitals, psychiatric beds in community hospitals, state psychiatric hospitals, Alcohol and Drug Abuse Treatment Centers (ADATC), neuro-medical treatment centers, psychiatric residential treatment facilities for children, facility based crisis beds, non- hospital based detoxification centers, and other residential treatment facilities in the state. This proposed bed registry would benefit the entire system by serving children, adolescents and adults.

**Background:**

Session Law 2014-100, Section 12F.3.(b)(1) required that the NC Department of Health and Human Services develop a comprehensive strategy that includes "the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed and non-licensed facility in the State." This report and its recommendations align with the November 1, 2014, report by the North Carolina DHHS, DMH/DD/SAS to the 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. A number of system improvement recommendations were provided in the November report, including the development and implementation of a hospital bed registry for children, adolescents and adults. This proposed bed registry would enable the emergency departments, as well as public or private facilities where patients in crisis are likely to present, to have access to a database which will assist staff with quickly finding inpatient treatment beds available statewide, in real time. If implemented, this bed registry would provide a number of benefits across different systems. Hospitals would likely see a reduction in the staff time needed to locate available inpatient mental health and substance abuse beds. These savings would be achieved because staff would no longer need to make multiple calls to multiple facilities as they do under the current system. A bed registry would facilitate faster discharges from the emergency room or hospital which would free up valuable emergency room and general hospital beds. For patients, the registry would shorten the time to treatment in the appropriate setting, potentially resulting in shorter inpatient stays and better outcomes. Lastly, being able to move patients quickly to available inpatient beds from the emergency room or hospital is likely to reduce the burden on law enforcement agencies in assisting emergency rooms with this population. Each of these outcomes may lead to increased efficiencies and cost savings across the various systems that serve patients in crisis.

## A Scan of Bed Registry Use Across the States

In 2014 a survey of bed registry use in the United States was conducted. This survey found that at least 24 states lack any computerized database accounting for available psychiatric beds, 22 states and the District of Columbia, have some type of computerized tracking database in place, and Alabama, Connecticut, Texas, and at least six other states track available beds only in their state hospitals or state-run funded beds. States such Massachusetts, track private acute care beds and Nevada's Hospital Available Beds for Emergencies and Disasters relies on mandatory reporting daily by every public and private facility in the state. Even states that have comprehensive databases often must rely on voluntary participation. (Israel, 2014)
Below are a few examples of operational statewide psychiatric bed registries with their reported benefits, this includes North Carolina's 2011 bed registry project.

### North Carolina:

The North Carolina Hospital Association (NCHA) currently operates North Carolina's only bed registry. This bed registry was the result of work done in 2010, by the Bed Board Exploratory Committee, DHHS, Division of State Operated Healthcare Facilities (DSOHF), and the NCHA which set forth "to identify the path to the implementation of a viable, easily accessible and updateable Eastern North Carolina Acute/Crisis Bed Board for the purpose of reducing wait times for patient placement into psychiatric or substance abuse inpatient care facilities" (NC Bed Board Exploratory Committee, 2010).

The original intent of the bed board was to include private psychiatric hospitals, community hospitals with psychiatric units, state facilities, private detoxification centers, facility based crisis beds, and non-state beds in the bed count. Initial plans also included providing access to the bed board to general community emergency departments, Critical Access Behavioral Health Agencies, local management entities (LME), walk in clinics, and mobile crisis teams (NC Bed Board Exploratory Committee, 2010) . The committee's work led to a bed board prototype developed by Theresa Edmondson, Director of the Walter B. Jones Alcohol and Drug Abuse Treatment Center (ADATC) and David Jackson from the ADATC's Information Technology Section. The NCHA turned this prototype into a web-based application that they currently maintain and manage. The committees' work also led to the development of a bed board pilot that began in 2011, and included Walter B. Jones ADATC in Greenville, participating hospitals and LME/MCOs in Eastern North Carolina. (NC DHHS press release, 2011).

The piloted bed board was a real-time web application representing openings at 16 facilities with more than 650 behavioral health and substance abuse beds in 38 counties in the Eastern Region. The state's Western Region providers joined the bed board registry in 2012, but the Central Region is not active yet. As of March 2014, 59 participating sites from the Eastern and Western Regions use the bed board to find the nearest appropriate facility match for their patients' needs. In one week, the bed board receives approximately 500 searches by hospitals and, to a lesser degree, other providers. The eventual goal of the pilot was to expand the bed registry statewide to more efficiently serve patients and providers.

The pilot program provided information on both the successes of the bed board and recommendations for improvement. The successes include program continuity, expansion to the Western Region, and a user-friendly searchable database. Also, the board was designed to be easily adaptable to include other populations and needs. Weaknesses of the bed board are the voluntary program participation, exclusion of LME/MCOs and crisis services providers, lack of data analysis, and no documented outcomes or reports on how the program impacts emergency department waiting times or any other data showing positive effects of the bed board.

While there is a tracking mechanism built in the web-based application to record users' actions, the data collected and tracked is not being analyzed and reported back to the state, providers, and other interested stakeholders. This information would be important for the evaluation of the bed registry to determine if it accomplished its goals. Additional information from the end users at the current participating sites could be collected via a survey to determine if the current bed board registry is working satisfactorily, as this would guide further recommendations for improvements to the registry.

**Minnesota:**

Minnesota's inpatient bed tracking system has been operational since July 2007. The tracking system was developed in partnership with the Minnesota Department of Human Services and Minnesota Hospital Association, This partnership, established at the outset of the program, was noted as being key to the success of the project. The statewide database is one component of a set of solutions aimed at improving access to psychiatric acute care by providing hospital ED personnel with real-time data on the number and type of beds available at other Minnesota hospitals so that appropriate referrals may be made. The bed tracker assists in locating inpatient acute care mental health beds and community-based services within the state of Minnesota.

In an initial evaluation of the statewide database completed by Sharon Autio, Adult Mental Health Division Director, Minnesota Department of Human Services, and the Minnesota Hospital Association, it was reported that participating hospitals reported positive outcomes, including a reduction in staff time spent locating available beds and a reduction in time patients are in the emergency room awaiting transfer and care, and clients are being referred to hospitals closer to their home community.

**Vermont:**

The Vermont Department of Mental Health Electronic Bed Board System was established in August 2012, as a means to track availability of inpatient and crisis bed capacity for placement of patients in need of treatment. This statewide system assists providers in quickly locating adult inpatient, crisis, intensive residential and residential beds, as well as children's inpatient and crisis beds. The noted strengths of this website is that it is fast and easy for providers to locate available services such as inpatient mental health hospital beds, saving hours of calling facilities to locate openings. The website also provides essential information including contact names and numbers and directions to the facility which assists in discharge planning.

**Virginia:**

The Virginia statewide inpatient bed registry has been operational since March 2014. The registry was recommended and planned for over ten years. The need for this registry became apparent in November 2013 when 24-year-old Austin "Gus" Deeds stabbed his father, Virginia State Senator Creigh Deeds, before fatally shooting himself. Gus Deeds had been detained under an emergency custody order the night before the shooting, but was released when an available psychiatric bed could not be located for him within the short four-hour window of the order (Israel, 2014). Several area hospitals later said they had beds and were never contacted (Newsleader.com, 2014). The purpose and benefit of this registry is that it assists emergency room staff in quickly locating available inpatient psychiatric beds therefore reducing the risk that those held under emergency custody orders will be released before receiving the appropriate treatment.

A review of each of these statewide systems indicates that the strength of a web-based, real-time site is the speed, accuracy, and ease which providers can identify and locate potential openings for services such as inpatient mental health hospital beds, thus saving hours of calling facilities to locate openings. Quickly locating appropriate beds and having updated facility contact information not only cuts down on staff time but also serves several other purposes: it frees up valuable emergency room and hospital bed capacity; may reduce the burden on law enforcement; and most importantly facilitates faster access to the appropriate care setting.

It should be noted that these websites are not designed to manage admissions or transfers of patients. After locating an available bed on the website, providers still need to contact the facility to discuss potential patient transfers and to make arrangements for services. It is imperative the provider check the website for a bed first, contact the facility to be sure the patient is appropriate for admission, and arrange for patient transfers and admissions. All of the facilities' admission and transfer policies would apply and each facility independently manages facility openings and admissions.

**Proposed Statewide Bed Registry**

The proposed statewide system would be designed as an expansion of the current bed registry operated by the North Carolina Hospital Association. The expanded bed registry would be funded through a contract with the NCHA. It would be more comprehensive than the current one, with mandated participation by all hospitals with EDs, all hospitals with licensed psychiatric inpatient beds, and all facilities with beds licensed under NC General Statute 122C. The proposed statewide bed registry would also be available for non-licensed mental health, addiction, and intellectual/developmental disabilities beds.

The intent of the proposed statewide bed registry is to assist health care providers to more rapidly locate available beds for persons with mental health, substance use, intellectual/developmental disabilities, resulting in a reduction of psychiatric boarding (i.e., wait times) in EDs. The bed registry is also expected to result in shorter lengths of stay for persons in inpatient and other crisis beds who may need a residential bed in an appropriate level of care following discharge

from the inpatient or crisis facilities by providing for more rapid identification of appropriate discharge beds.

Potential changes to the bed board system would:

a. Include descriptive information for all public and private inpatient psychiatric facilities, community psychiatric hospital, psychiatric beds in community hospitals, state psychiatric hospitals, ADATCs, neuro-medical treatment centers, psychiatric residential programs for children, facility based crisis beds, non-hospital based detoxification centers, intermediate care facilities, and every public or private crisis stabilization unit in the state.
b. Include current updated contact information for the facilities and centers.
c. Provide real-time information about the number of beds available at each facility and, for each available bed, the type of patient that may be admitted, the level of security provided, and any other information that may be necessary to allow employees and designees of the psychiatric and substance abuse treatment facilities to identify appropriate facilities for the admission and treatment of individuals who meet the facility's criteria.
d. Allow employees and designees of facilities to perform searches of the board to identify available beds appropriate for the admission and treatment of individuals who meet the criteria.
e. Require every state facility, community hospital with psychiatric beds, substance abuse treatment facility, and private provider licensed by the department to participate in the bed board.
f. Designate an individual to submit information for the bed board and serve as a point of contact for addressing requests for information related to data reported to the bed board.
g. Require information reported to the psychiatric bed board to be updated at least daily.
h. Require data collection and analysis on outcomes pertinent to emergency department waiting time and other areas.
i. Generate monthly reports to NC DHHS.

**Recommendation:**
Every state facility, community hospital, substance abuse treatment facility, and private psychiatric providers licensed by the NC DHHS shall participate in the bed registry, and shall designate an employee to submit information for this bed board.

In conclusion, the proposed registry if implemented will provide the State with a technological tool that improves the service delivery system for those who present in crisis and need to be admitted to lower levels of care. The infrastructure cost for the bed board expansion is minimal. Costs may be incurred through employing staff to monitor the bed board for real-time accuracy, analyze data, write reports, and promote and recruit for expanded bed board participation. To ensure that the bed registry is achieving the intended results, it will be important for DMH/DD/SAS to conduct quarterly evaluations of effectiveness once the bed registry is fully operational. Data collected will be used be used to determine continuance of the bed registry after two years.

**SECTION 12F.3.(1)(b)((c)**

**Include recommendations as to any regulatory changes necessary to ensure safety and quality in Facility-Based Crisis Programs for Children and Adolescents.**

Facility-Based Crisis (FBC) for Children and Adolescents is a service provided twenty-four hours a day at a licensed facility. Currently, a proposed clinical policy for FBC is under review. The proposed clinical policy requires FBC to serve children and adolescents with mental illness, intellectual/developmental disability (IDD), and/or substance use disorders. Staffing ratios and training requirements in the proposed clinical policy serve to ensure that children and adolescents will be safe and provided all of the necessary services to support stabilization and successful transition post FBC to the level of care indicated. Although FBC for children and adolescents is already allowed under current rule, the changes in the proposed clinical policy will require additional rules to be developed.

**Recommendations:**

1. The Facility Based Crisis for Children and Adolescents clinical policy was updated in October and November of 2014, by the Division of Medical Assistance and DMH/DD/SAS. The updated policy includes staffing ratios, staff training requirements, and physical facility specifications that are designed to ensure the safety of consumers and the quality of services. This policy was developed and posted for public comment in January 2015.
2. Facility Based Crisis for Children and Adolescents is allowed under the current rule. DMH/DD/SAS and Division of Health Service Regulation (DSHR) recommend a new rule under North Carolina General Statute § 122C Subchapter 10A NCAC 27G be developed and promulgated to outline the requirements for Facility Based Crisis for Children and Adolescents.

DHHS would like to thank the Governor and the General Assembly for the opportunity to set forth a collaborative and united vision for community-based and inpatient mental health and substance use disorder services for the state of North Carolina.

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