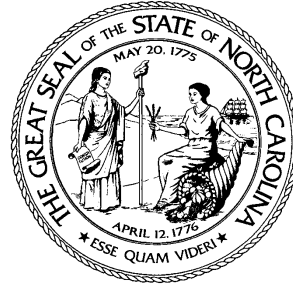


PUBLIC
CONSULTING
GROUP, INC.



STATE OF NORTH CAROLINA

FINAL REPORT

**STUDY OF STATE PSYCHIATRIC
HOSPITALS AND AREA MENTAL
HEALTH PROGRAMS**

*Public Consulting Group, Inc.
is an Affirmative Action/
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APRIL 1, 2000

OFFICE OF THE STATE AUDITOR
Ralph Campbell, Jr.
State Auditor

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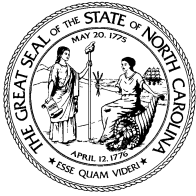


Ralph Campbell, Jr.
State Auditor

MISSION AND COMMITMENT

The mission of the Office of the State Auditor is to provide North Carolina's citizens and other users with **professional, independent evaluations** of the State's fiscal accountability and public program performance. Specifically, the Office of the State Auditor strives to assure that North Carolina state government is executing its management responsibility in compliance with applicable laws, rules, regulations and policies. Additionally, the Office of the State Auditor evaluates management controls and policies that should promote the efficient and effective use of public resources and assists state agencies in identifying areas of possible duplication.

In conducting these duties and responsibilities, the State Auditor is committed to thorough audits and examinations performed by a professional staff which result in useful and practical recommendations to improve services provided by North Carolina state government. Further, the State Auditor is committed to promoting cooperative efforts with those agencies and institutions under his statutory oversight.



Ralph Campbell, Jr.
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LETTER OF TRANSMITTAL

March 31, 2000

The Honorable James B. Hunt, Jr., Governor
Members of the North Carolina General Assembly
Secretary H. David Bruton, DHHS
Citizens of the State of North Carolina

Ladies and Gentlemen:

We are pleased to submit the *Study of State Psychiatric Hospitals and Area Mental Health Programs* conducted by Public Consulting Group, Inc. (PCG) under contract with the Office of the State Auditor. We are delivering this report as mandated by statute which required completion of this project by April 1, 2000.

This study of the State's mental health delivery system, including the State's psychiatric hospitals, was mandated by the General Assembly in Section 12.35A of Chapter 213 of the 1998 Session Laws. The General Assembly outlined work to be performed in two broad phases: confirmation and update of work done by MGT of America, Inc. on the psychiatric hospitals, and examination and assessment of the overall mental health delivery system for the State. The Office of the State Auditor was asked to oversee this important study by retaining and managing the work of an outside consultant. Because of the technical nature of the study issues, we engaged the services of the North Carolina Institute of Medicine as technical advisers for this project. In late February 1999, we contracted with Public Consulting Group, Inc. (PCG) to perform this work. A brief background and purpose of the report follows this transmittal letter.

As work progressed on the mandated portions of this study, the Secretary of the Department of Health and Human Resources asked that we include a related and very important issue: Should developmental disability services be a separate division, or should those services be reorganized within the existing Division of Mental Health, Developmental Disabilities, and Substance Abuse Services?

This report represents PCG's findings, conclusions, and recommendations relative to the overall delivery system for our State's mental health services. It includes specific recommendations as to the number and type of psychiatric beds needed, discusses the most reasonable options for the existing psychiatric hospitals, and identifies specific mental health services needed in our communities.

LETTER OF TRANSMITTAL (CONCLUDED)

But it goes further than that. PCG has recommended a “basic benefits” package that should be available to all North Carolina citizens. And, in order to assure that citizens in need of mental health services are afforded the needed services, PCG has recommended the most significant changes to the delivery system since the early 1970s.

Section 2.1 on *Governance and Organization* details the need for a paradigm shift in the way we oversee and manage our scarce mental health resources. PCG believes, as do I, that the role of the counties in the provision and management of mental health services should be significantly enhanced. The counties, composed of individuals who need mental health services, their families and friends, and the locally elected individuals whose job it is to provide needed services for their communities, are in a much better position to determine what the local needs are and how best to provide them.

Under the PCG plan, Area Programs and Area Boards would undergo a transformation over the next four to five years. The Boards would become true advisory boards and would assume much more direct involvement in the operations of the programs. Area Programs would be transformed into *County Programs*, becoming more closely aligned with county government thereby increasing accountability for resources. The State would set overall broad program policy, contract with individual or group county programs to deliver mental health services, and develop and implement strong quality assurance and technical assistance programs.

Lastly, PCG assessed the issues surrounding the organizational placement and structure of the Developmental Disabilities program. Based on the data collected, PCG has recommended the establishment of a separate DD division. However during implementation, the developmental disabilities system will need to simultaneously address two critical topics: how developmental disabilities services are managed in the new county program structure, and the final design and implementation of the new developmental disabilities structure.

Throughout the study, PCG has worked diligently to understand the issues and make sound, feasible recommendations to the citizens of North Carolina. I have been impressed with their efforts and willingness to do whatever was necessary to give North Carolina a good report. My staff and I worked closely with them during the study, and we feel confident that this report truly represents an open and objective assessment of the issues surrounding the delivery of mental health services in North Carolina. I commend the General Assembly for recognizing the need for such a comprehensive study and for giving PCG the time needed to deliver a quality report. While this report may not answer all the questions, it gives us what I have felt we needed from the beginning—***a blueprint for the future.***

Respectfully submitted,



Ralph Campbell, Jr.
State Auditor

BACKGROUND AND PURPOSE OF THE REPORT

Events Leading Up To This Study

In the fall of 1998, the North Carolina Legislature's Joint Appropriations Subcommittee for Health and Human Services was attempting to determine what funds were needed, and for what purposes, for the State's psychiatric hospitals and mental health system. Members of the Joint Subcommittee realized that changes in one segment of the mental health delivery system impacted other segments. Numerous studies had been conducted on various segments of the system, but there did not seem to be a clear consensus as to the needs.

MGT of America, Inc. had completed a study of the psychiatric hospitals in April of 1998 that recommended dramatic reductions in the number of beds at the State facilities by moving services currently provided by the hospitals to the community programs. That study also found that the psychiatric hospitals needed extensive renovations or to be completely rebuilt. At this same time, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services had been ordered to make significant Medicaid paybacks. HCFA had just stopped a Medicaid waiver program for children's services called Carolina Alternatives. Several area mental health programs had failed or were in serious financial trouble. Consumers, families, and advocacy groups were expressing a loss of confidence in the mental health system. The needs were many, and the questions about the stability and effectiveness of the system were growing.

Scope of the Study

In an attempt to understand what changes were needed to the entire mental health delivery system, the Joint Subcommittee asked the State Auditor to oversee and coordinate a comprehensive study of the psychiatric hospitals and mental health delivery system. Section 12.35A of Chapter 212 of the 1998 Session Laws directed the Office of the State Auditor to:

- build upon the results of the 1997-98 MGT of America, Inc., study of the psychiatric hospitals;
- include the costs of construction and operation of new facilities as compared to redesign and long-term operation of existing State psychiatric hospitals;
- weigh both cost efficiencies and the availability of and access to quality care;
- assess how many and what type of beds are needed statewide;
- assess the capacity and ability of area mental health programs to absorb specific services now provided at the State hospitals;
- assess the overall structure of the mental health, developmental disabilities, and substance abuse services delivery system to include:
 - changes that should be made to ensure an operating structure through which improved and adequate quality of services to clients will be delivered efficiently;
 - the kinds of structures and processes that should be established to ensure the most efficient and effective systems for governance, service delivery, program administration, and oversight;
 - changes that should be made in the relationships and roles pertaining to State and local government agencies so as to create and foster more efficient and effective program operations; and

- assess current operational and administrative policies and procedures, and current funding streams.

The Office of the State Auditor, after a competitive bidding process, engaged the services of Public Consulting Group, Inc. (PCG) to conduct the study. PCG began work in February 1999. As directed in the legislation, the State Auditor submitted interim reports on the study of the mental health delivery system and funding streams (March 1999), the State psychiatric hospitals (May 1999), and the second interim report on the delivery system (November 1999). Because the recommendations made for the psychiatric hospitals directly affect the community mental health programs, the State Auditor requested and received permission from the Joint Subcommittee to delay the final report on the State psychiatric hospital until April 2000, the date required for submission of the final report on the mental health delivery system.

Developmental Disabilities

At the time the legislation was passed, the Secretary of the Department of Health and Human Services was sponsoring a separate study looking at the feasibility of establishing a new division composed of Developmental Disabilities, Services for the Blind, and Vocational Rehabilitation. Therefore, the scope of the mental health study only addressed delivery of developmental disabilities services in general. As the study progressed, the Secretary asked the State Auditor to expand the scope of the on-going mental health delivery system study to include the issue of **state-level organizational structure and placement** for the Developmental Disabilities program. Due to time limitations, developmental disabilities **services were not examined** at the same detailed level, as were the mental health and substance abuse services. Nor were the services offered by the State's regional mental retardation centers examined in detail. These are areas where additional work needs to be done.

What This Report Does

This report contains the detailed recommendations made by Public Consulting Group to make the overall mental health delivery system more responsive to the needs of all North Carolinians. The report proposes a number of strategic changes that will begin the transformation of the state mental health, developmental disabilities and substance abuse service system. The recommended changes would result in more **local control** over programs and expenditures, better definition of statewide policy and procedures, and **more accountability** of resources at all levels. Most importantly, North Carolinians' access to **quality services** will be improved, financing will be better aligned with service goals, and a framework for future improvements will be established involving consumers, families, advocates, and local and state governments.

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Executive Summary

North Carolina has a long and proud tradition of providing services to citizens who have mental disabilities, including mental illness, developmental disabilities and addictive behavior. The State has built a statewide system of care valued at \$1.2 billion annually. This study is part of an effort to restore that tradition. It is an effort to resume North Carolina's history of innovative services, and its ability to reach out to all parts of a very complex and diverse population and to support community services by generating significant resources within the State and the Counties, and from the Federal government.

During the past decade, the tradition has been shaken. Issues of management, governance and finance have made it difficult to harness effectively all of the system's resources – those within the communities and the counties and those within the State hospitals and the regional centers – and to turn those resources toward common purposes. There have been a number of setbacks and warning signs: the loss of the Carolina Alternatives waiver for children's services; the financial crises that have closed several Area Programs; the required Medicaid paybacks for certain community-based services; the recent problems in staffing and record keeping at Dorothea Dix Hospital; the closing of several community residential and inpatient services; the turnover of leadership at the top of the agency; and several re-organizations of State agency staff. While these events are not foreign to a public mental health agency, their continuing occurrence has left staff discouraged, Area Programs and providers untrusting, and the Legislature and general public uneasy.

Among the professionals and advocates for developmental disabilities services, there is a growing sense that the system has lost its ability to innovate. The national movement toward self-determination, in which individuals with developmental disabilities and their families play a leadership role in making decisions about their future, has not yet taken root in North Carolina the way it has in other states. Services in large intermediate care facilities and regional centers dominate North Carolina's State spending. The ability of the State to provide direction and leadership for developmental disabilities services has repeatedly come into question.

This report, under the auspices of the State Legislature, and the leadership of the State Auditor, the Honorable Ralph Campbell, is an attempt to put forth a blueprint for transforming the system. It does not dwell on past problems, nor does it assess blame. It sets out a number of new directions, innovative ideas, changes in structure, and a process for bringing together the key elements of the system in an implementation process over the next five years. It does not attempt to paint the complete picture. Rather, it attempts to begin the work with a number of bold and perhaps controversial directions, creating a new public structure and process that will, eventually, transform the service system and restore the tradition.

One caveat is in order. Although a lot of money is involved, money, by itself is not the answer. In fact, we believe that the current amount of State spending is not necessarily to blame for system problems, although North Carolina can do better. The problem is that the spending patterns are not aligned with the directions the system should be taking. Too much money is being spent on too few clients. Too much money is being spent on State hospitals, on small groups of clients who have been under court order, and on intermediate care facilities – both small and large. To realign spending with innovation and quality services for people who rely on the public service system, and to create a structure that supports effective governance and financing mechanisms – these are the important challenges that North Carolina now faces.

Executive Summary

This report calls for the major changes outlined below. Many more recommendations are found in the report summary that follows. The details are in the full report.

1. A transformation of the governance structure is recommended, so that the responsibility of local management is shifted to counties and to groups of counties, acting under long-term contracts with the State to manage services. Local County Programs will coordinate all mental health, developmental disabilities and substance abuse services in community networks.
2. Benefit packages for community assessment and acute care services are recommended for all mental health and substance abuse clients entering the State system.
3. Specialized services are recommended for target populations which have been served in the State Hospitals inappropriately, for lack of appropriate services. These include individuals with serious and persistent mental illness; those with dual diagnoses of substance abuse and mental illness; clients who are geriatric; children; and adolescents.
4. The new County Programs are encouraged to increase local services to target populations through a matching process which will provide additional State funds for service expansion.
5. A new Developmental Disabilities Division is proposed. It should attract strong leadership, focus management resources on providing innovative and less costly community services, and restore confidence in the public developmental disabilities system.
6. It is recommended that the State hospital system be reduced by 667 beds over the next five years, with the savings going directly to community services. This involves the closure of Dorothea Dix Hospital and the substantial renovation and rebuilding of Broughton, Umstead and Cherry Hospitals.
7. The study projects that reduced reliance on State hospitals will save the State \$51 million in operating costs. The savings can be leveraged to over \$95 million in total resources from all funding sources.
8. Most of the resources necessary for the system's transformation should be achieved through State hospital savings and through the reconfiguration of current services, financial operations and administrative costs through the new County Programs. At first, however, "bridge" funding will be needed to strengthen the community as the primary locus of care. Additional funding for target populations may be necessary once the system is better aligned in the new County Program structure.
9. The Department of Health and Human Services, the State agency legally responsible for managing the State's Medicaid program, must restructure and unify Medicaid policy and operations across the three agencies responsible for services to persons affected by this report: the Division of Medical Assistance (DMA), the new Division of Developmental Disabilities (DDD), and the new Division of Mental Health and Substance Abuse Services (DMHSAS).
10. The State should establish a Blue Ribbon Implementation Commission to oversee and provide guidance for these changes over the next five years.

We sincerely hope that this report and its recommendations will stimulate a productive and lasting public discussion that will lead to the transformation of North Carolina's system of services for persons with mental disabilities.

Methodology

Public Consulting Group, Inc. (PCG) has conducted this study for the Office of the State Auditor, in two phases, beginning in February, 1999 and ending in March, 2000.

The PCG project team is a multi-disciplinary team with experience in policy and service delivery systems, both in North Carolina and in other states. In addition to the PCG project team, several additional consultants played important roles on different parts of the work. Gail Hanson-Mayer, a clinical nurse specialist with more than twenty years experience in program development and implementation, assisted in visiting and evaluating the mental health and substance abuse clinical services in the Area Programs. John Vinton and Christopher Pilkington of Hoskins, Scott & Partners, Inc. (HSP), an experienced team who have worked together on the Massachusetts Blue Ribbon Commission on State Hospitals and on other State facility projects across the nation, analyzed the physical conditions and developed cost estimates for the four State Hospital campuses. Valerie Bradley, the Chairman of the President's Commission on Mental Retardation and the President of Human Services Research Institute (HSRI) conducted much of the analysis of the developmental disabilities structure.

State Auditor Ralph Campbell provided invaluable leadership throughout all phases of the work, including every public meeting and presentation. All drafts and final products have been reviewed in detail by staff from the Auditor's Office. Marvin Swartz, M.D., of Duke University and Joseph Morrissey Ph.D., of the University of North Carolina, with the North Carolina Institute of Medicine, provided helpful ideas and criticism throughout the project. PCG bears full responsibility for the final product, findings and recommendations.

Phase I of the project focused on an independent analysis of a report done by MGT of America in 1998. MGT's report to DMHDDSAS analyzed operating efficiencies and construction/renovation needs at the four State Hospitals. PCG reviewed MGT's methodology, data, analysis, findings and recommendations. We then developed additional approaches to analyzing issues and topics not addressed by MGT. PCG's Phase I Report (April 30, 1999) included the following analyses:

Facility Construction and Renovation. Analysis of facility and renovation costs at the four hospitals included: review of MGT's report and meetings with personnel from MGT and O'Brien/Atkins Architects; site visits to all campuses, including a review of building plans; interviews with administrators, physical plant staff and direct care staff; and review of proposals for repairs and capital improvements. Cost estimates for new construction were generated using estimates both for cost per square foot and cost per bed.

Community Service Options. PCG reviewed MGT's recommendations that children, geriatric, and substance abuse patients be served in the community rather than the State's four psychiatric hospitals. PCG's approached this policy in the context of nationwide trends in best practices for these populations.

State Hospital Bed Demand. PCG assembled and integrated quantitative data from: the MGT report; the Annual Statistical Report on North Carolina Psychiatric Hospitals, 1995 through 1998; the National Center for Mental Health Statistics; comparative information supplied to PCG by other states' mental health agencies; and scholarly journals. The data was analyzed to establish a benchmark estimate of North Carolina's hospital use compared to other states, and to devise a method for more accurately estimating future bed demand.

Federal Disproportionate Share (DSH) Revenue Projections. PCG updated MGT's estimates, factoring in the projected effects of the Federal Balanced Budget Act of 1997.

Methodology

Phase II of the project focused more broadly on North Carolina's entire public system of mental health and substance abuse services. The elements of the study included:

DMHDDSAS Review. PCG reviewed DMHDDSAS statutes, regulations and policies; analyzed relevant aspects of its financial operations, management, organization and structure; and reviewed reports on clinical services, quality assurance, and program evaluation. Our methodology included interviews with senior level staff in MH, DD, and SA services and with senior level personnel from DHHS and DMA. This initial set of interviews provided a State-level perspective.

Area Program Site Visits. PCG made a series of intensive on-site visits to eight Area Programs. The eight were selected based upon the criteria designed to provide a representative cross-section of the community system. Analysis focused on governance and structure, services and financial operations. Interviews were conducted with Area Program administrators and professionals, Area Board members when available, county officials and Area Program clients.

State Agency Data Request. PCG submitted a comprehensive data request to DMH and DMA, requesting clinical, patient and financial data. This was used to validate or discount issues raised during the site visits, and to determine their statewide applicability.

Public Meetings. From June to August, 1999, State Auditor Campbell conducted eight regional public meetings to gain public input. About 520 individuals attended the meetings, with 206 addressing the panel directly.

Expert Panel – September 21-22, 1999. An Expert Mental Health Panel sponsored by The Office of the State Auditor included mental health directors from five peer states. These individuals provided their insight and experience in creating an effective continuum of care; organizing successful community-based care; financing new systems of care; and building consensus for positive system change.

Presentation of Findings and Ideas for Considerations. PCG conducted regional information sessions in November and December, 1999 to review our initial findings and elicit input from Area Program directors, advocates, the North Carolina Council for Community Programs, the North Carolina County Commissioners Association and other stakeholders. A total of 12 public presentations were conducted. These meetings were instrumental to PCG in verifying findings and developing recommendations.

State Hospital Bed Demand. PCG selected a methodology to best use available data for predicting demand for beds in State Hospitals. This resulted in a simultaneous top-down and bottom-up approach, using both national data and local experience of all North Carolina counties and Area Programs during the past three years.

State Hospital Capital Costs. The costs of renovating and/or rebuilding the State Hospital campuses were revisited after the bed demand analysis was set and regional State Hospital bed targets were established.

Developmental Disabilities Structure. A comparable, but more focused methodology was used for the DD structure portion of the report. It included: (a) site visits to six Area Programs; (b) interviews with the directors of the five regional centers and visits to four centers; (c) extensive interviews with Area Program DD staff, State agency staff, consumers, providers, advocates and other stakeholders; (d) an Experts Panel was convened involving representatives from four state DD agencies; (e) an independent analysis was conducted of national trends and DD agency organizational structures; and (f) a financial analysis was completed on the costs of establishing a separate Division for Developmental Disabilities. A series of five presentations were held with State agency staff, Area Program staff, advocates and other stakeholders to review the findings and analysis.

OVERVIEW

There is enormous variability in the management and governance of the Area Programs in North Carolina. Although there are some similarities among multi-county and single county programs, their differences are more apparent. The seriousness of the issues and the widespread problems in financial structures and provision of services warrant an overhaul of the current governance structure.

Analyses of the local and State governance structure support two conclusions:

- ***The current Area Program structure lacks accountability to either State or local government.*** Lack of accountability contributes to the Area Programs' sense of political powerlessness. It keeps them from acting as equal partners with State agencies. In addition, their relative operational independence compounds recent financial and service crises in the local system.
- ***Organization of service and finance policy at the State level is split between the Department of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS).*** The split in service provision, rate setting and policy making and the lack of clear roles and coordination at the State level have contributed to organizational instability and financial and service crises in the local and State systems. Resolving structural issues in Area Programs without improving State-level policy coordination and management would not resolve the system's current crisis of confidence and performance.

FINDINGS

1. ***Governance and funding are not coordinated.*** Area Boards do not provide funding and are not financially accountable for their decisions, yet their actions impact State and county budgets. Area Programs often call upon counties as the funder of last resort, but, under the current structure, counties' commitment to that role is questionable.
2. ***The statutory structures of the Area Boards and Area Programs lack direction from, and do not promote accountability to, local government.*** Even though County Commissioners sit on Area Boards and appoint members, the boards are neither a part of nor accountable to county government. In most cases there is little interaction between the boards and the counties' professional management staff. Additionally, the structure and membership of the boards is oriented more toward advocacy for clients and services than toward financial and management oversight. This composition does not support the financial and management competencies that are needed to oversee budgets ranging from \$6 - \$65 million.
2. ***The structures of the Area Boards and Area Programs do not promote accountability to the State.*** Although the State DMHDDSAS and DMA agencies distribute the majority of funds to the Area Programs and have extensive oversight responsibilities, they have no role on the Area Boards. Nor do they direct, supervise or contract with the Area Program directors. Area Programs do not consider themselves accountable to the State agencies, which must, nonetheless, maintain accountability for State funds. In response to recent crises, the State agencies have fallen into an ineffective role of policing, and sporadic efforts to promote accountability of Area Programs.

3. ***The Area Boards lack political standing and are not able to be strong advocates for Area Programs.*** Area Board members report feeling disempowered in their interactions with State agencies. As local political subdivisions of the State, they are separate from county government. They do not have the political power to effectively assert themselves legislatively or in State agency rule-making. Although the North Carolina Council of Community Programs is a well-organized and professionally competent advocacy organization, it is hindered by a lack of members who are politically powerful.
4. ***The responsibilities of DMHDDSAS and DMA sometimes overlap or compete, but they are not rigorously coordinated at the DHHS level.*** Areas of overlap include rate setting, utilization management, quality assurance, credentialing, standard setting, and management of programs funded by Medicaid, including Carolina Alternatives. The distribution of responsibility for managing program operations is unclear. This diffuses authority and creates confusion at the local level.
5. ***The Commission for Mental Health, Developmental Disabilities and Substance Abuse Services does not currently play a significant role in rule making or in State agency oversight.*** The Commission appears to have become marginalized. It does not have a vehicle for public comment on agency rules, nor is it provided with information on key events in the service system. The Commission's members are a significant source of untapped talent.

RECOMMENDATIONS

PCG proposes major changes in the local level governance and structure of the mental health, substance abuse and developmental disability systems, as well as a number of operating changes at the State level. We believe these recommendations will create more accountability in the local and State systems.

The proposed **County Program** model will shift management responsibility for mental health, developmental disabilities, and substance abuse services to North Carolina's counties. Within this system, groups of counties may operate as partners. This model will improve services by broadening revenue streams, mandating and supporting more consistent service packages, and re-engineering the business and governance relationships between State agencies, counties, providers, and the local mental health service delivery mechanism. It will help to re-establish trust and confidence in the system.

Local Recommendations:

1. ***Responsibility for providing mental health and substance abuse services at the local level should be shifted from Area Programs to County Programs.*** Counties will assume the management responsibility for these services, at their option, and under contract with the State. The service system will become a part of a strong governmental structure with management capability. The new entities will be known as County MH/DD/SAS Programs, referred to here as County Programs.
2. ***Counties, acting within State guidelines, should choose their own county partners.*** Partnerships among counties will be entered into freely. Partnership boundaries should be determined locally so that they can be politically viable. State standards for County Programs will require sufficient financial, service, and management capacity. The resultant number of county partnerships is expected to be substantially smaller than the current number of 39 Area Programs.

3. ***Area Programs should no longer exist as local political subdivisions of the State.*** Counties might call upon current Area Program staff and board members to assist during the transition phase. Existing Area Programs might become part of new systems, but would then act under the direction of county government. Staff and assets of Area Programs might also become part of new service systems. Alternatively, current Area Programs might choose to restructure themselves as private non-profit 501(c)3 corporations, in order to provide management services or direct services to clients.
4. ***Area Boards should be replaced by County Program Boards with Advisory Committees.*** The new County Program Boards will make recommendations to the County Commissioners on the mental health, developmental disabilities, and substance abuse annual plan and budget. The boards will have 5 to 7 members, including at least one Commissioner from each participating County. Larger multi-county programs may have larger boards. Each board will have three advisory committees, one each for mental health, substance abuse and developmental disabilities, to ensure that the views and concerns of consumers, family members, and advocates are heard in county government.
5. ***The county-State contracts should have built -in protections.*** By design, the State contracting system will ensure that State service standards and requirements are met; that the county has sufficient management control over financing; that consumer service needs are the focus of the County Program; and that all parties are protected in the process. The contracting process will not be price-competitive. Rather, the process and resultant contracts with the State will rest on detailed plans from proposed County Programs to demonstrate their willingness and capacity to provide services, manage finances, and meet State standards. It should guard against unfunded mandates.
6. ***The counties should be given incentives to increase their financial contributions over time.*** Interviews with county commissioners and managers during site visits suggest that new local funding must be accompanied by a high level of local accountability. Although some counties have not been inclined to allocate additional money for mental health services, many have indicated a willingness to contribute financially if they are assured that local citizens will be served.
7. ***The State should ensure service coverage for residents of all counties.*** The State will play an active role in ensuring that all counties participate in becoming County Programs. As a last resort for counties that are unwilling or unable to participate in County Programs, the State will manage local services directly, charging those counties a fee for management services.
8. ***The process for assumption of county responsibility should ensure adequate time and resources.*** Over a five-year transition process, counties will be given time and resources to make appropriate management and partnering decisions. The implementation planning and roll-out processes will be overseen by a special Blue Ribbon Legislative Implementation Commission.

Statewide Recommendations

9. ***A Division of Developmental Disabilities (DDD) should be established as a separate Division, independent of the restructured Division of Mental Health and Substance Abuse Services (DMHSAS).*** This recommendation is discussed later in this report.
10. ***The new DMHSAS and DD structures should be designed to administer contracts with the counties and to manage the downsizing of the State hospitals.*** Each County Program will have a single contract with the Department of Health and Human Services (DHHS) to include mental health, developmental disability and substance abuse services. Both divisions will administer the contracts with County Programs. DMHSAS will manage the downsizing of the State hospitals and the transfer of hospital resources to the County Programs.

11. ***The Secretary of Health and Human Services should implement changes in Medicaid administrative responsibilities that improve policy development and coordination.*** As director of the single State agency under contract with HCFA, the Secretary of DHHS should move a number of Medicaid functions to the DMH/SAS and DDD service agencies. These could include (a) coverage and reimbursement policies, (b) financial operations including rate setting, provider audits and budgets, (c) program integrity, (d) provider enrollment and provider relations, and (e) contract monitoring.
12. ***A Blue Ribbon Legislative Implementation Commission should be created to oversee the process and advise the Secretary of Health and Human Services.*** This commission will advise the Secretary on the transformation of the current system from an Area Program structure to a County Program structure; on the phase-down and reconstruction of the State Hospitals; and on the changes to be planned for DD services and regional centers.
13. ***A Mental Health and Substance Abuse Advisory Council and a Developmental Disabilities Advisory Council should be established.*** These councils will provide ongoing review and advice to the division directors on a wide range of topics, including the process of establishing the County Programs and monitoring the changes at the State schools and regional centers.

OVERVIEW

State hospital beds provide a safety net for North Carolina's citizens when services are not available locally. They are a special resource that should be designed to provide certain services that are not available in safe, less restrictive settings close to home.

The previous study by MGT of America in 1998, projected a reduction of nearly half the State hospital beds in North Carolina. This required eliminating *all* beds used for children, elderly, long-term clients, and those requiring substance abuse services. No consideration was given to providing acute care in the community, and no consideration was given to the feasibility of these recommendations within the North Carolina system.

PCG's approach is a bottom-up approach based on "best practice" benchmarking used in Total Quality Management. The "local best practice" model identified six existing Area Programs whose performance might serve as a target for the entire State. The difference between the current performance level of these programs and the tentative Statewide target was examined. This analysis highlights areas and services that require the most immediate interventions and helps each program devise detailed strategies for achieving key objectives.

The "local best practice" approach selected and profiled existing programs, rather than relying on idealized composites, in order to set targets that are demonstrably achievable. Area Programs with low utilization of State hospitals and a reasonably comprehensive mix of local services were selected and profiled to construct a "local best practice" model. These programs are regarded as well-run by providers and consumers. They do not necessarily set a high standard in every category of service. The Area Programs for this group were selected to form an aggregate that fairly represents the State in such factors as economic terms, regional affiliation, urban/rural composition, racial characteristics, and age mix.

North Carolina's bed utilization and admissions rates were only used against a peer group of nine other states: Illinois, Kentucky, Massachusetts, Michigan, Missouri, Ohio, Pennsylvania, South Carolina and Virginia. This peer group is used throughout this report to compare North Carolina practices and policies.

FINDINGS

1. ***The State hospital inpatient bed capacity of North Carolina is higher than that of "peer group" states.*** At 32.3 beds per 100,000 persons in the general population, the bed capacity is 23% higher than the average in the peer group of comparable states. North Carolina's rate of adult admissions, at 243 per 100,000, is second highest among peer group states.
2. ***No comparable peer group data exists for utilization of State hospital beds for children and adolescents, however, in general, North Carolina relies heavily on State hospitals for services that could be provided in community settings.*** Some peer group states have adopted policy goals of providing all services for children and youth outside of State hospitals.
3. ***There is very wide variation in how State hospital beds are used across the State.*** Counties which use the State hospitals least, ranked in the 5th percentile of utilization, use about 10 beds per 100,000. Counties which use the beds most, at the 95th percentile, use about 55 beds per 100,000 population.

RECOMMENDATIONS

1. *North Carolina's State hospital bed capacity should be reduced by 667 beds.* This will reduce capacity from 2288 beds to 1621 beds. This will bring North Carolina's utilization rate to the average of the peer group states and within the local operating capacity of many well run Area Programs.
2. *This reduction should occur over the next five years to permit sufficient development time for the new County Programs.* Beds should not be closed until resources are in place locally.
3. *PCG projects target numbers for bed closure according to the geographic regions served by existing State hospitals.* These projections should be viewed as the demand within existing regions. No allocation is made to individual Counties or Area Programs.

Cherry region	333 beds
Umstead region	340 beds
Dix region	430 beds
Broughton region	518 beds

Total	1621 beds
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4. *The 1621 beds should be seen as a "floor" for beds serving the current population of the State hospitals.* No specific user group has been eliminated. All have been reduced according to the best State practice models. When County Programs have developed local plans and budgets, there may be the further reductions in hospital bed numbers, and these may result in a user mix that is different than what is projected.

Hospital Replacement/Renovation Cost Analysis

OVERVIEW

In its Phase I report to the Office of the State Auditor, PCG's discussion of construction and renovation of mental health facilities was focused on a hospital efficiency study conducted in 1998 by MGT of America, Inc. PCG's current report builds on our findings of Phase I in order to estimate the capital costs associated with several options for construction and modernization of North Carolina's State hospitals.

In order to reach an appropriate capacity of 1621 beds at the State hospitals, construction options were analyzed. New construction, renovation, and hybrid approaches were compared. A "hybrid approach" includes a mix of renovation and new construction. In Phase I of the study, PCG observed that a hybrid option might be most cost effective at Cherry and Umstead hospitals. After further analysis, this finding was confirmed. Both facilities have reasonably good infrastructures and require only "enabling" construction, infilling of courtyards, and gut renovation of existing buildings. At Broughton Hospital, extensive renovation of the Avery complex is still the most cost-effective approach. In order to provide any level of modern patient care, Dix Hospital would require new construction in a location off the hill. Infrastructure repair and modernization costs at Dix would not be economical. New patient care would be difficult to integrate into the current hilltop complex. For that reason, a hybrid option was not explored.

Because Dix Hospital does not have any patient care facilities worth renovating, we have also analyzed a potential construction model that would exclude Dix. This three-hospital model is feasible from the point of view of physical location and access.

FINDINGS

1. ***A four-hospital model for 1621 beds is estimated to cost \$339,324,362, for a per bed cost of \$209,459.*** The recommended options for the four hospitals are as follows:

<u>Hospital</u>	<u>Beds</u>	<u>Recommended Option</u>	<u>Total Cost</u>	<u>Cost per Bed</u>
Cherry	333	hybrid	\$ 63,191,117	\$189,763
Umstead	340	hybrid	\$ 63,769,632	\$187,558
Dix	430	new construction	\$106,106,925	\$247,760
Broughton	518	all renovation	\$106,256,688	\$205,128

2. ***A three-hospital model for 1621 beds is estimated to cost \$319,167,088, for a per bed cost of \$196,895.*** Dorothea Dix Hospital was explored as a candidate for closure because the proximity of Umstead and Cherry allows for reasonable access to these other facilities. Renovation at Dix would not be cost-effective and Dix is the most expensive hospital to replace.

The recommended options for the three-hospital model are as follows:

<u>Hospital</u>	<u>Beds</u>	<u>Recommended Option</u>	<u>Total Cost</u>	<u>Cost per Bed</u>
Cherry	465	hybrid	\$ 88,110,339	\$189,485
Umstead	638	hybrid	\$117,531,791	\$184,219
Dix	0	closing costs	\$ 7,268,270	NA
Broughton	518	all renovation	\$106,256,688	\$205,128

RECOMMENDATIONS

- 1) ***The State should pursue a three-hospital model, closing the Dorothea Dix Hospital.*** Hybrid construction and renovation would take place at Cherry and Umstead Hospitals. Broughton Hospital would be renovated. In addition to the accessibility issues and the renovation costs, there are a number of other reasons why the three-hospital model with the closing of the Dix is the most cost-effective and appropriate for the State:
 - *The Dorothea Dix Hospital is the most expensive hospital to operate. Its closure represents potential additional savings of \$13.2 million annually. These savings would be transferred to the community for State hospital replacement services and financing of the basic benefit package. When leveraged with Medicaid and other revenue sources, the Dix closure is valued at \$24.4 million annually. (Section 2.6)*
 - *The area in which the Dorothea Dix Hospital is located offers good opportunities for the development of community-based services. The mental health programs of Wake and Durham Counties are particularly active. In addition, the medical schools and their teaching facilities and the community general hospitals in this region make the closure of Dix a more feasible choice.*
 - *The location of Dorothea Dix Hospital in the Raleigh/Durham area makes it feasible to consider employment alternatives for staff. State hospitals in rural areas provide significant employment opportunities that are unduplicated in the community. Staff at the Dorothy Dix hospital have better access to employment in other State agencies or in the private sector.*
 - *The "safety net" currently represented by the State hospitals can be maintained. The modernization of Broughton, Cherry and Umstead Hospitals, coupled with the State and local commitment to expanding community services, and the creation of the new Dorothea Dix Mental Health Transfer Account will support the "safety net." (See sections 2.5 and 2.6)*
 - *Among the State hospitals, the Dix Hospital represents the richest opportunities for re-use. Multiple uses of the large campus are possible for the benefit of the mental health community and for the benefit of the State.*
- 2) ***The State should commit to the following principles for the closure of the Dorothea Dix Hospital:***
 - The replacement beds in other hospital should be as good as, or better than, the ones to be eliminated.
 - The replacement services in the community should be of high quality and accessible.
 - The closing process should be planned carefully and managed closely.
 - There should be clear accountability to the mental health community for the resources saved by the hospital closure.
- 3) ***Additional analysis will be needed to determine the exact distribution of beds and services at the three hospitals under the County Program model.*** Determining the specific bed types and services that will be needed to meet regional demand within a three-hospital model should take into account the options for increased community-based services and their feasibility at the local level and Statewide.

OVERVIEW

In the Phase I report, PCG presented its findings concerning the potential movement of groups of individuals out of State hospitals and into community treatment. Proceeding from an understanding of the history of the service system and recent efforts to change it, Phase II reports PCG's comprehensive review of the system and makes system-level recommendations to facilitate major organizational and service shifts. This section of the report focuses on programs and services for individuals in need of mental health and substance abuse services. Service issues and trends for individuals with developmental disabilities are dealt with in section 3 of this report.

- ***Many of the individuals currently residing in North Carolina's four State hospitals, in all levels of care, could be treated in community-based services if such services were available.*** Additional analysis is needed in order to assess current services and to develop a strategy for planning, funding and implementing high-quality community-based programs, especially for individuals with substance abuse problems and for the geriatric, youth, and adult inpatient populations.
- ***North Carolina's mental health system does not currently have the capacity to treat all groups of individuals at the community level. Proposals to move entire populations into the community are not realistic and would not constitute an appropriate plan.***

This Phase II report presents the results of the additional analysis needed for planning and implementing new systems for delivering services.

FINDINGS

1. ***Accessibility and quality of clinical assessment varies widely across Area Programs.*** Despite the Division's new assessment standard (July, 1999), clinical assessment practices observed during site visits ranged from excellent to poor. Systems on the lower end of the continuum had most difficulty providing assessment in rural locations, during night and weekend time periods, and for children. Expert urgent assessment is especially important to a system with limited resources and many competing needs.
2. ***Services for acute substance abuse are particularly lacking across the State; this leads to inappropriate use of State hospitals as the "default" treatment setting.*** The substance abuse system is a "hodgepodge" of services. It is especially difficult for people to gain access to acute care services if they exhibit aggressive or self-injurious behavior. More often than not, these individuals are sent to a State hospital that provides "security" but little in the way of focused treatment. Access to aftercare for these individuals is also highly variable and often inadequate. The State's Alcohol and Drug Abuse Treatment Centers (ADATC) often do not provide the level of intensive services needed for the most difficult populations. While the services currently provided at ADATC's are certainly needed, it would be possible to provide these services in the community.
3. ***The role of the State hospitals is unclear and varies among Area Programs.*** Public mental health hospitals in North Carolina serve as the setting of last resort for individuals with nowhere else to go. There are great disparities in how the Area Programs use the State hospitals. For some, State hospitals are the primary resource for acute psychiatric care. Others use the State hospitals for treatment of individuals who are intoxicated and unstable. Some Area Programs use the State hospitals for long term care only, while others rarely use the State hospitals at all. Attempts by DMHDDSAS to alter this chaotic pattern have had little success. A recent Division report identified 2,054 substance abuse admissions out of a total of 3,592 total admissions, a staggering 57%.

4. ***Populations with exceptional needs are frequently under-served, including dual diagnosed (MH/SA) clients, children and adolescents, and elderly. State hospitals have become the service provider by default.*** Lack of existing resources and specially trained staff makes it difficult for the Area Programs to serve populations other than the traditional target group, adults with severe mental illness. Within the adult population, individuals with co-occurring disorders represent a sizable group requiring special programming. Other underserved groups are: the homeless population; individuals with mental illness and developmental disabilities; individuals with developmental disabilities and substance abuse disorders; incarcerated individuals with mental illness or substance abuse disorders; victims of physical and sexual abuse.

5. ***With the demise of Carolina Alternatives and the end of the Willie M. lawsuit, children's services are experiencing a major crisis in confidence and direction.*** The two dominant forces shaping children's services during the 1990's were the lawsuit and consent decree that created the Willie M. program and the Medicaid waiver that created Carolina Alternatives. Neither of these major initiatives remains fully intact. The dismantling of services at the provider level, especially in Area Programs participating in Carolina Alternatives, has resulted in a sense of confusion and disappointment that threatens to undermine the progress of the last five years. The Report of the Futures Committee (1999) has developed a widely endorsed set of guiding principles to update the Child Mental Health Plan (1987). Children's Services must re-group and develop an action plan to pursue its mission

6. ***Willie M. programs have thus far retained their sense of purpose and uniqueness, but there is significant concern about the end of judicial oversight.*** It is not possible for the system to continue to fund the Willie M. Programs and all other services needed for children and adolescents at the same the level at which the Willie M. Program has been funded (\$37,000 per person per year). However, it would be a mistake to unravel the best local example of defining, treating, monitoring, and evaluating a specific target population.

7. ***The current system suffers from a lack of clarity about what, specifically, it is trying to accomplish.*** Although both State and federal policies and guidelines play a major role in the service system, there is currently no Statewide system that defines who will be served with what resources and in what way. Defining populations, services, and resources is the necessary pre-condition for creating a rational system that monitors itself effectively and uses that information to continually improve.

Efforts to clarify which resources can be used for which populations reveal several issues:

- Despite its attempts, the DMHDDSAS has extremely limited capacity to serve those who are underserved within the present system.

- Even if it had more authority, DMHDDSA would not be able to back up its edicts with financial resources.

- In the current system, rationing of care among different populations occurs continuously and idiosyncratically at the Area Program level, guided by local forces and the individual priorities of county and program leaders.

RECOMMENDATIONS

The following recommendations are designed to begin the transformation of the system. They are not intended to be comprehensive, rather they are intended to initiate work on the service issues that require immediate attention for the implementation of the County Program and general system requirements.

1. ***The recently issued standard for assessment developed by DMHDDSAS should be adopted for Statewide use and incorporated as a condition of participation in the contracting process.***
Implementation of the standard should be monitored through the Council on Accreditation process or by periodic audits by State-contracted reviewers.
2. ***The development of a continuum of care for individuals with substance abuse and addictive disorders should be a top priority for DMHDDSAS and the State of North Carolina.*** This process should begin with the development of acute care capacity at the ADATC's and in community hospital settings. In addition, specialty programming and/or additional services for individuals with co-occurring disorders should be provided within current treatment settings because such a large portion of the traditional target population is affected. Providing intensive services for adolescents could head off the vicious downward spiral of addiction, and would be cost-effective in the long run.
3. ***DMHDDSAS should re-define the role of the State hospitals as intermediate and long term care facilities.*** A major part of this change requires a strategy for development of acute care capacity in community settings. Structures needed to accomplish this transition include: conversion of all ADATCs to acute care; development of partnerships such that Area Programs could use former State hospital buildings; development of innovative hospital alternative programs in the provider network; and partnerships with community hospitals and other intensive care providers. Some funding for these ventures should become available as the State hospitals serve fewer individuals. However, additional funding, especially start-up capital, will be needed. Additionally, DMHDDSAS and DMA should restructure inpatient bed rate-setting so as to optimize the use of community inpatient beds.
4. ***North Carolina should adopt a process of defining specific target populations and benefit packages that match the needs of the targeted group. Adults with serious mental illness, elderly and dual- diagnosed individuals currently residing in State hospitals should be priorities.***
Movement of these individuals will require the development of new community-based capacities and structured living environments. DMHDDSAS should immediately begin developing pilot programs to determine the optimal mix of services for this population. Pilot partnerships might include assertive community treatment providers, skilled nursing facilities, and residential service providers. These groups require special focus to implement the State hospital bed closure recommendations.
5. ***PCG recommends the development of a standard "Evaluation and Acute Care" benefit package available to every North Carolinian through any local program.*** This benefit package should provide a designated set of services, subject to Statewide criteria for medical necessity. These services are critical to managing the front door to the State hospitals and to providing acute care close to home. Specifics of assessment services, acute care services for mental health, and acute care services for substance abuse are included in the full report. PCG understands that many of these services exist in area programs, but some will require development. All will need to be structured specifically to meet benefit package requirements.

6. ***North Carolina needs a new plan of action for caring for the psychological and emotional needs of children.*** In caring for children and the needs of their families, this plan will build on the experiences of Carolina Alternatives and the Willie M Program. It will establish accountability for effectiveness and clinical outcomes. More specific recommendations are:
 - *Develop local inter-agency partnerships for the care of children based on the concept of “joint total responsibility” for program outcomes.* These programs should be supported by the respective State agencies. Funding allocated by the legislature for that specific purpose would be an incentive.
 - *Expand the Willie M. program by adding new target populations to be served under that administrative umbrella.* Using the 20% annual turnover rate, the populations served can be slowly increased without increasing the budget.
 - *Continue to develop alternatives to hospitalization and long-term residential placement.* Alternatives include: expansion of model programs for emergency assessment and crisis intervention; crisis respite; home-based family treatment; and school-based intervention.
 - *Promote early identification and intervention for children at risk for severe emotional disturbance, sexual offenses, and substance abuse.*
7. ***PCG recommends an annual review and modification of the benefit packages based on outcome evaluation data.***
8. ***Responsibilities for monitoring and managing the system of care should be clearly designated to the re-organized DMHSAS and the County Programs.*** Specific recommendations designate the changes in roles of the Division and of the County Programs in the following domains: standards of care; utilization management; appeals/grievances; quality management; outcome evaluation; consumer satisfaction; clinical guidelines. This plan provides a comprehensive structure for managing the system of care with appropriate checks and balances at each level.
9. ***Consumers and families must be actively involved in leading the effort to manage and monitor the system at every level.*** The involvement required of consumers and their families includes but is not limited to: initial process design with DMHSAS; management input at the county level; quality management; serving on grievance and appeals committees; and serving on advisory groups for developing guidelines.
10. ***DMHSAS should develop a Statewide training plan and resources to support the new service structure in the County Programs and the new role of the State hospitals.*** This plan should identify core clinical competencies required to provide cost-effective essential clinical services across State facilities and Area Programs. These competencies should include: standard assessment and evaluation skills for all disability and age groups, crisis stabilization and ongoing treatment techniques and targeted treatments for special populations. Particular attention should be paid to children’s treatment, treatment for adults and children with co-occurring mental health and substance abuse disorders and in providing culturally sensitive treatment for minority populations, including the State’s rapidly growing Hispanic population.

OVERVIEW

This section analyzes how mental health and substance abuse services are funded, and how North Carolina compares to other "peer group" States and to national patterns of public financing. Attention is given to the role of Medicaid as a primary funding source, to the multiple State agencies involved in managing Medicaid funding, and to the role played by Area Programs in Medicaid billing and operations. Different patterns of local financing by counties Statewide are analyzed. Certain issues in State financial operations are reviewed.

The recommendations of this section build on the primary recommendations made in earlier sections, including: governance and finance; basic service benefit packages; financing according to target populations; and moving resources from State hospitals to community-based services. Additional recommendations are made to strengthen the financial health of the system, including recommendations for: improving billing and collections; establishing comparable financial standards and practices across the State; and improving the development of Medicaid policy and operations in support of mental health and substance abuse services. It should be noted that PCG does not recommend moving the system toward managed care financing. Many current issues would have to be resolved, and new standards for operations would have to be met, before a managed care approach would be feasible for North Carolina.

FINDINGS

Finances

1. ***North Carolina's overall funding for mental health and substance abuse services is \$73 per capita.*** This is slightly higher than the *per capita* expenditure of \$71 in the "peer group" States analyzed and higher than the national average of \$64. North Carolina ranks 22nd among all states in overall mental health and substance abuse financing.
2. ***North Carolina spends a high percentage of its budget on State hospitals, with 44% of its budget used to support the four State hospitals.*** Both the peer groups and national average is 37%. To reach this average expenditure, North Carolina could shift \$38 million from State hospitals to community services.
3. ***North Carolina's State expenditures for funding clients covered by the Willie M. lawsuit totals \$59 million for about 1569 clients.*** This is about 35% of the State's overall contribution for community mental health services. The expenditure for Willie M clients is \$37,000 per client.
4. ***State expenditures for community mental health services for the 217,653 people who are not Willie M. clients totals \$73.4 million, or \$337 per client.***
5. ***State expenditures for community substance abuse services for 87,215 people totals \$34.6 million, or \$396 per client.***
6. ***The high level of State commitment to its hospitals and to the Willie M. clients makes it increasingly difficult to provide quality services, or any services, to individuals who are neither a member of a court class nor receiving services in one of the State hospitals.***

Finances and Financial Operations

7. ***Total Area Program budgets increased by 25% over the last four years, due to continued increases from court-ordered services and increased funding at the county level.*** State funds, Medicaid funding, and other third party funding have grown slowly. Funds available for non-Medicaid, non-class clients have stagnated.
8. ***Area Programs receive funding from 11 different sources, most of which require their own form of reporting and documentation, as well as having their own rules as to which clients may be served.***
9. ***Counties provide more than \$91 million in cash to the system.*** This is about 12% of their financing. If their non-cash contributions were taken into account, their contribution would increase considerably.
10. ***There is wide variation among Area Programs in budgets and administrative costs.*** The largest Area Programs (there are 14 with budgets over \$20 million), provide an average of \$2,689 per client with an overhead rate under 6%. Smaller Area Programs (there are 25 with budgets under \$20 million), provide an average of \$1,967 per client, with an overhead rate of almost 11%.
11. ***The State hospitals' allocation of beds per Area Program has not been updated by DMHDDSAS since 1995. As a result, the allocation is meaningless.*** Area Programs are not charged for overuse of State hospitals. This creates the wrong incentives for the system's most expensive and restrictive services, and it undermines the use of more appropriate and cost effective local resources.

Financial Operations

12. ***Many Area Programs are struggling with the requirements for Medicaid billing and compliance and with those of other third party funding sources.*** Substantial amounts of potential third party income is not billed and not collected.
13. ***The State uses four different systems for unit cost reimbursement: Medicaid, Pioneer, Thomas S., and Willie M.*** These are not integrated, thus increasing Area Program's administrative costs and the potential for errors.
14. ***Private providers are faced with different requirements for contracting and documentation from each Area Program.*** This increases local administrative costs and time, particularly for Medicaid payments.
15. ***The Management Information Systems (MIS) used by Area Programs vary widely, from state-of-the-art systems to older systems that are inadequate and expensive to maintain.*** Tying into the county's MIS has not been adequate in most cases.
16. ***In spite of considerable State oversight of reporting and accounting, DMHDDSAS has not been able to identify financial issues and prevent financial crises at the Area Program level.***
17. ***The current relationship between DMA, DMHDDSAS, and the Area Programs is loosely coordinated and not well defined.*** This has created documentation, cash flow and administrative cost problems for Area Programs and providers.

RECOMMENDATIONS

1. ***DMHDDSAS should develop a financing process for new basic benefit packages that, over time, will allow access to services for all North Carolinians.*** The financing process should acknowledge the actual costs of services, require full use of Medicaid and other third party resources, and clearly define the State's funding responsibility.
2. ***DMHDDSAS should define target populations and the services required by those populations. It should establish a "matching process" for additional funding for new services.*** All counties would be required to maintain their current level of funding and services for seriously and persistently mentally ill persons and for other target populations. Only new, expansion dollars would benefit from this matching process. The matching formula would provide incentives for all counties to participate and it should accommodate counties that are financially distressed. For example, the State might initially require a 20% cash contribution from counties, and a 10% match from those financially distressed.
3. ***DMHDDSAS should develop a financing process for moving funding from the State hospitals to County Programs.*** The projected closing of 667 beds will save the State from \$38 million to \$51 million. These funds could be leveraged to purchase \$71 million to \$95 million counting all reimbursements to reduce State hospitalizations. This process should include at least four components:
 - An opportunity for County Programs to develop detailed proposals that demonstrate their interest and ability to reduce use of State hospitals.
 - Initial funding of those proposals by means of a State-managed "bridge fund" that would allow unspent hospital resources to be used for this purpose and to be carried over at year's end. State "bridge funds" would be available for two years.
 - A hospital downsizing management program and accounting methodology that would aggressively consolidate hospital operations and reduce costs. Hospital resources would be allocated to the County Programs within two years, freeing up the State 'bridge funds' to initiate further downsizing.
 - A realistic and annually adjusted allocation of State hospital beds that would require County Programs to pay the full cost of overuse of State hospitals. This should be coordinated with the 667 bed reduction goal.
4. ***A standard accounting of county contributions to mental health programs should be established.*** This should include cash and non-cash contributions, such as building and space costs, transportation, and other in-kind local resources. Once this methodology has been developed, a floor should be established for cash and non-cash contributions. This new methodology would encourage aggregate use of county resources by the new County Programs.
5. ***The Willie M. program should be re-evaluated to permit more flexibility to serve additional, newly defined groups within the current budget.***
6. ***The State should pass a mental health parity law that builds upon the Mental Health Parity Act of 1996.*** It should allow County Programs and contracted providers to become preferred providers.

Finances and Financial Operations

7. ***In order to increase and maximize the amount of Medicare reimbursement in the mental health system, DMH should develop technical resources to assist County Programs. Currently, these skills are limited at both the community and State level. These resources need to assist County Programs with the technical aspects of establishing compliant programs and billing processes/requirements.***
8. ***PCG strongly recommends continuation of DMH's Residential Treatment initiative for Children in DSS custody and the plan to maximize available financial resources for these services.***
9. ***The current confusion among all parties concerning the specific role of Area Programs in the system needs to be clarified. Other than in certain parts of the system, Area Programs currently play varying administrative and service roles. It is necessary to establish in the new county-based system, County Programs as the "lead agency" on behalf of Medicaid and the State.*** Some of these administrative tasks lie clearly in the centralized domain of DMA while other tasks could be the responsibility of DMHSAS, DDD or the County Programs. There are some tasks that could be the joint responsibility of the parties. ***During the implementation phase of the new system, DMHSAS, DDD and DMA will be responsible to finalize the specific scope of responsibility of County Programs prior to contract negotiation. A detailed contract or memorandum of understanding between DMHSAS, DDD, DMA and each County Program would be required to document the relationship, as well as the roles of DMA and DMH.***
10. ***A target should be established for maximum County Program administration costs.*** Due to the expected variation in County Program size, the target should be a percentage of total expenses rather than a specific dollar figure.
11. ***DMH must develop and implement a singular Unit Cost Reimbursement (UCR) system.*** The current Pioneer system is outdated and ineffective while the Willie M and Thomas S systems create additional administrative requirements. The system needs to include consistent service definitions across all funding sources and client-specific reporting.
12. ***PCG recommends increasing the financial participation of Counties through a minimum contribution level as the system migrates to a County-based operation.*** Counties must be incentivized to increase both direct (cash) and indirect (in-kind services and facilities) participation.
13. ***In order to improve private providers' financial stability and cash flow, the State should enroll private providers directly with Medicaid, removing Area Programs as financial intermediaries.*** This would decrease County Program administrative costs through eliminating duplicated efforts. Private providers would use their own Medicaid provider numbers to submit claims.
14. ***There is a need to streamline the contract management process in order to decrease administrative costs, improve results, and decrease frustration levels.*** Overall, the premise is the State setting standardized policies, procedures, and documentation while locally the County Programs are executing the processes in a coordinated fashion without unnecessary duplication of effort. The end result is lower administrative costs for both the County Programs and private providers.
15. ***The State should standardize the private provider accreditation process and require County Programs to either internally accredit private providers located within their own catchment areas or use the results of the COA process more effectively without adding a duplicative administrative effort.***

Finances and Financial Operations

16. ***Standard intake protocols should be implemented across all County Programs.*** Financial information gathered during the intake process is extremely important in maximizing County Program revenue.
17. ***We recommend that DMH establish a unit to oversee the County Programs' financial performance and provide guidance.*** In the Governance and Structure section of this report, PCG has recommended that this responsibility lie within the newly established Office of County Programs (OCP).

OVERVIEW

This section uses the findings and policy recommendations from the preceding work to build two financial models: one for hospital downsizing and one for the basic benefits package. These models demonstrate a progression from program policy to financial policy in order to develop a broad foundation for transformation of the system.

HOSPITAL DOWNSIZING

Findings Regarding Hospital Downsizing

1. *PCG's analysis and models for hospital downsizing have been based on four factors:*
 - The analysis takes careful consideration of each element of current expenditures, both fixed and variable costs, at the State Hospitals.
 - The projection of expected savings from a downsized State Hospital system takes into consideration the current number of inpatient beds at each facility; the specific units and types of service provided at each facility; and the related cost of operating these services.
 - The downsizing model is based on a transition period of five years and an expectation that the State will set realistic goals for decreasing inpatient beds from these hospitals, and that the State will ensure that these goals are correlated with the overall goal of reducing 667 beds by FY 2004.
 - In order to achieve this model of downsizing, the State must make an initial investment into the mental health system. This investment will be needed to increase the service capacity within the community. The State investment should serve as "bridge funding" until savings can be realized from downsizing State Hospitals. These bridge funds should be available in "stages" of at least two years.

2. *PCG's model compares the costs and the revenues of the current system to two different options: a four-hospital model with an overall decrease in inpatient beds of 667 or a three-hospital model with an overall decrease of 667 beds.*
 - The current operating costs of all four State Hospitals is \$272 million. Patient care services represent \$241 million of these expenditures. With the current capacity of 2288 beds, the patient care cost is \$105,307 per bed per year or \$289 per diem.
 - Current Hospital patient care revenues total \$58 million, resulting in a net-State cost of \$183 million. These net-State costs are partially offset through the Federal funding of DSH, which amounted to \$96 million in FY 99.
 - In the four-hospital model, all four State Hospitals would remain in use but with a reduction of a total of 667 beds. This would reduce patient care operating costs to \$191 million, an annual savings of \$50 million. The annual cost per bed would be \$117,829 per year, or \$322 per day. This is 12% higher than the current operating cost per bed.

Financial Modeling: Hospital Downsizing and Basic Benefits

- In the three-hospital model, three State Hospitals would continue in operation and the Dorothea Dix Hospital would be closed, with an overall reduction of 667 beds. This model would reduce patient care operating costs to \$173 million, an annual savings of \$68 million. The annual cost per bed would be \$103,591, or \$283 per day, a decrease of 2% over current operating cost. The per bed and per day cost projections exclude \$3 million in non-patient expenses required to maintain the Dix campus.
3. ***The three-hospital model represents a net advantage.*** The net advantage is \$18 million in annual operating expenses in four years. Of the incremental operating saving, the three-hospital model achieves \$13 million in additional savings over the four-hospital model which would be available for developing additional community programs to replace certain services currently provided in State Hospitals. A total of \$51 million could be transferred to the new County Programs.
 4. ***Recent changes to the federal disproportionate share hospital (DSH) program will decrease the revenue streams that North Carolina will derive from the State hospitals.*** In August of 1997, the US Congress passed the Balanced Budget Act of 1997 (BBA 97). In FY 99, North Carolina received \$96 million in Federal funding under the DSH program. Due to changes imposed under BBA 97, Federal funding of the DSH program will decrease by \$15 million beginning in FY 03.
 5. ***One mechanism for reducing reliance on IMD DSH funds is to reduce the use of State hospitals and, instead, to serve those patients in community settings.*** Services in community hospitals, residential programs, nursing homes and other community-based programs are eligible for reimbursement under traditional Medicaid.
 6. ***Two important requirements must be taken into account in a financial model for downsizing the State Hospitals:***
 - the need to create a predictable flow of resources for financing community services to replace services which are currently provided at State Hospitals
 - the need to reduce the losses to the General Fund that result from providing services at State Hospital which are not reimbursable under Medicaid due of the Federal reimbursement limitations for hospital-based psychiatric services.

Recommendations for Hospital Downsizing

1. ***North Carolina should immediately begin the reduction of 667 beds from its State Hospitals.*** This will create opportunities for transferring funds from State Hospitals to community-based operations.
2. ***The three-hospital model should be adopted.*** The three-hospital model provides significant financial benefits to North Carolina, by creating additional funding for community services.

PCG believes that the differences between the three- or four-hospital models are more significant than is immediately apparent. Although the cost reduction projected for four hospitals is feasible and well-documented, achieving and maintaining this reduction would require continued and aggressive management at all four hospitals. The three-hospital model is more likely to achieve its financial goals.

3. ***The State should establish a special “Dorothea Dix Mental Health Transfer Account” that would account for all of the savings and revenue operations accrued from hospital downsizing.*** All operational savings should be budgeted to this new fund before being allocated to County Programs. If revenue opportunities are created as a result of the closure of Dix, for example through lease agreements of the land or property, a portion of that money should be placed in the Transfer account. It will be crucial for the State agencies to regain the public's trust in its financial management of mental health resources. The Dorothea Dix Transfer Account will add an opportunity for public review and scrutiny of the process.

BASIC BENEFIT PACKAGE

This section provides a financial model for a basic benefit package for North Carolina. Benefits included are a core group of services that should be available to each citizen of North Carolina, regardless of location or ability to pay. PCG recommends that these services, offered as basic benefits for all citizens, be provided by each participating County Program and funded through a combination of State and other sources.

The availability of a basic benefit package assures a consistent level of care across County Programs. A consistent funding mechanism allows the State to distribute the funds allocated by the General Assembly on an equitable basis. County Programs could use additional local dollars to expand services based on the needs of the region.

PCG developed this financial model for the basic benefit package in two phases. In Phase I, the PCG clinical team performed a detailed analysis of the services available within the system. During the second phase of the study, the team completed a thorough review of standard clinical practices and methods of delivering care as found in other states. Based on this information, the team developed a proposed basic benefit package for North Carolina. (See section 2.4)

PCG has developed a financial model to estimate the cost of the basic benefit package. Although the State provided PCG with substantial data, much of it was inconsistent or conflicting. Other data was not available. It was not possible to attain a high degree of certainty in the determination of costs for the basic benefit package. Where data was conflicting or unavailable, PCG was forced to make assumptions based on experience in other states and knowledge of North Carolina's mental health and substance abuse systems. Despite the use of assumptions to calculate the cost of the basic benefit package, the projections included in our report reflect a reasonable cost associated with these services.

METHODOLOGY

PCG analyzed current utilization statistics to determine the number of people who might need mental health and substance abuse services in future years. This number was used to estimate utilization of these basic services. Medicaid rates were used to calculate the total cost of each component of the basic benefit package. While PCG does not endorse the use of Medicaid rates to determine the cost of benefits, these rates provided the most comprehensive data available. Estimating the total amount that would be collected from Medicaid, Medicare, commercial insurance, and self-pay clients, PCG determined an estimated net cost to the State. The net State cost is the revenue needed by the State to fund the basic benefits package at the local level.

Findings Regarding the Basic Benefit Package

1. ***Implementation of the complete assessment benefit, for all new clients entering the system annually, would cost an estimated \$26 million.*** A projected 100,000 clients per year will enter the system. Of this cost, mental health clients account for \$18.6 million and substance abuse clients for \$7.4 million.
2. ***This benefit includes up to three sessions for initial assessment, one session for psychiatric evaluation, initial case management, and psychological testing, if needed to clarify eligibility for intensive services.***
3. ***Implementation of the new benefit for acute care is estimated to cost \$17.5 million.*** Of this cost, mental health clients account for \$14.0 million and substance abuse clients for \$3.5 million.

This benefit, for acute mental health care, includes:

- Urgent assessment by a qualified clinician, available 24 hours a day, every day
- Inpatient treatment for up to 15 days.

Acute care for substance abuse includes:

- Urgent assessment by a qualified clinician with expertise in substance abuse, available 24 hours a day, every day
- Medically monitored inpatient detoxification for up to 5 days
- Clinically managed residential treatment for up to 10 days.

4. ***Implementation of a variety of non-hospital "step down" services that permit clients to avoid hospitalization is estimated to cost \$53.4 million.*** Of this cost, mental health clients account for \$40.5 million and substance abuse clients for \$12.9 million.

As part of this benefit, unused inpatient benefits can be converted to non-hospital services, on a two for one basis, so that two days of non-hospital services are allowed for every day of unused hospital-based services

5. ***Implementation of a new short-term treatment and follow-up benefit is estimated to cost \$22.2 million.*** Of this cost, mental health clients account for \$15.8 million and substance abuse clients for \$6.4 million.

This benefit includes:

1. Initial psychiatric consultation and medication follow-up visits
 2. Six individual or family outpatient sessions
 3. Conversion of unused individual outpatient sessions to group treatment, on a two for one basis
6. ***PCG estimates the total cost for this benefit package to be approximately \$119 million.*** Of this cost, mental health clients accounted for \$89 million and substance abuse clients for \$30 million. The marginal cost to the State of this new benefit package will be substantially reduced, because many local Area Programs currently offer these services, or more extended services, and most of these services are eligible for Medicaid and other third party reimbursement.

Introduction of these benefits will have a substantial impact on the use of State Hospitals for acute care and detoxification. Of the 667 beds to be closed, approximately 141 beds are currently used for acute care and detoxification episodes that would be covered by the new basic benefit. The operational savings of hospital costs should be factored into the cost of this new benefit.

Recommendations for the Basic Benefit Package

1. ***North Carolina should implement a standardized, affordable benefit for assessment and acute care services Statewide.*** This will have a direct impact on the use of State Hospitals for short-term inpatient hospitalization and detoxification.
2. ***Preliminary review of the findings indicates that savings achieved under the three-hospital model might support the cost of the Basic Benefit Package without additional operating funds.*** Capital funding, bridge funding, and DSH-replacement funding are still required. Funding of target populations may require additional funding once the system is better aligned under the County Board structure.
3. ***More work needs to be done to arrive at the true cost of the Basic Benefit Package, including actuarial analysis with standardized data sets.*** The model presented in this analysis projects a reasonable cost of the proposed Basic Benefit Package, however, a more thorough investigation into the existing service system is required to determine the utilization and cost of these services and to determine the levels of services which already exist in the system.

OVERVIEW

The success of Statewide reforms to mental health systems depends both on widespread support and on an implementation plan that balances the goals of system change with the realities of public management and financing requirements. Many reforms that have begun with strategies supported by legislators, State mental health officials, consumers and their families, advocates, and providers have succumbed to the pressures of an implementation process that could not reconcile the issues of daily management with major system change.

Information from other states which have had success in implementing major changes in their mental health systems provides valuable insights.

- It is not necessary to convert the whole State system at once. A phased-in process can be successful.
- It is helpful to have an oversight group representing consumers, families, public officials, and legislators to monitor and guide the implementation process against the goals of reform. The oversight group is not the subject of the changes, but serves as a trustworthy and credible third party committed to transforming the system.
- Initially, daily business operations should be managed apart from the detailed planning for new initiatives. When new initiatives are completely ready for implementation, they can be brought under the umbrella of operations.

It is recommended that North Carolina implement these changes in three phases: (I) legislative, (II) planning and (III) system rollout. Each phase carries distinct responsibilities and objectives and each is overseen by an entity of State government. Full implementation is expected to take approximately five years, beginning April 2000. It is important to note that during that time frame North Carolina will be administering two systems, the current Area Program model and the replacement County Program model. The restructuring of the Developmental Disabilities Division is also to be accomplished during the first two phases of implementation. The implementation process summarized below is based on the recommendations in the full report. Significant changes in approach would, of course, require changes in implementation.

PHASE I – ENABLING LEGISLATION (APRIL-JUNE 2000)

Implementing changes in the governance structure will require major revisions in Chapter 122C and Chapter 159 of North Carolina's General Laws. These changes would enable counties and multi-county associations to administer the State's mental health system but would not create "unfunded mandates" for the counties. General guidelines for County Boards and Advisory Committees would specifically require that interested Commissioners and knowledgeable consumers, family members and advocates for mental health, developmental disabilities and addiction services be involved in the county governance structure. It is assumed that these changes could be enacted during the upcoming short legislative session.

PHASE II – IMPLEMENTATION PLANNING (JULY 2000-DECEMBER 2001)

Implementing the changes in the State's enabling legislation for mental health, developmental disabilities and substance abuse services, as well as implementing the policy recommendations in this report, will require an intensive and broad-based planning process that PCG estimates will take 18 months. We see the *planning* work proceeding on three separate but related tracks: (1) mental health structure, services, and finances, (2) developmental disabilities organizational change, and (3) State hospital masterplanning. In addition, there is *a critical fourth track for public information and communications*, including working directly with county management and County Commissioners.

It is essential to have a credible and trustworthy public body to oversee this work. We recommend establishing a special Blue Ribbon Implementation Commission for a period of five years for this task. Two thirds of its membership should be comprised of Legislative leadership and interested State senators and representatives, with a third of the members appointed by the Governor to represent consumers, family members and advocates. Representatives from participating counties also should be on the Commission. The Commission should be designed to oversee and approve all major steps and decisions of the process, and should go out of business at the end of implementation.

The planning staff should have a structure that can coordinate efforts, as well as provide leadership for the work apart from daily operations. This should be handled by the Department of Health and Human Services, under the leadership of the Secretary, who oversees all the State agencies essential to implementation: DMHDDSAS, DMA and the Division of Facility Services. A high level project manager who reports to the Secretary will be needed to direct and coordinate the work. The project manager will need senior level staff drawn primarily from the affected agencies.

An outline of the work of implementation follows. More detail can be found in the full report.

Track 1 - DMHDDSAS Policies and Operations

Task A - Services

Task B – Finance and Financial Operations

Task C – Human Resources Planning

Task D –Structure and Operations of DMHDDSAS

Task E- County Contract Documents and Procurement Process

Track 2 – Developmental Disabilities Restructuring

Task A- Organizational Structure and Personnel Actions

Task B- Future of Developmental Disabilities Services

Task C – Financial Analysis

Task D – Office Plan

Implementation Process

Track 3 – State Hospitals and Facilities

Task A - Facility Masterplans for Umstead, Broughton and Cherry Hospitals

Task B - Closure Plan for Dorothea Dix Hospital

Task C-Dorothea Dix Mental Health Transfer Account

Task D Private Psychiatric Facility Improvements

Track 4 – Public Information and Communications

Task A – Public Information Products

Task B – County Communications

Phase II is expected to take 18 months.

PHASE III – ROLLOUT PROCESS (JANUARY 2002 - DECEMBER 2004)

The purpose of Phase III is to administer the process by which counties, working singly and in groups, enter into long-term contracts with DMHSAS and DDD. By these contracts, they will assume State funds, authority, and responsibility for providing mental health, developmental disability, and substance abuse services. It is assumed that not all counties will be prepared to enter into contracts initially, and the State will have to administer a dual system for several years while the County Program model is phased in. During this time, DMHSAS and DDD will continue to administer a system that is comprised of a declining number of Area Programs and a growing number of County Programs.

The heart of the process will be a Request for Application (RFA) process, in which counties will demonstrate their interest, commitment and capacity to enter into contracts with the State. They will be measured against State standards, not against each other. This will not be a competitive bidding process.

The RFA will encourage counties to form voluntary associations with each other. This could be done under different auspices such as local inter-county agreements, new county authorities, councils of governments, contracts, and other legal mechanisms, so that eligible residents will have access to a wide range of services and the counties will be able to establish a full range of cost effective administrative functions. It is anticipated that most single counties will not be able to meet the State's service, management, and financial standards. Partnerships of counties will need to be formed across the State. In some case, partnerships will be based on current Area Program configurations, in others, new partnerships will emerge. The State will determine the criteria for voluntary partnerships. The State will not independently determine the boundaries.

Pre-Qualification

During the pre-qualification phase, the State will assess whether counties are prepared to become County Programs. The State can use the results of the pre-qualification process to determine: (1) which counties are prepared to begin the Request for Application (RFA) process; (2) what work will be required to get the remaining counties prepared and (3) how the RFA process and contracting can be improved to reflect county concerns. At the end of pre-qualification, the State will determine which counties will be included in the first round RFA process, and which will be held for the second round.

First Round Application Process

The first round procurement will focus on counties that are ready to enter into contracts with the State to become County Programs. Only counties identified as ready during pre-qualification will be invited to bid as County Programs. The full report details the considerations that must be made as part of this process.

Once the State awards the contract, the counties will begin an implementation process that will require close coordination among the members of the county partnership and the Area Programs involved in the transfer. A key to the effective start-up of services will be a formal readiness review by the State. Implementation may be delayed if the County Programs are not able to meet State readiness standards. The first round will take 18 months.

Second Round Application Process

The second round application process should complete the RFA process Statewide. It will focus on the population not covered in the previous round. The steps in round two will be substantially the same as round one, with the possibility of modifications and improvements based on the experience of the first round process. The second round will also take 18 months.

Counties Not Participating

It is likely that a number of counties will not be prepared to meet the State's requirements or will not have sufficient resources to do so. In these cases, the State may exercise either of two options. The first is to encourage the formation of multi-county associations. The second is to form State-organized programs for those counties, particularly those which appear unwilling to participate. These State programs would meet identical standards, but would do so under the auspices of DMHSAS. County Commissioners would have no authority or responsibility for mental health, developmental disability and substance abuse services. They would be expected to maintain their cash contributions at current levels, as well as pay the State a management fee.

OVERVIEW

This portion of the study focuses on the State administrative structure for North Carolina's developmental disabilities (DD) system. The study's objectives were:

- To document the challenges and issues facing North Carolina's public developmental disabilities system.
- To analyze ways to address these issues through changes in the management structure. The DD study specifically addresses two alternatives: creating an independent Division of Developmental Disabilities or restructuring the management of the current Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS).

DEVELOPMENTAL DISABILITIES SERVICES IN THE NATIONAL CONTEXT

Services for people with developmental disabilities and the policies that shape those services should be considered in the context of national trends. There are fundamental difference in the principles and philosophies that guide services for people with developmental disabilities and those that guide mental health and substance abuse services.

1. *The high number of non-institutionalized people with developmental disabilities highlights the need to develop a service delivery system that does not depend upon public institutions to provide care.* More than 3.6 million non-institutionalized Americans have either mental retardation or developmental disabilities. Only 1 out of 10 of them lived in a residential setting in 1998.
2. *Deinstitutionalization of people with mental retardation and related developmental disabilities has been different and far less problematic than for the mentally ill populations.* The population of persons with mental retardation and developmental disabilities is more stable, easily identifiable and definable than those with mental illness. The nature of admissions to psychiatric facilities tends to be episodic and transitory. Consequently, psychiatric facilities often have persons who are reinstitutionalized, whereas facilities serving the mentally retarded and developmentally disabled population do not.
- *The principles underlying new systems of services for people with developmental disabilities emphasize the following:*
 1. People with disabilities can and should live in communities as fully participating members. People with developmental disabilities have the same needs for social connectedness as do any other persons living in communities.
 2. Support systems should be designed to respond to the unique situation of each individual in his or her community, rather than mandating that people be made to fit into available program "slots."
 3. Consumers should be able to exercise the right to make choices about where and with whom they live, how they spend their time, and how the supports they need are provided.
 4. The task for the public developmental disabilities system is to assist consumers in making informed choices and to ensure that meaningful choices are available.

Developmental Disabilities Structure

- *National trends and the experiences of other states emphasize the following:*
 1. There are not sufficient resources to meet the current demand for residential services; an additional 20% funding would be needed.
 2. Growing waiting lists and increasing concern from aging parents place serious pressure on existing service agencies.
 3. There is a need to fully develop local services that emphasize supports and consumer and family control over resources to meet growing demand.
 4. Monitoring of the service systems' performance through outcome assessments results in an improved quality of life for those with developmental disabilities and their families.
 5. New pressures on direct support workers, especially in a full-employment economy, mandate planned efforts to recruit, retain, and insure competence of direct support staff.
 6. In the *Olmstead* decision of 1999, the Supreme Court required that States provide community-based services for people with mental disabilities, as long as treatment professionals determine such services to be appropriate and the affected individual does not object. The Court also requires that States demonstrate that they have a comprehensive, effective plan for placing people in less restrictive settings. States must make good faith efforts to move people from waiting lists into community programs at a reasonable pace.

FINDINGS

North Carolina Within The National Context

North Carolina's financial support for services for its citizens with developmental disabilities is only slightly less than the national average. This level of parity was achieved when North Carolina's per capita expenditures for developmental disabilities services increased more rapidly between 1988 and 1996 than did the national rate of increase. Overall, North Carolina has followed the general national trend of shifting residential services to smaller, community living arrangements. However, the average number of persons served at residential sites remains considerably higher in North Carolina than the national average. North Carolina will not keep up with demand for services unless new, cost-effective models are developed.

1. ***Expenditures for developmental disabilities services in North Carolina are about on a par with other states.*** In 1996, per capita spending for developmental disabilities services nationwide was \$86.30; in North Carolina, it was \$85.17.
2. ***North Carolina serves a greater proportion of its people with developmental disabilities in large State-operated residential centers than is the national norm.*** North Carolina is 45% higher than the national average in its reliance on large State facilities.
3. ***Residential services are less widely available in North Carolina than nationwide.*** The gap between the availability of residential services and the demand for them was higher in North Carolina in 1998 than in other states.

4. ***Residential services for people with developmental disabilities are provided in ICFs/MR 35% more frequently in North Carolina than in the rest of the nation. Since a greater proportion of Medicaid recipients in North Carolina are served in ICFs/MR, the State's per recipient expenditure for these services is one-third higher than national levels.***
5. ***The CAP/MR-DD program expanded considerably, but North Carolina has not used the Medicaid HCB waiver program to pay for community services as extensively as have other states. As a result, the more flexible and cost effective waiver services represent only 22% of spending in the community, about half the national average of 42%.***
6. ***In 1999, North Carolina officials reported that 6,126 persons with developmental disabilities had been put on waiting lists for residential services because the necessary services were not available. This is the 6th highest per capita rate in the country. Two thousand people have been on the waiting list for more than two years.***

FINDINGS ON NORTH CAROLINA'S STRUCTURE

PCG conducted interviews with key State officials involved in Medicaid and in developmental disabilities, mental health and other human services. Self-advocates, family members, and providers were also interviewed. Site visits were made to four regional MR/DD centers, and all five directors were interviewed. Site visits to six Area Programs included interviews with program administrators, providers, and case managers. Area Programs visited were: Catawba, Mecklenburg, Tideland, Smoky Mountain, V-G-F-W, and Wake.

Findings Of Interviews And Site Visits

1. ***The array of supports offered to people with developmental disabilities and their families is limited and the ability of the system to meet individually tailored needs and preferences is constrained.***
2. ***Existing quality assurance systems and contract oversight mechanisms are geared to measure input and process, but have little relevance to the outcomes of intervention for people with developmental disabilities.***
3. ***Staff turnover has a negative impact on service quality, both in direct support and in case management.***
4. ***The administration and expansion of the home and community based waiver is improving, but still has not acted as a catalyst for the development of more flexible supports. This is critical in view of the inflexibility of other funding sources.***
5. ***There does not appear to be a consensus among stakeholder groups about the future delivery of supports to people with developmental disabilities.***
6. ***Regional Centers increasingly see themselves as providers of specialized services and training for local programs and providers.***
7. ***At the Area Program level, many of those interviewed expressed concern about the administrative burden that might fall on local administration if a separate division for developmental disabilities were created.***

8. *There is no consensus as to the best structure for the developmental disabilities system. There is ongoing concern that the problems experienced in the mental health system are draining resources and energy away the challenges facing the DD system.*
9. *The local administrative structure of Area Programs resembles a behavioral program with a developmental disabilities component added on.*

Findings of DD Experts Panel

In January, 2000, the North Carolina Office of the State Auditor, in conjunction with the North Carolina Institute of Medicine at the University of North Carolina at Chapel Hill, sponsored presentations by a panel of State directors of developmental disabilities services. They represented Pennsylvania, Oregon, South Carolina, Missouri, states with effective, but varied models for service delivery. These presentations highlighted certain necessary ingredients and conditions for successful State oversight and policy direction of MR/DD services and supports:

1. The State provides categorical funding for MR/DD services to the local point of service delivery or purchase of service.
2. Control and influence over Medicaid waiver policy and reimbursements lies with the MR/DD agency.
3. The HCBS waiver plays a central role in shaping the kinds of services and supports offered and in making the system more responsive to individual consumers and families.
4. Comprehensive local plans are developed to phase down public institutions.
5. The importance of person-centered planning and respect for individual choices and preferences is clearly recognized.
6. Outcome-based performance expectations are developed specifically for mental retardation and developmental disability services.
7. There is a direct line of authority from the State agency to the local agencies which provide or purchase services.

CRITERIA FOR STATE-LEVEL STRUCTURAL CHANGE

Based on an analysis of all of the site visits and interviews, reviews of previous reports, analysis of the allocation of resources in the State, and demographic and service utilization information, PCG recommends the following criteria for selecting a structural arrangement for the State's developmental disabilities system. Any new structure should:

1. Facilitate implementation of the recommendations of the PCG *Study of State Psychiatric Hospitals and Area Mental Health Programs* in a manner responsive to the interests of stakeholders in the developmental disabilities system. Provide a platform and the necessary authority to develop strong leadership at the State level.
3. Create momentum, resources, and direction for a unified vision--both for programs and for policy--for the developmental disabilities system across the State.

4. Secure fiscal accountability for funds used for the developmental disability system, and keep that funding in alignment with system goals.
5. Facilitate the expansion of a flexible HCBS waiver geared to individual supports
6. Ensure the ongoing stability of service providers, and enhance training and the likelihood of retaining direct support professionals within the State.
7. Provide an emphasis on the measurement of outcomes that are relevant to the lives of people with disabilities and their families.
8. Make it possible to coordinate DD services and funding with other relevant services and funding streams.
9. Create a strong, meaningful role in State policy for people with developmental disabilities and their families and advocates.
10. Minimize the administrative burden on Area Programs and build on their strengths.
11. Minimize additional administrative cost and duplication of functions at the State level.

COST OF CREATING AN INDEPENDENT DEVELOPMENTAL DISABILITY DIVISION

PCG has investigated the costs of establishing an independent Developmental Disabilities Division. The figures developed for this purpose provide a reasonable estimate rather than an exact cost. PCG estimates that annual administrative costs would increase by \$1,505,000 - \$2,283,000 if a separate Developmental Disability Division were created.

RECOMMENDATIONS

Based on the factors described in the report and on analysis against the criteria, PCG recommends that the Secretary of Health and Human Services create a separate Division of Developmental Disabilities. *It is extremely doubtful that the State, acting under the current structure, would be able to develop the necessary resources, leadership, and momentum to meet the growing challenges and provide for the needs of persons with developmental disabilities and their families.* It is important to emphasize that this recommendation is for reconfiguration at the State level only.

The report discusses a number of actions that should be explored as part of the design and implementation of a new Division of Developmental Disabilities:

- Preparation of a new DD plan that implements the PCG recommendations for the new County Programs.
- An organizational and staffing plan for the new division of developmental disabilities that demonstrates: (a) the administrative cost and source of funds for the new organization; (b) an organizational structure designed to administer the County Program contract and to provide adequate oversight and technical assistance; and (c) the ability to work effectively with the new DMHSAS Division, under the auspices of the Blue Ribbon Implementation Commission and the Secretary of the Department of Health and Human Services.

PROJECT METHODOLOGY FOR MENTAL HEALTH AND SUBSTANCE ABUSE STRUCTURE, SERVICES AND FINANCES

PCG's Study of State Psychiatric Hospitals and Area Mental Health Programs was initiated under a contract with the Office of the State Auditor in February 1999. It has spanned 14 months, from February 1999 until submission of the final report in April 2000. The original legislature requested a study composed of the following two phases:

- Phase I: Analyze the costs of construction and operation of new facilities as versus redesign and long-term operation of the State's four existing psychiatric hospitals
- Phase II: Assess the community mental health system

Another phase was added in August 1999:

- DD Phase: Review the state-level organizational structure of the developmental disabilities services, and whether a separate developmental disabilities division should be established.

This section outlines the methodology to complete the first two phases listed above. The methodology for the DD Phase is contained in Section 3 of this Report.

Even though each phase of this study had separate timeframes and scopes of work, the phases are inter-related and dependent upon each other as they all effect the same State and local service system. The staff who worked on the different phases communicated regularly with each other in order to fully understand the overall project. This Report includes PCG's analysis, findings, and recommendations for all the phases of the project.

The Office of the State Auditor recommended and PCG implemented a consultation process that attempted to gather input from all affected parties. Our methodology included public meetings, interviews, written input, and status reports to various constituencies across the State. We interviewed advocates, family members, clients, Area Program management and Area Board members, County Commissioners, county management staff, DMHDDSAS staff, DMA staff, DHHS staff, as well as private providers. All of this input was reviewed by PCG personnel and used to formulate our findings and recommendations.

PCG utilized an experienced project team with varying skill sets with both national and North Carolina specific knowledge. We augmented our team with subcontracted clinicians and architects, described below. Marc H. Fenton, one of the five Principals in our firm, served as the Project Director. He coordinated and directed the assessment, planning, and operations of all phases. Mr. Fenton has more than ten years experience in state psychiatric hospital operations and management, and more than twenty years working with public mental health and developmental disabilities agencies across the nation. He, along with other Boston staff, spent an extensive amount of time on-site in North Carolina during this consultation.

Our consulting team included a clinical team anchored by individuals with a significant number of years in the field. The team was led by Stuart Koman, Ph.D., who has more than twenty years experience in the field of behavioral health, and Gail Hanson-Mayer, a clinical nurse specialist with more than twenty years experience in program development and implementation. Additionally, we utilized experienced personnel dedicated to the analysis of the financial, governance, and operational aspects of the system. Although PCG's central office is in Boston, a large portion of our team was drawn from our Charlotte, North Carolina office, and worked under the direction of Grant Blair, a PCG Manager. This office has

extensive experience with the State's public mental health system, including Area Program operations. Its staff brought first-hand experience in previous engagements working for various Area Programs and North Carolina State human service agencies. As a result, PCG began consultation with significant insight into the issues facing Area Programs, private providers, and DMHDDSAS.

In order to bring the required technical skill and experience to the capital construction and renovation options for the State hospitals, PCG utilized planning and architectural subcontractors Christopher Pilkington and Hoskins, Scott & Partners, Inc., an experienced team who worked together on the Massachusetts Blue Ribbon Commission on State Hospitals and other projects across the nation.

PHASE I METHODOLOGY

PCG's Phase I approach began with a critical analysis of the March 1998 MGT of America Report, which had been commissioned by DMHDDSAS to analyze the operating efficiencies and construction/renovation needs at the four State hospitals. In order to verify and update their recommendations for State hospital downsizing, we reviewed their methodology, data collection, findings, analysis, and recommendations. We then developed additional approaches to analyzing issues and topics not addressed by MGT. PCG's Phase I Report (April 30, 1999) included our analysis and findings in the following areas:

- Facility
- Community Service Options
- State Hospital Bed Demand
- Federal Disproportionate Share (DSH) Revenue Projections

Facility Construction and Renovation

Hoskins, Scott & Partners, Inc. (HSP) analyzed the facility construction and renovation costs at the four State psychiatric hospitals. This analysis was initially presented in the Phase I Report, and was based upon hospital downsizing estimates in the MGT Report. It was revised during Phase 2, based upon new State hospital bed demand/downsizing projections developed by PCG. The final analysis is in Section 2.3 of this Report.

HSP utilized a multi-faceted approach to the problem that included:

- Review of MGT Report and pre-conference with key personnel from MGT and O'Brien/Atkins Architects
- Site visits to all campuses, including review of building plans
- Interviews with administrators, physical plan and direct care staff
- Review facility-generated repairs and capital improvements proposals (funded and proposed).

Estimates of capital costs were developed as concept-level repair, capital improvement and modernization costs for existing buildings and systems, based on a square-foot or systems-based cost analysis. Their working assumptions were based on North Carolina hospital projects and facility and agency reported data. Concept-level cost estimates for new construction were generated utilizing cost/square-foot and square foot/bed estimates.

Community Service Options

PCG reviewed MGT's recommendations that children, geriatric, and substance abuse patients be served in the community rather than the State's four psychiatric hospitals. Our methodology was limited to placing this policy in the context of nation-wide trends in the best practices for these populations; PCG did not believe that the issue could be fully analyzed without the extensive review of community capacity and system structure that was to be completed during Phase II of the consultation.

State Hospital Bed Demand

The bed demand analysis was presented in part in the Phase I Report, but extended throughout the consultation. Final recommendations are included in Section 2.2 of this Report. For the analysis of the state hospital bed demand, PCG selected from among several statistically sound approaches. Our criteria were to select methodologies that made the best use of the available data, were most actionable, and were most easily enhanced as superior information became available. This resulted in a simultaneous top-down and bottom-up approach.

The top-down approach refers to a comparison of overall mental health bed capacity and admissions data in North Carolina to nine other selected states: Illinois, Kentucky, Massachusetts, Michigan, Missouri, Ohio, Pennsylvania, South Carolina and Virginia. North Carolina's inpatient adult bed capacity, at 32.3 beds per 100,000 adults, was 23% higher than the peer group average. North Carolina's rate of admissions, at 243 per 100,000 adults, was the second highest in the group. This analysis provided an independent test of the reasonableness of the results of the bottom-up approach.

PCG's bottom-up approach was a variation on "best practice" benchmarking used in Total Quality Management. The "local best practice" model sought to identify existing Area Programs whose combined historical performance might serve as a future target for the entire state. These programs were not specifically the lowest utilizers of the state psychiatric hospitals. They were Area Programs generally regarded as well-run by key-informants in the provider and consumer communities.

The selected programs were profiled to establish that they did not differ substantially from the remaining programs in certain critical characteristics that were outside their control. A tentative state-wide target was then set at the historical utilization levels of the selected programs. This level was about 30% below the current state-wide average. Finally, the distance between the tentative state-wide target and every other program's current performance levels was examined. This analysis highlighted those areas and services that require the most immediate interventions, and could help each program to devise detailed strategies by which they may achieve the Division's objectives over the next several years.

In order to provide the State with the most accurate projection for hospital beds and facility recommendations, we revisited our downsizing projections during the last two months of this engagement. This analysis of the community mental health system provided us with additional and necessary insight to more appropriately recommend hospital bed requirements based upon our understanding of the community capacity. These revised estimates were used by Hoskins, Scott & Partners in Section 2.3 of this Report to revise their hospital renovation and construction cost estimates that were originally included in the April 10, 1999 Report.

DSH Projections

The Disproportionate Share Revenue (DSH) Projections were critically examined by Thomas Entrikin, a Manager at PCG, with twenty years of experience at the Health Care Financing Administration (HCFA). This source of revenue had been used by MGT to support an argument for rebuilding North Carolina's State hospitals. While PCG does not recommend a capital construction program based on these specific revenue sources, we did update MGT's estimates, including factoring in the effect that the Federal Balanced Budget Act of 1997 (BBA) had on North Carolina's DSH projections.

PHASE 2 METHODOLOGY

Our review of the community mental health system was conducted from March 1999 to March 2000. As stated, our approach was multi-faceted and included: data analysis, public meetings, advocacy group interviews, client interviews, provider interviews, Area Program site visits, state-level personnel interviews, regional meetings, and an expert panel, among others. Overall, our methodology was intended to invite input in writing and in person from numerous sources. This information was instrumental in developing our findings and recommendations in all of the areas of this Report.

Throughout our consultation, PCG has reviewed extensive materials on past analyses and reports related to the MH/DD/SAS system. A bibliography of the reports and other materials we have reviewed is provided in the Bibliography of this Report.

DMHDDSAS Review

PCG reviewed DMHDDSAS statutes, regulations and policies; we analyzed relevant aspects of its financial operations, management, organization and structure; and we reviewed (but did not attempt to verify) reports on clinical services, quality assurance, and program evaluation. Our methodology included interviews with senior level staff in MH, DD, and SAS services to elicit their views and perspectives on the current State and local operations of the system. We also interviewed senior level personnel from DHHS and DMA. This initial set of interviews provided a state-level perspective from various agencies concerning strengths and weaknesses, and various opinions and plans to improve the current system.

Area Program Site Visits

PCG's next step and the cornerstone of our methodology was a series of intensive on-site visits at eight Area Programs. The eight were selected based upon the criteria designed to provide a representative cross-section of the community system. The criteria ensured variations related to hospital catchment areas; single-county and multi-county Area Programs; rural and urban locations; and Area Program size. The Area Programs visited were:

- Rockingham County Area MH/DD/SA Program
- CenterPoint Human Services
- Sandhills Center for MH/DD/SA Services
- Wake County Human Services
- Southeastern Center for MH/DD/SA Services
- Wayne County Mental Health Center
- Mecklenberg County Health, Mental Health and Community Services

- Blue Ridge Center for MH/DD/SA Services

These on-site reviews were multi-disciplinary covering the following areas: clinical/services, financial operations/administration, and management/governance. Our team of six to eight consultants spent one to two days at each Area Program conducting interviews, visiting clinical programs, and analyzing data. Interviewees included Area Program Directors, Finance Directors, Board Chairpersons, Board Members, County Managers and Assistant County Managers, Clinical Program Directors, clients, and other various staff members. Data requests were used both before and after our visits to enhance our analysis.

An Area Program profile was drafted for each one of these on-site reviews. They were reviewed by representatives at each Area Program in order to ensure accuracy of Information. See Section 2.9 for a summary of our findings, and the profiles themselves.

Public Meetings

From June to August, the North Carolina State Auditor's Office conducted a series a regional public meetings across the State in order to garner input on the current system from the public. These meetings gathered input from various individuals on the current status of mental health, developmental disabilities, and substance abuse services provided in the community. Individuals from the community were able to verbally express their opinion to a panel of representatives from the Office of the State Auditor, North Carolina Institute of Medicine, Department of Health and Human Services, and Public Consulting Group, Inc. These regional meetings were very well attended with significant verbal and written comments submitted concerning strengths, weaknesses, issues, and concerns with the current system. In all, more than 520 individuals attended the meetings, with 206 addressing the panel directly. The following table lists the regional public meeting locations, dates and number of attendees:

Location	Date	Approximate Number of Attendees
Raleigh	June 15, 1999	40
Fayetteville	June 17, 1999	50
Greensboro	June 23, 1999	75
Asheville	July 13, 1999	93
Charlotte	July 15, 1999	67
Greenville	July 20, 1999	75
Wilmington	July 27, 1999	50
Newton	August 4, 1999	72

PCG staff members attended the regional public meetings, and transcripts of comments and copies of all written material were forwarded to and reviewed by PCG for consideration. Our summary is included in Section 2.8 of this Report.

State Agency Data Request

Upon completion of the eight on-site Area Program reviews, we submitted a comprehensive data request to DMH and DMA, requesting clinical, patient, and financial data. This was used to validate/discount some of the issues that were raised by the site visits, and to determine their state-wide applicability. It is important to note that due to the lack of management information systems at DMH and non-standardized reporting requirements, some data was not available at all from DMHDDSAS, or difficult to gather.

Expert Panel – September 21-22, 1999

An Expert Panel sponsored by the Office of the State Auditor included mental health directors from five peer states. It was held at The Carolina Inn in Chapel Hill, and was facilitated by the North Carolina Institute of Medicine. It was attended by members of the PCG team; representatives of the General Assembly; staff from DHHS, DMHDDSAS, and DMA advocacy groups; and the North Carolina Council of Community Programs. The Expert Panel included a representative from Massachusetts, Michigan, South Carolina, Pennsylvania, and Ohio. These individuals provided their insight and experience into various topics, including:

- Creating a sound continuum of care in the community
- Approaches to organizing successful community-based care
- Successful models of financing care
- Building consensus for positive system change

Further detail on this meeting is provided in Attachment A.

Regional Area Program Presentation

PCG conducted regional information sessions in November, 1999, to review our initial findings and elicit input from Area Program Directors and other stakeholders. These 2-3 hour sessions included a presentation by PCG, followed by questions and answers. The presentation included problems to be solved, criteria to meet, and ideas for consideration within each of the areas of services, finance/operations, and governance. We previewed some of our recommendations in order to begin focusing attention on system solutions, rather than problems. All but two of the 38 Area Programs attended one of these sessions. The four sessions are shown below:

- Hickory – November 18, 1999
- Durham – November 19, 1999
- Goldsboro – November 22, 1999
- Raleigh – November 23, 1999

Presentations to Stakeholders

Similar presentations were given separately to various stakeholders from November through February. These meetings were instrumental to PCG as we verified our findings and developed our recommendations. They included:

- North Carolina Council of Community Programs – November 23, 1999
- North Carolina County Commissioners Mental Health Subcommittee – December 14, 1999
- Coalition 2001 – December 15, 1999
- Mental Health Study Commission – January 12, 2000
- North Carolina Commission for MHDDSA – February 7, 2000
- County Commissioner Association Board of Directors – February 9, 2000

OVERVIEW

This section provides an overview and analysis of the current governance model and structure of North Carolina's mental health, substance abuse, and developmental disabilities system at both the local and the State levels. It includes:

- A. Overview, analysis, and findings related to current governance and structure at local and State levels
- B. PCG recommendations for changes to current governance and structure at local and State levels
- C. Background information and detail on governance and structure recommendations, including other states' structures, and design options for new structures in North Carolina

Note that Section 3, Developmental Disabilities Structure, includes detailed information about our analysis and findings related to that system in particular. The scope of PCG's work regarding the DD system was limited to the structure at the State level. Based on that work, we are recommending a separate Division. We assume that the local and State structure changes in this section apply to developmental disabilities as well, and are not inconsistent with the recommendation to create a new DD Division. For purposes of the recommendations in this section, and in the Implementation section (2.7), we will refer to the mental health and substance abuse agency as DMHSAS -- assuming developmental disabilities has been removed to a separate division.

A. CURRENT DMH/DD/SAS STRUCTURE

The overview and analysis is based upon fourteen (14) Area Program site visits (eight related to the mental health study, and six related to the developmental disabilities study); interviews with State agency personnel; interviews with stakeholders; a review of Chapter 122C, The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, Chapter 143B-47, Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, and Chapter 153, The Local Government Finance Act; and a review of North Carolina's State Medicaid plan and approved waivers. For both local and State level structures, it provides an overview of the organizational configurations as set in statute, and our analysis and findings of the resulting structures, as they have evolved.

There is substantial variability in the actual management and governance of Area Boards in North Carolina. While there are some similarities among multi-county and single-county programs, it is important to note that each Area Program appears to operate somewhat differently. The issues raised in this section, and in the subsequent analysis, are based largely upon interviews and site visits. They may not be applicable to all Area Programs. However, we believe that they are at the root of many of the services and financial issues in the system, and that an overhaul of the current governance and structure is warranted.

2.1 Governance and Structure

The local and State analyses in this section support the following two conclusions:

- ***The current Area Program structure generally lacks clear direction from or accountability to either State or local government.*** We believe that this contributes to their sense of political powerlessness, and hinders their ability to act as an equal “partner” in relation to State agencies. Furthermore, the Area Programs’ relatively independent operations, in single and multi-county Area Programs, have contributed to recent financial and service crises in the local system.
- ***Policy development and leadership at the State level is fragmented and has contributed significantly to the difficulties faced by Area Programs.*** The State level organization of service management, rate setting, and policy making in the Department of Health and Human Services (DHHS) is split between the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). DMA acts primarily as an insurance program, and DMHDDSAS as a service provider and administrator. Coordinating the roles and responsibilities of both agencies in a way that acknowledges their respective expertise, system functions, and impact upon Area Programs and providers is crucial. This Report’s findings on Area Program Mental Health Services (2.4) provides additional detail on the clinical impact of this fragmentation.

Area Program Governance and Structure: Overview

At the heart of the system is a service network comprised of 39 Area Programs – which are established in statute as Area Authorities. We refer to them as Area Programs in this Report, but note their statutory status as authorities. This local structure has been in place in North Carolina for approximately 30 years, with minimal change. Some of the defining characteristics of the structure are outlined below. Refer to Chapter 122C of the General Statutes for additional detail and a more comprehensive explanation of this structure.

- Area Programs operate under rules established by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Secretary of the Department of Health and Human Services (DHHS).
- With the exception of Wake County and Mecklenburg County, Area Programs are independent local political subdivisions of the State. They relate to the counties they serve through county appointments to Area Boards.
- With the exception of Wake County’s and Mecklenburg County’s Programs, Area Programs are governed by Area Boards, which are each comprised of 15-25 members appointed by the respective county commissioners according to guidelines for membership set by Chapter 122C.¹ They are required to meet six times per year (some meet more often), and they are ultimately responsible for the Area Program activities, including appointing the Area Program director. Multi-county Area Boards must include at least one county commissioner from each member county.
- The Area Program Directors are employees of the respective Area Boards.

¹ Members include at a minimum: At least one county commissioner from each county in the area except that in a single-county area authority the board of commissioners may instead appoint any resident of the county; a physician (preferably a psychiatrist); a professional representative from the fields either of psychology, social work, nursing, or religion; a primary consumer or individual from a citizens organization representing consumer interests; a primary consumer presently and openly in recovery from alcoholism or other drug abuse; family consumers each representing the interest of individuals in the three service areas; an attorney; an individual experienced in finance. (Ch. 122C-118)

2.1 Governance and Structure

- Area Program human resources policies must conform to certain State structures, including the same or substantially equivalent classifications and pay grade assignments, and disciplinary structures. Additionally, in multi-county Area Programs, the salaries cannot exceed the highest equivalent salaries among the counties' staff. Besides that, the Area Programs (particularly those that are multi-county) operate relatively independently of State or county structures, although the level of involvement with regional State personnel offices differs, and in some cases is considered administratively onerous. Personnel rules and structures have evolved that are very different across the Area Programs.
- Area Programs serve as providers, managers and “brokers” of services. With exception of CAP-MR/DD programs, they may choose whether to provide services directly, or through contracts with other public and private agencies and institutions. Overall, they directly provide approximately 50% of services system-wide – although the amount varies widely across the Area Programs.
- Area Programs may serve as the “single portal of entry” for admission to both State run psychiatric hospitals and mental retardation centers, and privately run institutions, including ICF/MR facilities. In practice, their roles vary, and are minimal, especially in relation to privately run institutions.
- Ultimate control over Area Programs lies with the Secretary DHHS. He has the authority under Chapter 122C to suspend funding, implement plans of correction, and assume control of financial affairs or service delivery as he deems necessary and in compliance with Chapter 122C guidelines.

Structure and Size

- 24 Area Programs are multi-county programs, and serve between two and seven counties. Total population ranges from 72,609 to 366,318. Approximately 58% of North Carolina's population live in counties that are within multi-county Area Programs.
- 13 are single county programs that serve just one county, with total population ranging from 55,182 to 388,519. There are two exceptions, shown in the next bullet. The single county Area Programs are technically departments of their respective counties under Chapter 159 – the Local Governance Act. This means that the counties are ultimately responsible for the financial operations, and liabilities, of the Area Programs. For all other purposes - including governance and management - the programs are independent of county government and report to the Area Board. However, due to the financial relationship, in some of these counties the county manager serves in a *de facto* supervisory role to the Area Program Director. Including Wake and Mecklenburg Counties, 42% of North Carolina's population is currently served by single county Area Programs.
- 2 additional Programs, Wake County and Mecklenburg County, are technically departments of county government for all purposes. Their unique legal status was achieved through Chapter 153A-77(B) of the General Statutes. This statute allows counties with populations greater than 425,000 to assume full control of the Area Authority. In these cases, MH/DD/SAS services operate within the counties' human services departments.

Area Program Governance and Structure: Analysis and Findings

The governance by Area Boards, and the Area Programs' relationships with county and State government differs across the Area Programs. However, we have identified several State-wide universal problems that contribute to what we believe to be major flaws in the system: a lack of accountability by the Area Programs to either State or local government, and a lack of political standing by the Area Programs which hinders their ability to be powerful advocates for the MH/DD/SAS programs at the county or State levels.

Area Programs are local political subdivisions of the State governed by Area Boards. They are not regional or local offices of the DMHDDSAS and are considered relatively independent entities with a separate governance structure. With two exceptions, they are technically not part of county government. PCG believes that this Area Program governance and structure lacks clarity and hinders their accountability and political influence of the public MH/DD/SAS system for several reasons:

Finding 1: Governance and funding are not coordinated.

Area Boards do not provide funding, and are not financially accountable for their decisions. However, their decisions and the actions of the Area Programs impact State and county budgets. Whether by statute or by a commitment to maintaining local services, counties are often called upon as the funding source of last resort by Area Programs. Their commitment to performing that role is questionable in the current structure.

Technically, financial liability is most relevant for counties that have single county Area Programs, which are departments of county government for the purposes of the Local Government Finance Act. This is not well understood, even within those counties, and the level of oversight and accountability from the Area Programs differs widely. Currently, 42% of the State's population is under single county Area Programs. In multi-county programs, on the other hand, counties do not have statutorily defined financial responsibility for Area Programs. However, due to their role in local communities, some feel a responsibility to maintain and protect the services system and to serve as a funding source of last resort.

On the State level, even though DMA and DMHDDSAS provide the vast majority of Area Program funding, they have no formal role in their governance, including no seats on Area Boards or direct control over Area Program directors' appointments. They have no decision-making authority over local expenditures on a day-to-day basis. However, they have extensive statutory powers over the Area Programs, including the DHHS secretary's authority under Chapter 122C to suspend funding and assume control of financial affairs or service delivery. The powerful role of the State has marginalized the Board's role in some areas, and has diluted "ownership" of Area Programs' finances and services. Area Program directors must answer to the State on a wide range of finance, management, and other technical issues while the Boards struggle to stay informed.

Finding 2: The statutory structures of the Area Boards and Programs do not promote local accountability.

Despite the fact that county commissioners sit on Area Boards and appoint members, in practice, the Area Programs are not considered a department of county government. This limits their accountability and political influence. There are several reasons for this:

- The structure of the Area Boards is prescriptive and limits counties' flexibility to appoint individuals of their choosing. Besides the county member, 10 other positions on the 15-25 member boards are prescribed, including a doctor and other professionals, consumers, and family members. In multi-county programs, the respective counties are allotted a certain number of appointees. Some Boards appear to have broken down into subgroups according to individual county loyalty, while others are reported to act more cohesively.

2.1 Governance and Structure

- The membership of the volunteer Area Board is oriented more towards client and service advocacy than financial and management oversight. The ten statutorily prescribed Area Board appointments include six consumers or family members, whose interests and roles are often one of advocacy for services. There is only one required member with financial experience, although finance committees including at least two individuals with expertise in budgeting are called for in Chapter 122C. Nevertheless, Boards are responsible for overseeing complicated financial operations and decisions involving up to eleven different State, federal, and county funding sources. Despite the finance committee, and the training required of Board members, this composition and their volunteer nature does not support the financial and management competencies necessary to oversee entities with yearly operating and services budgets ranging from \$6 million to \$65 million. The six annual meeting requirements also do not lend themselves to active management oversight. Even if Boards meet monthly or more frequently, they lack the financial accountability for their actions and are unlikely to attract members who are capable of exercising financial and management oversight of Program expenditures.
- Since multi-county Area Programs are not departments of county government, the commissioners do not have professional management staff, such as county managers, to assist them in their oversight of the Area Programs. County staff rarely meet with Area Program directors. The county commissioners on Boards generally do not assume this role, nor do they necessarily keep other commissioners informed of Area Program operations in the same manner as the commissioners are kept informed of operations of county government departments. Again, this is less of a problem in some single county Area Programs.
- In multi-county Area Programs, the Area director is accountable to several groups of county representatives. This distribution of authority leads to a lack of “ownership” of Area Program operations by any one county, and results in relatively independent operations. The downside of this for Area Programs is that the member counties feel dis-empowered, and are often unwilling to increase financial support in times of need.
- In single counties, there is often confusion over the role of county managers versus Area Boards to manage the programs. This has worked out differently in different cases, and sometimes results in a diffusion of authority of the Board, or a negative relationship between Area Program directors and county staff due to a lack of clear reporting and authority.

Finding 3: The structures of the Area Boards and Programs do not promote accountability to the State.

The State DMA and DMHDDSAS agencies distribute the majority of funds to the Area Programs, and have extensive oversight including receivership authority. However, they have no role on the Area Boards, or in directing, supervising, or contracting with the Area Program directors. As a result, the agencies exert their influence through administrative mandates, including multiple expectations developed throughout the year. The State agencies are in a difficult position of maintaining accountability for the funds under their purview in a system that is comprised of 39 Area Programs that all operate somewhat differently and do not consider themselves strictly accountable to the State.

The Area Programs and the State agencies have traded blame for some of the recent crises in the system, including the Carolina Alternatives failure and Medicaid pay-backs. It is difficult to accurately assess the responsibility for these incidents. However, it is clear that the breakdown in professional communications and respect between the State agencies and Area Programs, the lack of structure in their interactions, and the Area Programs’ lack of a formal role in rule-making are also major contributors to these crises and will continue as long as the current structure is in place.

2.1 Governance and Structure

As a result of the crises, the State agencies have fallen into a role of policing the Area Programs and instituting sporadic efforts to promote accountability. Occasionally, this includes promulgating detailed guidelines that lack enforcement. Sometimes they become unfunded mandates. The administration of the annual Memorandum of Agreement (MOA) between the State and the Programs that governs the disbursement of funds was fraught with contention in 1999. The associated Performance Agreement included strict new accountability standards that were not developed with adequate input by and discussion with Area Programs, and which some believe are not achievable. Many MOAs were signed under protest in 1999, and there is not a clear process to resolve these protests.

PCG does not believe that a more strenuous policing role by the State agencies, and the continued lack of influence in the process by the Area Programs will lead to improvements in services. The relationship has become too contentious for the entities to work effectively together as part of a smooth and well-managed services system, and each of the entities lacks leverage to create substantial improvement. We note several other factors that contribute to this:

- The respective roles of DMA and DMHDDSAS in managing the funding streams for Area Program operations diffuses authority and “ownership.” This will be discussed further in the next section.
- The State agencies have not made themselves available in a structured and responsive way to the Area Programs. The Area Programs, as well as consumers and families, are not clear about “who to call” for various issues and problems. DMHDDSAS has played only a nominal role in providing technical assistance to Area Programs over the past several years and likely lacks appropriate personnel to do so. There is no strong presence of senior Division staff in the field, nor would such presence be welcome in the current structure. We were told that no director of DMHDDSAS has called a meeting with Area Program Directors together as a group in over 5 years.

Finding 4: The Area Boards lack political standing in the State which weakens their ability to be strong advocates for Area Programs.

Area Board members report feeling dis-empowered in their interactions with State agencies. As local political subdivisions of the State, they stand apart from county and State government, and do not have the political power to strongly assert themselves legislatively, or in State agency rule making. While the NC Council of Programs is a well organized and professionally competent organization, it is hindered by a lack of powerful members.

On the local level, Area Programs often have little political influence because they are not considered part of county government. It is difficult for them to exert influence with counties. From a financing perspective, they are considered last by the counties since they are not part of county government and county commissioners do not know, in most cases, what they get for their money.

MH/DD/SAS System Structure and Management at the State Level

The State level structure of the MH/DD/SAS system is described below, followed by PCG analysis and findings. Note that further detail about the State level structure of the developmental disabilities system is contained in Section 3 of this Report, as well as more detailed findings on State financial policies and operations in Section 2.5.

Commission

Chapter 143B-47 of the General Statutes establishes the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. This is an independent Commission working with DHHS and DMHDDSAS, and is charged with setting rules that are implemented by the Secretary of DHHS, and reviewing rules established by the Secretary. It has 26 members – 4 appointed by the General Assembly, 22 by the Governor. Section 122C requires that it meet at least once per quarter.

State Agencies

The State-level management of the system is accomplished primarily through two agencies that report to the Secretary of DHHS: the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), and the Division of Medical Assistance (DMA).

These agencies, together, are responsible for managing the flow of federal and State funding to the 39 Area Programs, and monitoring programs and services. DMA manages all Medicaid funding, which is approximately 25%, and DMHDDSAS manages the rest of the State funding, which is approximately 52%. (The remainder is self pay, third party, and county contributions). DMHDDSAS operates State facilities, and is charged with integrating Area Program and State services into a unified system. It approves plans and budgets of Area Programs, and adopts rules governing the expenditure of Area Program funds. The DHHS Secretary is authorized to appoint a temporary administrator to take over a Program (financial and service delivery) if it is in danger of failing financially, or not providing services in accordance with statutorily established guidelines. If a Program fails to comply with a corrective plan of action, DHHS can appoint a more permanent caretaker. Technical assistance to Area Programs, or improvement of operations, is not currently emphasized in the DMHDDSAS structure.

The “single State agency” responsible for the administration of the State Medicaid plan is the Department of Health and Human Services, which is under the direction of the DHHS Secretary. The Secretary has authority over all aspects of the State Medicaid program. No other health insurance program covers services as broadly as Medicaid. In addition, the Secretary is responsible for policy and operational coordination across the 14 DHHS divisions. Besides DMA and DMHDDSAS, these include: Public Health, Social Services, Aging, Services for the Blind, Services for the Deaf, Child Development, Citizen Services, Economic Opportunity, Facility Services, Information Resource Management, Rural Health, and Vocational Rehabilitation Services.

DMA is responsible for day-to-day administration of the State Medicaid program. All Medicaid decision-making authority rests with the Secretary of DHHS, but DMA has operational responsibilities which include:

- Eligibility, coverage, and reimbursement policy
- Financial operations, including rate setting, provider audits (including Area Programs), cost settlements, budgets, and financial and statistical reporting

2.1 Governance and Structure

- Program integrity
- Provider enrollment and provider relations
- Beneficiary (recipient) services
- Medicare buy-in
- Contract monitoring
- MMIS planning, design, development, and oversight

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Department of Medical Assistance interact with the Area Programs through an annual Memorandum of Agreement (MOA) with each Area Program.

MH/DD/SAS System Structure & Management at the State Level – PCG Analysis and Findings

Finding 5: The strong and uncoordinated roles of DMA and DMHDDSAS have created fragmented leadership at the State level in finance and management policies affecting Area Programs and services.

Although DHHS is the single State agency under contract with HCFA to manage the Medicaid program, it has not provided strong and consistent oversight over the two agencies responsible for MH/DD/SA services. Many financial and management problems at the Area Programs have their genesis in poor policy coordination between DMHDDSAS and DMA at the State level. Areas of overlap include rate setting, management of the Medicaid funded programs including Carolina Alternatives, utilization management, quality assurance, credentialing, and standard setting. Because of the dominant role of Medicaid funding in the system, and DMA's efforts to maintain accountability for that funding on the local level, it has a strong influence on MH/DD/SAS service policy. However, the respective agencies' roles in setting policies affecting Area Program operations diffuses authority and creates confusion at the local level. The recent debate over which of the two agencies will manage a utilization management contract highlights the general lack of clarity in State level responsibilities. It is difficult to enforce accountability on the local level in a structure that allows agencies to trade blame, shift responsibility, and often disagree publicly on their respective roles and policy directions.

Within DMHDDSAS, the structure and management allows MH, DD, and SA services to operate somewhat independently – creating separate standards and even separate payment rates for the same services. Since this Study began, PCG has seen at least two attempts to reorganize DMHDDSAS. We believe that any such reorganization will fail if it does not actively include the Secretary of DHHS and address the respective roles of DMA and DMHDDSAS in Medicaid policy and management. However, reorganization of State agencies alone cannot solve the inherent problems in the Area Program structure.

Finding 6: The DMHDDSAS Commission does not currently play a significant role in rule-making or State agency oversight.

The Commission appears to have been marginalized over the past several years; it is not given a public hearings venue to comment on Division rules, and is not provided with information on key events in the services system. For example, the Commission was never alerted to the adverse report by HCFA on the conditions at Dix Hospital in November 1999, and the Hospital's subsequent probation by HCFA. The Commission's members are a significant source of untapped talent that has not been brought to bear on recent crises in the system. They have expressed frustration with their current role, and an interest in becoming part of the solution.

B. GOVERNANCE & STRUCTURE RECOMMENDATIONS

INTRODUCTION

PCG proposes major changes in governance and structure of the MH/DD/SAS system at the local level, and some operating changes at the State level to improve current operations and support the new local structure. We believe the recommendations will create more accountability in the local *and* State systems, and will empower the local MH/DD/SAS programs by giving them a stronger base of power in local government. The new roles of counties, former Area Programs, and State agencies will not be easy to implement. The transformation of a \$1.2 billion system with a thirty year history will require a change process over the next five years. The current lack of trust in the system will need to be addressed in order to make this a reality. The implementation plan that follows in Section 2.7 outlines a process for achieving this.

Local Structure Recommendation

PCG proposes to shift management responsibility for the local delivery of mental health, developmental disabilities, and substance abuse services to North Carolina's counties, to be managed by single counties or, in most cases, groups of counties. This addresses our primary finding that the current management by Area Programs, which report to local Area Boards, leads to lack of accountability to county or State government, and poor consequences for local management and financing. PCG believes that Area Programs' relatively independent status has contributed to local financial and management problems over the past several years, and that many counties will be interested in taking a larger role if it is structured to protect them from unfunded mandates and capricious State policies. The PCG proposal will require statutory changes to Chapters 122C, 159, and 143B-47 of the General Statutes.

The recommendations are intended to provide parameters for the new system, which may take various forms according to local needs and interests. We believe this approach may be implemented with some flexibility and have provided examples of different local models at the end of the section. Section 2.7 provides detail on how to use a State-wide process to develop the new relationships between and among counties and State agencies.

In developing the County Program recommendation, PCG considered other local management structures, some of which are currently in place in other states. We chose the county solution over the three other options discussed below:

- **Fix the existing system:** Solutions could be offered to change the structure and membership of Area Boards, and the relationship between Area Programs and the State. In fact, we have received many such suggestions during the course of this Study. These include different Area Board appointments, different boundaries, fewer Area Programs, and a new contract imposed on all Area Programs. We think these suggestions could solve specific problems, but not the fundamental ones, that are embedded in the current structure. Further, implementation of these changes would be difficult within the current environment, as was the case with implementing a new Performance Agreement in 1999. We do not believe that the current structure can be sufficiently changed to hold all parties accountable and financially responsible, to ensure that services will be provided adequately and clients will be safe. Also, the current system has little capacity to capture the political energy and interest of local governments or State agencies. It cannot be used to effectively strengthen and broaden the support for the State's mental health system.
- **Make Area Programs a function of State government:** This is currently how several States provide services. However, we believe that this expansion of State authority into the regions is

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inconsistent with the strong role of county government in North Carolina, and would prove to be prohibitively expensive. The states that use state employees to manage or provide services locally, e.g. Massachusetts, generally have weak county government structures. We believe that creating a strong regional system requires more new staff, is more expensive, and uses a higher percentage of State dollars on management as opposed to services than the County Program proposal. Lastly, it is unlikely that any counties will want to contribute local funding, even including in-kind services or facilities, to a State-run system. Most, if not all, of the local funding would be at risk if the State assumes full responsibility for local services. Also at risk would be the tens of millions in indirect contributions (administrative services and facilities) that counties currently provide.

Additionally, due to recent crises in the DMHDDSAS system at the State level, and changes of leadership at the highest levels, there is little confidence in the ability of State leadership and staff to expand its role to take on local management, in addition to State management of the system. The larger Counties would not want to participate, and a dual State/county system would emerge, creating more management cost and complexity.

- **Privatize Area Programs:** This involves competitively bidding out the right to manage and provide services locally to private for-profit and non-profit firms. Many stakeholders in the system are opposed to this scenario because of the (real or perceived) loss of local influence, especially if out-of-State firms are involved. This type of structure would require the State agencies to take on new duties in overseeing all of the contracts. Again, it is unclear that the counties, with their \$100+ million contribution, would maintain any interest in contributing to the privatization of local services and management. Privatization of service system management is usually an option States choose when implementing HCFA waivers and/or managed care approaches. It allows States to bring in sophisticated new management entities with proven data systems and deep pockets, to assume risk in financing services. That is not the situation in North Carolina today.

PCG believes that the County Program model explained below will improve services by coordinating revenue streams, mandating and supporting more consistent service packages, and re-engineering the business and governance relationships between State agencies, the local mental health service delivery mechanism, counties, and providers. It will help to re-establish trust and confidence in the system:

- Counties' ownership and accountability will be increased – they will have more of a financial and operational “stake” in the system. They will have the option to play a smaller or bigger role. The financial responsibility for County Programs will build on the precedent that has been set by the current status of the 13 single county Programs as county departments under the Local Government Finance Act, and the two large counties under Chapter 153A-77B.
- Replacing unclear relationships between DMHDDSAS, DMA, counties, Area Boards, and Area Programs with formalized contractual relationships will ensure that policies are jointly agreed upon and understood.
- The number of Area Programs will decline from the current 39 as counties join together to gain the critical mass needed to meet operating functions and service requirements. This will decrease system-wide administrative costs. It will be a catalyst for consolidation of Area Programs without State prescribed combinations.

PCG's local governance recommendation is as follows:

Recommendation 1: Responsibility for providing MH/DD/SAS services at the local level will be shifted from Area Programs to counties. Counties will assume the management responsibility for these services, at their option, and under contract with the State. The goal is to make the service *system a part of* rather than *apart from* a strong governmental structure with management capacity. The new entities

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will be known as County MH/DD/SAS Programs. This Report will generally refer to them as County Programs. The County Programs may include one or more counties. This decision will be left to the counties, as part of their analysis of the critical mass needed to meet State service, management, and financial requirements. Furthermore, the services may be managed in the following ways, again at the counties' discretion:

- In-house by county staff;
- through a new county MH/DD/SAS authority; or
- through a subcontracted not-for-profit agency.

(Section 2.1 C provides further detail about possible management structures).

PCG is not recommending that all counties institute the structure allowed under Chapter 152A-177(B) which calls for a Human Services Board, or any other attempt to merge all human services. This, however, should remain an option, and its current use in Wake and Mecklenberg Counties should not be affected. Wake and Mecklenberg Counties could continue using this structure, but would now do so within the new contractual relationship with the State.

Recommendation 5, as well as the Implementation section (2.7), provide detail on the development and ultimate form of the contracts with the State. They should be long-term, three to five year contracts, developed mutually with clear expectations regarding payment rates, quality assurance requirements, data standards, and all other aspects of the services delivery system. They will include detail on how that County Program has chosen to manage services – whether alone or with other counties, and whether in-house, through an authority, or contracted out.

Recommendation 2: Counties will choose their own partners to meet State standards. Partnerships among counties will work only when those partnerships are entered into freely. State standards for County Programs will require sufficient financial, service, and management capacity. Subsequently, it is expected that there would be a substantially smaller number of county partnerships than the current 39 Area Programs. Partnership boundaries should be determined locally if they are to be politically viable.

This recommendation will not result in the development of 100 separate County Programs but will result in fewer, but stronger, and more locally run Area Programs than currently exist. The State will establish strict requirements for management, finance, and service capacity before entering into a contract with a county. It is highly unlikely that most counties in North Carolina could meet this requirement, and as a result, they will need to join with other counties (at their option) to create a critical mass of management capability and service provision. Multi-county MH/DD/SA services have a strong precedent in this State; 58% of residents live in counties that are within a multi-county structure. We expect that some current multi-county alliances will change, and others will remain as they are now. This will be a local decision; the State will not establish regions or define county partnerships. Rather, it will set standards and assist counties in this process as needed. (See Section 2.7 of this Report for more detail on the implementation process).

2.1 Governance and Structure

Recommendation 3: Area Programs will no longer exist as they do now, and their status as local political subdivisions of the State will ended. Counties will probably call upon current Area Program staff and Board members to assist them during the transition phase and to continue to play a role under the new system. It is likely that many of the current Area Program staff and assets will continue to be employed in this local system, under the direction of county government. The new structure will give Area Programs the opportunity to reconsider their role in the service system. Some will choose to become service providers and incorporate as 501(c)3 not-for-profit companies to do so. Others will become part of county government, or a management entity that one or more County Programs could contract with for management services. In either case, we believe that the talent and experience in many local programs can and should become part of the new County Program structure.

The current Area Programs will remain in operation as they are now until the new system is in place. PCG notes that the State Legislature may need to address the issue of employee benefits and pensions for those individuals who will leave Area Programs, including those who may become employees of a non-profit provider or a County Program.

Recommendation 4: Area Boards will no longer exist as they do now; they will be replaced with County Program Boards and Advisory Committees. The primary role of the new County Program Boards will be to make recommendations to the County Commissioners on the MH/DD/SAS annual plan and budget. In addition, they will be available to review and advise on other areas of program operations as requested by the Commissioners. The County Program Boards should be appointed by county commissioners, and will have five to seven members, including at least one County Commissioner from each participating County. Large multi-county programs may have larger boards, but the focus should be on a small, manageable number to make recommendations on the County's complex contractual responsibilities to the State.

Through their Advisory Committees, the Boards will also be responsible for ensuring that the viewpoints and concerns of consumers, family members, and advocates are heard at the county level. The major responsibility of the Advisory Committees will be to help the counties identify the need for services, advocate for people who need services, and participate in the counties' quality assurance programs (which could include reviewing grievances). The Committees will be oriented specifically towards MH, SA, and DD, and should have representatives from all of the counties in multi-county structures. The County Program Boards will ensure that the Advisory Committees have a real voice and are heard in a formal manner by the county commissioners and county management staff. The Legislature should consider granting the Boards and Committees the right to formally review and comment on the county MH/DD/SAS budget and any other major rules or policies - and to be heard by the County Commissioners when they have an adverse report.

Recommendation 5: The contract with the State will be designed to ensure that State and Medicaid service standards and requirements are met, that the county is able to exercise sufficient management control over available financing sources, and that consumer service needs are the focus of the County Program. The counties' assumption of this responsibility would be achieved through a Request for Applications (RFA) process, and subsequent contract with DHHS, representing the State DMHSAS, DDD, and DMA agencies. The multi-year contracts would include a number of new concepts for financing mental health services, such as:

- opportunity to develop local alternatives to State hospital care with initial State start up funds, followed by hospital reallocation of resources to County Programs;
- basic service package fully financed by the State (includes acute care and substance abuse);

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- enhanced services to target groups (children, elderly and long term care) that will be jointly funded by the State and local counties in a formula that will encourage counties to make additional investments;
- allocation of State hospital bed days to the counties, full payment for over use and incentives for developing alternatives that reduce State hospital utilization;
- Everything should be structured up front in the contract, including rates, quality assessment criteria, and reporting requirements; and
- DMA adjudicates Medicaid claims submitted by Medicaid providers and by State and local governmental agencies on behalf of Medicaid providers. Once DMA obtains Medicaid FFP on an expenditure, it can transfer the FFP to the provider, to the agency that has submitted claims on behalf of the provider, or to the General Fund. (Please see Section 2.5 for more detail on aspects of the financial relationship, that will be built into the contracts).

Recommendation 6: Counties should have incentives to increase their financial contributions over time. Some counties are not inclined to allocate more money for MH/DD/SA services, partially due to the lack of connection with and oversight of Area Programs. Based on interviews with county commissioners and managers during our site visits, we believe that local funding can only be expanded if it is accompanied by a high level of local accountability. Some counties have indicated a willingness to invest in services if they can determine how local people will be served and are able to document the impact of their investment. Using State dollars to match county dollars for services to target populations is another concept that should be used in the contract.

Section 2.5 on Finances and Financial Operations provides detail on the proposed county financial role. Over time, county total financial contributions (not limited to cash) are expected to rise to minimum levels (e.g. 10% of expenditures). Initially this requirement may be met by aggregating the financial contribution of counties joining together to create a County MH/DD/SA Program. The PCG proposal also includes an allowance for and recommends consistent valuing of county non-cash contributions – such as buildings and vehicles. Finally, it is important to note that the contracts between the State agencies and the County Programs will be crafted to prevent the imposition of unfunded mandates on the counties, and to assure the State of the counties’ commitment to providing services.

Recommendation 7: The State will ensure service coverage for residents of all counties. The State should play an active role in encouraging all counties to participate in becoming County Programs. This may include an active “matchmaking” role on behalf of counties needing partners. If there are counties that ultimately decline, the State will manage local services directly, charging counties a fee for management services.

Recommendation 8: The process for assumption of county responsibility will be structured over several years, and will ensure that counties are given time and resources to make both management and partnering decisions. The implementation planning and roll-out process will take five years. It will be overseen by a special Blue Ribbon Legislative Commission. It should be noted that DHHS and the North Carolina Association of County Commissioners should play strong partnership roles in providing start-up technical assistance, planning, and financial consultation to counties throughout the transition process.

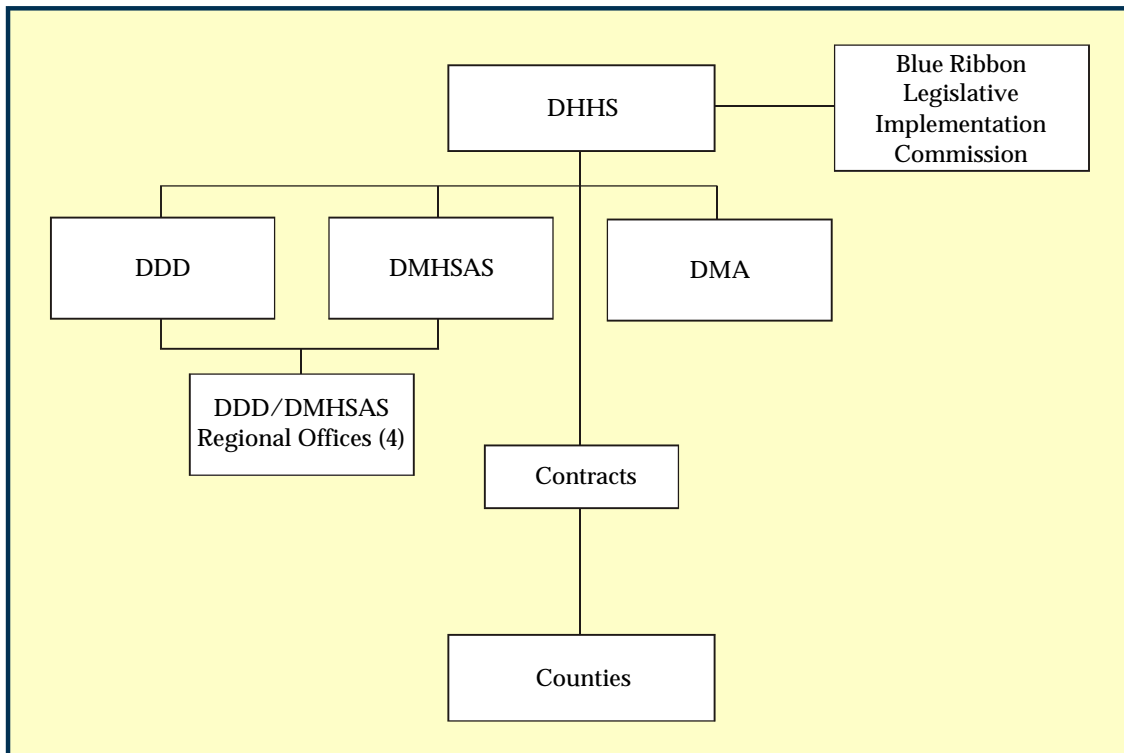
State Structure Recommendations

We do not believe that the critical changes in the local governance and management structures can be accomplished without complementary changes in the structures within and relationships among DHHS, DMA, DMHSAS, and a new Developmental Disabilities Division (DDD).

Recommendation 9: Developmental Disabilities should be established as a separate Division, independent of the MHSAS Division. The new Division will report directly to the Secretary of DHHS, parallel to DMHSAS. The rationale and background of this recommendation are detailed in Section 3 of this Report. It is important to note that developmental disabilities services continue to be under the auspices of the County Program and are included in the contract with the State.

Recommendation 10: The contracts between the State and the counties should be designed and negotiated under the auspices of the Secretary of DHHS. A new DD agency creates the potential for confusion and lack of coordinated State policy in the new State/county contract. To ensure coordination and to create a single point of oversight, the State authority for the new contracts should be with the chief executive of a single agency. DHHS, responsible for all human services and Medicaid administration, is the logical choice for this role. It is expected that DMHSAS, DDD, and DMA will have input in all of the terms and conditions of the contracts, but that it will be approved and signed by the Secretary of DHHS. The day-to-day administration of the MH/SAS and DD contract requirements will be managed respectively by DMHSAS and DDD.

DHHS Structure

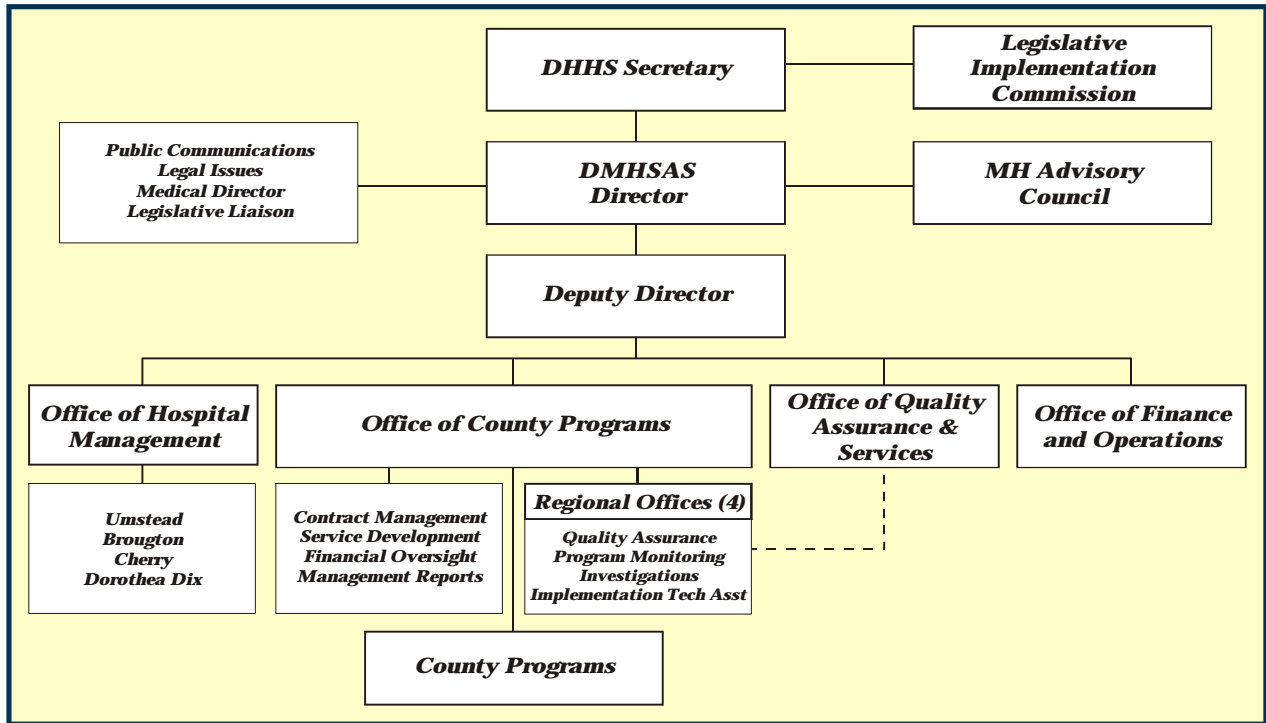


2.1 Governance and Structure

Recommendation 11: *The new DMHSAS and DDD structures should be designed to accomplish two new strategies: (a) to administer the MH/SA and DD contracts with the counties and (b) to manage the downsizing of the State hospitals and the transfer of hospital resources to the County Programs.* The separation of DD will allow each of the new divisions to concentrate on developing service standards customized to the needs of their respective clients. The new DD Division will have a greater level of visibility and accountability, and will be better able to ensure that its clients are protected during this major system change.

We have included some preliminary thinking on how the internal structure of the new DMHSAS Division could be organized to meet its new challenges. *We note that the structure of a new DD Division would need to include similar mechanisms for managing the contracts with the County Programs.* In DMHSAS the management of these new functions could be accomplished in a new organizational structure, such as the one outlined below. It is for discussion purposes only; PCG has not considered all ongoing responsibilities and operations in this structure, including structured means for interaction with DMA and DDD. Also, PCG has not reviewed current staffing to propose how they could be assigned in this new structure. That will occur during implementation planning.

Internal DMHSAS Structure



Notes:

¹This is not intended to be a complete organizational structure. It is intended only to show how certain key functions and roles could be organized to achieve the strategic direction recommended in this Report.

²The Office of Hospital Management would not include Dorothea Dix Hospital if the PCG recommendation in Section 2.3 to close it is implemented.

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There are several organizational considerations in the new structure. First, there must be a single point of contract management for the counties with respect to mental health and substance abuse services. The agency must speak with a single voice if it intends to hold County Programs accountable. For this reason, we suggest that there be an Office of County Programs (OCP). This office would, in effect, oversee the development and management of the County Programs, serving as the Division's chief operating office for community services and operations. It would establish and maintain the new business relationship between the State and County Programs. Secondly, an Office of Hospital Management (OHM) would oversee hospital operations including the transition of clients and resources to the County Programs. This would require close coordination with OCP, particularly in matters of resource allocation and budgeting.

The development of the new County Programs, while the Hospitals are going through changes in functions, bed utilization, and resources, will require a strong Division presence in the field during the next five years. Certain key management functions such as policy, budgeting, data processing, quality management tools and standards should be done from a single, Statewide perspective in Raleigh. There will be an ongoing need to monitor the changes, conduct quality assurance reviews and investigations, and provide technical assistance and communications to the field – to both the County Programs and Hospitals – on an intensive, ongoing basis. We think this calls for the establishment of four regional offices, staffed specifically for these functions and to serve as the Division's presence in the field during these operational changes. These regional offices should report to the Director of the OCP, to be a clear field voice for the Division. Staff will coordinate their efforts with other central office functions, particularly the OHM, and quality assessment program standards promulgated by the Office of Quality Assurance and Services (OQAS). *The regional offices should play a parallel function for the new DDD, and be staffed accordingly. They should be jointly operated and financed.*

The Director of the Division should continue to report directly to the Secretary of Health and Human Services during the five year implementation process. This is critical to assure that policy development and implementation are closely aligned with executive leadership. The Secretary will report to the Blue Ribbon Legislative Implementation Commission, involving the directors of the affected divisions – DMHSAS, DDD, and DMA – on a regular and ongoing basis throughout implementation. In addition, we assume the restructuring of the Mental Health Commission into two advisory councils, one for DD and one for MH/SAS (see Recommendation 14).

Recommendation 12: The Secretary of Health and Human Services, responsible for the development and administration of the State Medicaid plan, should implement changes in Medicaid administrative responsibilities among DMA, DMHSAS and DD that will unify Medicaid policy, leadership and management. The primary focus for these changes should be to ensure that (a) Medicaid operations fully support innovative program development in the County Programs, (b) North Carolina maximizes the amount of Medicaid reimbursements and contains State costs for MH/DD/SA services, and (c) the County Programs have the appropriate responsibilities and tools to manage services financed by State, Medicaid and local funds.

PCG has reviewed the Medicaid state plans of other states that have embarked upon similar ambitious system changes, while attempting to support and strengthen a local administrative agency that is responsible for managing the community service system and implementing state Medicaid policy. We find the state plans and administrative structures of three states – Pennsylvania, Michigan, and New Hampshire – potentially applicable. In each of these cases, the state's human services agency, acting as the single state agency, coordinates Medicaid operations and policies across MH, SA, and DD services.

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PCG concludes that the new system would benefit from the Secretary moving a number of administrative Medicaid functions to the DMHSAS and DDD service agencies. These include (a) coverage and reimbursement policies, (b) financial operations including rate setting, provider audits and budgets, (c) program integrity, (d) provider enrollment and provider relations, and (e) contract monitoring. It is essential that the new DMHSAS and DDD structures and staff are chosen for their abilities to carry out these tasks. A Memorandum of Understanding between and among DMA, DMHSAS, DDD would be developed to clarify these roles and responsibilities. A review of the DHHS administrative structure should be done to determine how to best equip DHHS in coordinating this new distribution of responsibility.

Recommendation 13: A Blue Ribbon Legislative Implementation Commission should be created to advise the Secretary on the transformation of the current system. Oversight of the system's transformation should involve elected representatives, State officials from the executive branch, county representatives, and other interested citizens to ensure that the spirit and the letter of the new statutes are effectively and fairly implemented. The Commission's oversight should include mental health, developmental disabilities, and substance abuse services to ensure that they are properly administered by the new County Programs. The Commission should act as a public forum for input on the application of the new statutes. Also, the Commission should monitor the phase-down and reconstruction of the State hospitals, and the changes to be planned for DD services and regional centers. Members should receive regular and ongoing reports from the Secretary and his/her staff, and make requests for whatever data they think is necessary to effectively monitor the process. They could make recommendations for further changes or modifications in the statutes affecting the administering agencies.

Recommendation 14: There should be a Mental Health and Substance Abuse Advisory Council, and a Developmental Disabilities Advisory Council established to provide ongoing review and advice to the division directors on a wide range of issues. Each of the two service divisions, DDD and DMHSAS, should be advised by a Council that represents the consumers it serves, their family members, advocates and other interested professionals. The councils should focus on service policy, program standards, the role of the State hospitals/regional centers, response to the Supreme Court's Olmstead decision, quality assurance, program evaluation, and related topics. PCG suggests that the Legislature consider re-constituting the current Chapter 143B-47 Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to assume these roles.

C. BACKGROUND INFORMATION ON GOVERNANCE AND STRUCTURE

TYPES OF MANAGEMENT STRUCTURES POSSIBLE UNDER PCG RECOMMENDATIONS

The recommendations in this Report to shift the management of MH/DD/SAS services from the Area Programs to counties are intended to provide a structural framework. Counties are encouraged to develop a structure that suits their unique needs and interests. It will be important to give Counties flexibility to create appropriate and effective local structures that allow them to meet State service goals. Section 2.7 provides detail on a proposed implementation process that will allow counties the time and resources they need to make key decisions regarding their County MH/DD/SAS Program structure.

The recommendations allow for various types of management structures. Flexibility is provided through the following key elements:

- ***Partnering with other counties, and possible vehicles for doing so:*** The State will establish standards for management capacity that must be met by the counties in order for them to qualify to manage MH/DD/SAS services. It is likely that most counties will seek to partner together in order to achieve the economies of scale to meet these standards. However, the State will not establish these regions or partnerships; it will be the choice of the respective county commissioners. It is likely that some counties that are currently part of a multi-county Area Program will choose to continue to work with that same group of counties, or allow additional counties to join.

There are several existing vehicles for multi-county initiatives in North Carolina. Counties should use these as they see fit, or create new ones. A likely vehicle to bring counties together is inter-local agreements. Counties may also consider creating local authorities, using existing Councils of Government regions, or devising simple contracts between counties for specific services.

- ***Managing services in-house in the county, versus through a subcontracted management entity:*** Counties may choose to establish management and service functions within county government, as a department of county government. In this case, the County Program could be a department of county government, and the staff would be county employees. Multiple counties joining together may decide to appoint any one of the individual counties to establish this internal capacity on behalf of the other counties. If counties wished to manage services outside of county government proper, but not subcontract to a private organization, they could establish a new local MH/DD/SAS Authority, with a county-appointed board.

Alternatively, counties may choose to subcontract with a local non-profit organization(s) to provide these services. The counties would maintain the risk of contract performance, and would need to dedicate some county staff to manage this contract. The capacity to provide management services locally exists in some of the current Area Programs. These entities may choose to re-establish themselves as non-profit 501c3 corporations and to provide these services.

County Programs may even choose to contract with one another for specific management or direct MH, DD, or SA services.

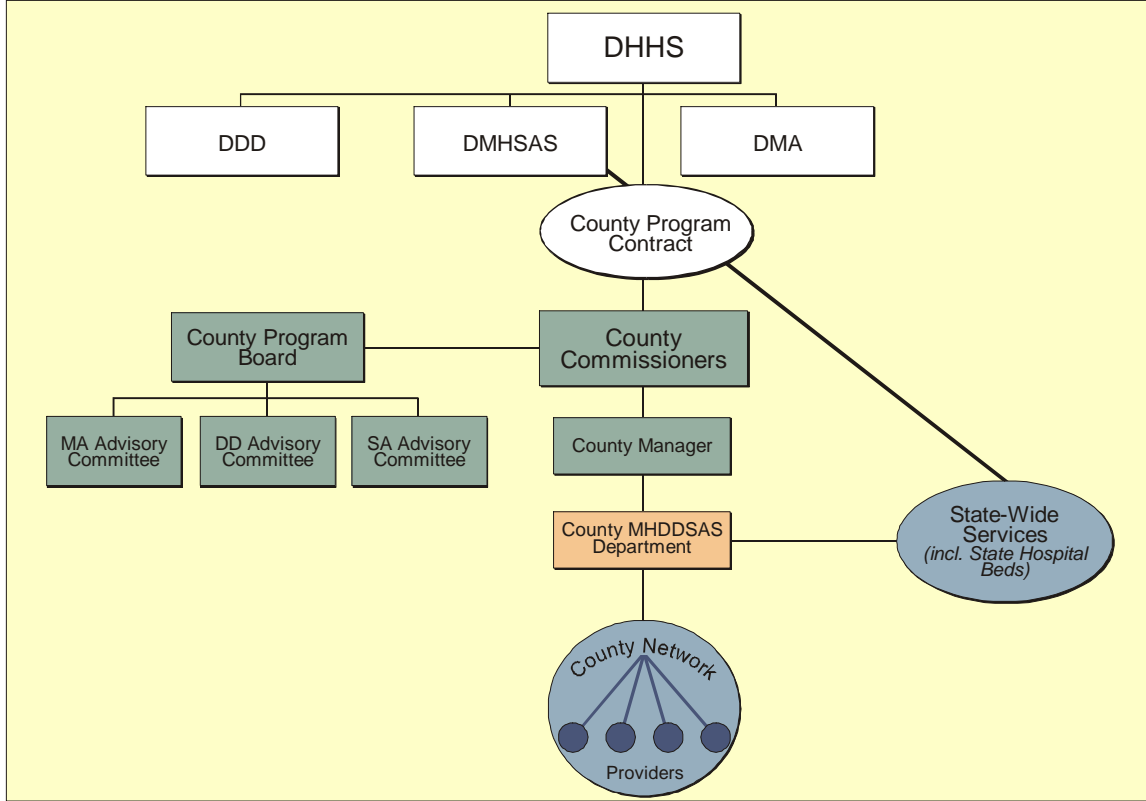
2.1 Governance and Structure

- ***Providing services in addition to managing services:*** County Programs must be responsible for managing the MH/DD/SAS service systems, whether in-house, through an authority, or through a subcontracted non-profit organization. They may also provide some services directly, as is the case with approximately 50% of services currently overseen by Area Programs. In the case of an in-house County Program, this would likely involve the development of service capacity, as most counties do not currently provide MH, DD, and SA services. If management is subcontracted to a non-profit organization, that organization may also be a service provider. (This is especially likely if it is a reconstituted Area Program). The extent of the service provision by County Programs and/or their subcontracted management entities will be a county decision. The State will establish mechanisms to ensure that competition is required, and that consumer choice is promoted. County run services must meet the same standards as private providers.
- ***The structure and role of County Program Boards:*** The Boards will be an important vehicle to ensure input into the service delivery system by consumers, families, and advocates. Although the Boards may be relatively small (5-7), they will have Advisory Committees with larger membership (up to 20 in all) to help inform their decisions. The Boards and Committees could be given various types of responsibilities, including budget review, and oversight of clients' grievances and appeals. The Boards must include client, family, and advocacy representation, but County Commissioners will appoint members to these Boards and Committees with more flexibility than is currently allowed by Chapter 122C of the General Statutes.
- ***Structuring relationships between the counties, County Programs, management entities, advisory boards, and the State:*** Contracts between and among the counties and the State will provide a basic structure for the relationships. However, the counties may institute various methods and structures for service management and reporting/oversight. Although each county will have an individual contract with the State, multi-County Programs would conduct their business jointly. For example, a multi-County Program may manage services through a joint subcontract with a non-profit management entity. There are many options for managing such a joint contract: they may choose to establish a group of county managers or other employees as a committee to manage the subcontract; they may assign one or more of the counties' managers to oversee it; they may grant the County Board authority to oversee it; or county commissioners may choose to oversee it personally. Another example is the day-to-day working relationship between non-profit management organizations, counties, and the State. The counties may choose to become very involved in management activities on a daily basis, or may choose to allow the management entity staff to work directly with State staff in a relatively independent manner.

As these examples illustrate, there are numerous types of County Program management structures that could be developed. *The organizational charts shown on the following page provide some examples, but county options are not limited to these structures.*

- Chart A is a single County Program that is managed as a department within county government. The director is a county employee, who reports to the county manager.
- Chart B is a multi County Program that is managed as a department within one of the member counties.
- Chart C represents a multi County local authority structure.
- Chart D represents a multi County Program that subcontracts with a non-profit management entity. The contract is overseen by a three member contract management committee, comprised of the three counties' managers or deputy managers.

CHART A - COUNTY PROGRAM: SINGLE COUNTY GOVERNANCE MODEL



2.1 Governance and Structure

CHART B - COUNTY PROGRAM: MULTI COUNTY GOVERNANCE MODEL
MANAGED AS A DEPARTMENT WITHIN ONE OF THE COUNTIES

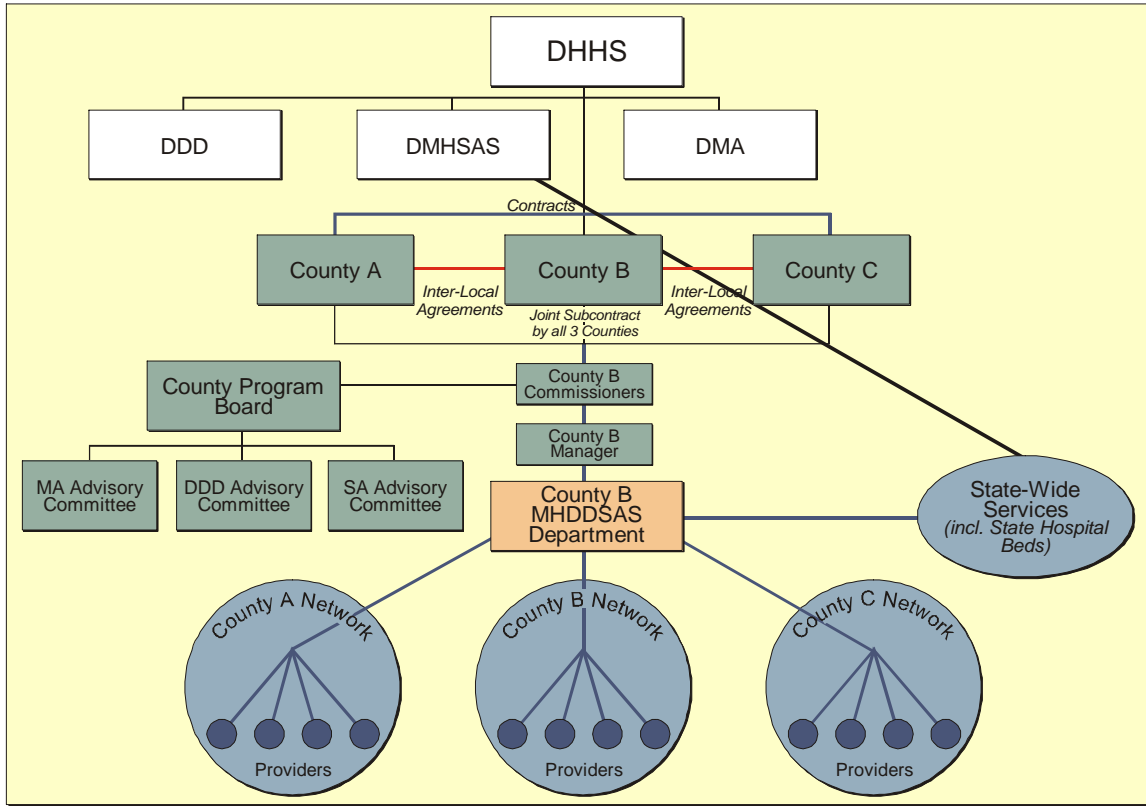


CHART C - COUNTY PROGRAM: MULTI COUNTY GOVERNANCE MODEL WITH LOCAL MHDDSAS AUTHORITY

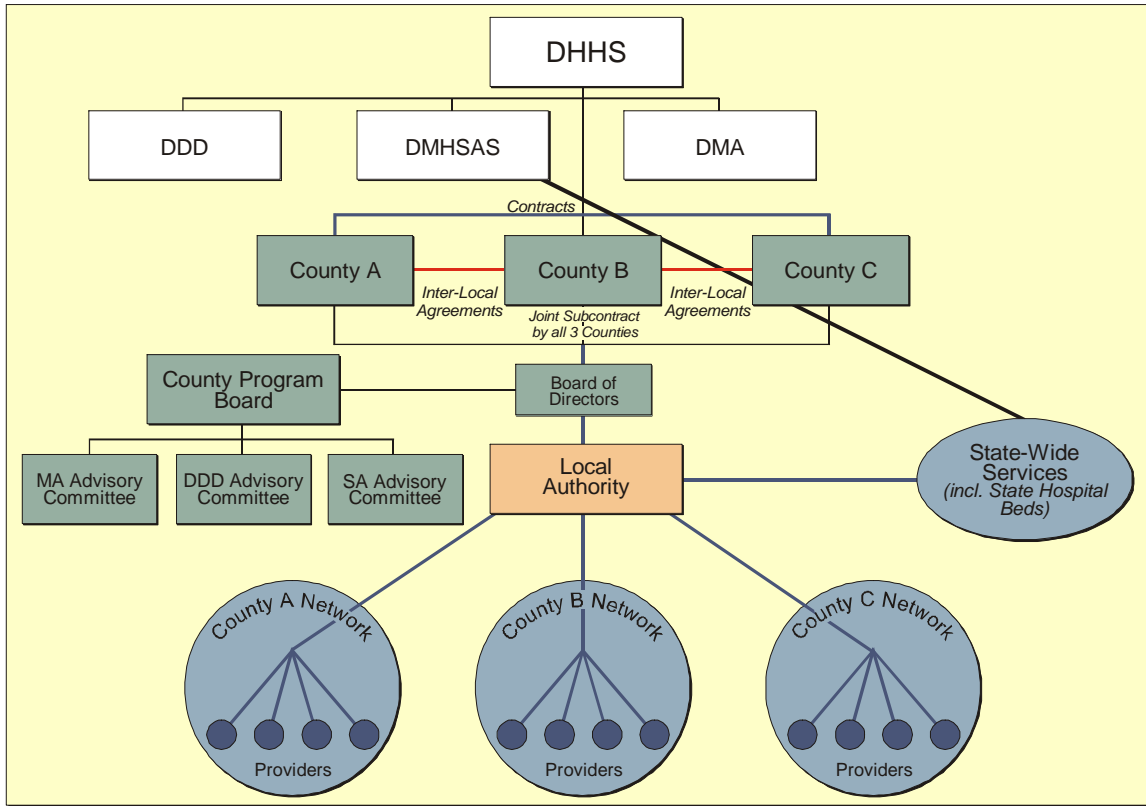
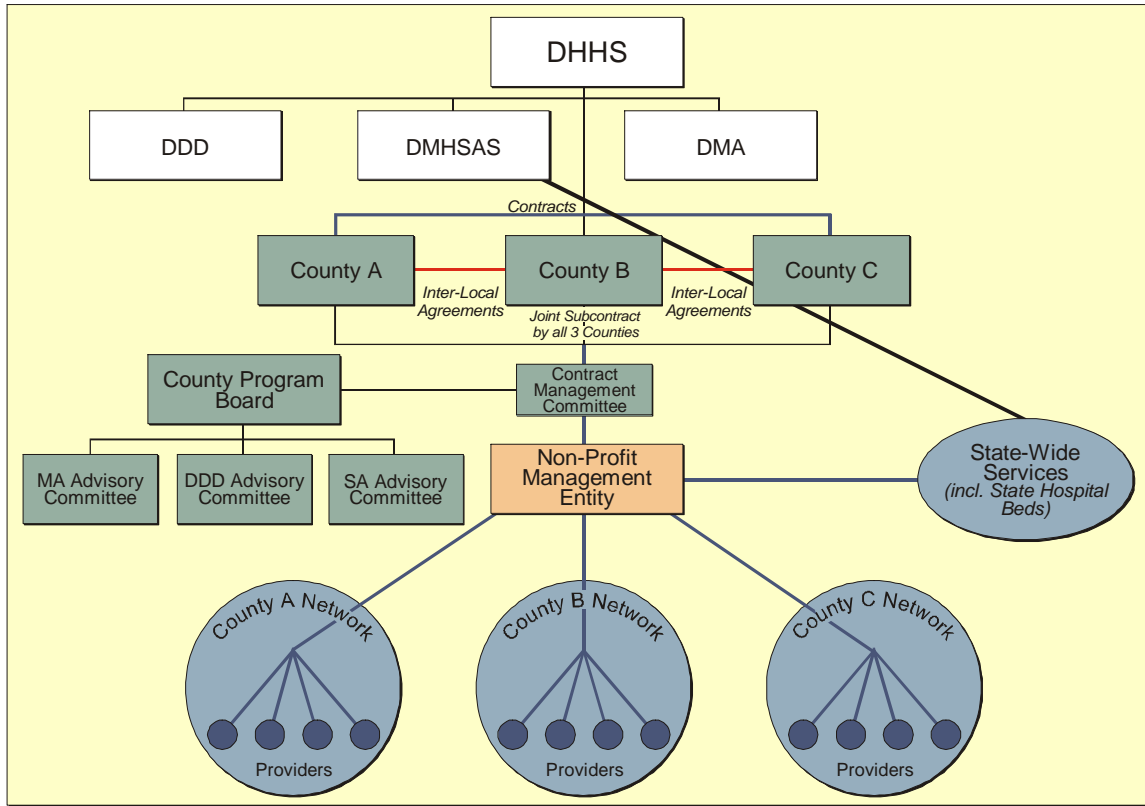


CHART D - COUNTY PROGRAM: MULTI COUNTY GOVERNANCE MODEL WITH NON-PROFIT PRIVATE MANAGEMENT ENTITY



OTHER STATES' STRUCTURES

There are many different state and local structures for managing MH/DD/SAS services across the country. This section provides an overview of other states' structures, and one peer group analysis for state MH/SA expenditures and State hospital bed use. Most of the states shown were involved in the Mental Health Experts Panel (See Attachment A), and most are also represented in peer state comparisons of MH/SA expenditures (Section 2.5), and state hospital bed use (Section 2.2). PCG considered the applicability these states' structures to the North Carolina system. We believe that the proposed County Program structure would be the most effective means of managing services in North Carolina.

This section is intended to inform the reader's analysis of the essential elements of the management structure proposed for North Carolina by explaining other structural possibilities. The chart on the next two pages compares several general aspects of these management structures, including:

- **Administration of Medicaid funding by the State:** The agencies responsible for managing Medicaid funding differ in the states shown. In North Carolina, the DHHS "single state" agency has appointed DMA to manage the program. DMA plays a considerable role in MH/DD/SAS policy development as a result. PCG recommends that some of these management tasks be delegated directly to the MH/SAS and DD agencies in order to consolidate funding and service policy decision making. This is similar to the dispersion of Medicaid authority in Pennsylvania, and to a lesser extent, Michigan.
- **Integration of MH/DD/SAS:** The consolidation of these programs under one state agency differs in other states. As we note in Section 3.3 of this Report, approximately 60% of states include MH and DD in one state agency, 40% for state's of North Carolina's size, or larger. The local administration of services does not always mirror state structures, as is the case in Pennsylvania, Ohio, and Connecticut. PCG is recommending that North Carolina create a separate Division of Developmental Disabilities, and continue to integrate DD and MH management at the local level. (Further study is required regarding local DD services).
- **Local management and governance structure:** There is enormous variability in local management structures – ranging from state-run offices, to privatized lead agencies. PCG's analysis of these structures' applicability to North Carolina, and our reasons for recommending the County Program model are outlined earlier in this Section, under Local Structure Recommendations. As we discuss there, the success of various local structures is highly contingent upon the respective roles of local, county, and state governments. The County Program structure we have proposed is similar to Pennsylvania and Ohio.
- **Integration of service management and service provision:** This is generally a hybrid in other states; some service and management tasks are integrated into one agency, others are not. Currently in North Carolina, Area Programs are able to both manage and provide services; the exception is that they may not provide CAP MR-DD services. PCG is recommending that the County Programs be given the flexibility to integrate service management and service provision as they see fit, as long as competition is ensured, consumer choice is promoted, and all services meet the same quality standards.
- **Role of local funding:** The levels of local funding varies, often related to the localities' role in managing and governing the services. Even within states, the level of local funding provided differs across regions. PCG is recommending that counties be motivated to increase their levels of funding for MH/DD/SAS services; with the exception of several counties that already provide a large percentage. Hardship exemptions, such as those provided by Michigan, may be warranted.

2.1 Governance and Structure

OTHER STATES' MH/DD/SAS Management Structures

State	Administration of Medicaid Funding by the State	Local Structure	Integration of MH/DD/SAS	Inte Ser Ma Prc
North Carolina	DHHS is the single state agency. Medicaid agency (DMA) administers	39 Area Programs, both single and multi-county, that are local political subdivisions of the State. Governance through Area Boards that include county appointees. Level of county oversight differs; is generally higher in single than in multi-county programs. Structure exceptions: the programs are fully integrated into Wake and Mecklenberg Counties.	Currently all three are together at state and local levels under DMHDD/SAS and the Area Programs.	Are the ma sen exc CAI pro
Pennsylvania	DPW is the single state agency. Mental health agency (OMHSAS) administers those services.	Each county is responsible through its human services agency. Some counties are legal "Jointers" and manage services jointly. Others have partnered together to manage the HealthChoices Medicaid behavioral health carve-out waiver program.	MH and SAS are together on the state level. Locally, they are consolidated under county human services agencies, but may be separate divisions within them. DD is separate on the state level, but consolidated locally under the human services agency.	Col pro ma sen out sen pro net
Michigan	Department of Community Health (MDCH) is the single state agency; it includes MH, SA, DD services management and Medicaid administration.	49 County sponsored Community Mental Health Services Programs (CMHSPs) that are both single and multi-county. Since 1996 they have been able to act as authorities, which provides administrative flexibility. CMHSPs operate under full risk managed care, including all state and federal funds. Federal waiver has been approved to allow non-governmental organizations (non-profit and for-profit) to compete with them to take over the management of federal, state, and local funds.	Together on the state level under MDCH. Locally, the CMHSPs manage MH, DD, SAS (the latter through subcontracts with regional county sponsored coordinating agencies (CAs))	CM botl ens CM citi ma can
Massachusetts	DMA is the single state and administering agency.	Mental health services are managed by regional offices of the Department of Mental Health. DD services are managed by regional offices of the Department of Mental Retardation. SA services managed by central office with local contractors.	They are all separate agencies on the state level (SAS is within the Dept. of Public Health). They are all administered separately on local level as well.	Reg not the con pro

2.1 Governance and Structure

State	Administration of Medicaid Funding by the State	Local Structure	Integration of MH/DD/SAS	Inte Ser Ma Prc
Ohio	DHS is the single state and administering agency.	50 county level boards (consisting of 1-5 counties) operate as local authorities known as Alcohol, Drug Addition and Mental Health (ADAMH) Services Boards. DD services, as well as some SA services in large urban areas, are administered in by separate county board structures.	MH, SAS, and DD are operated by separate state agencies. MH and SAS are managed together under ADAMH Boards in the smaller counties, but under separate boards in the larger counties. DD is managed under separate county boards.	AD/ pro/ pro/
Connecticut	DSS is the single state and administering agency. Responsibility for administration of the GA population is delegated to the MH/SA agency (DMHAS).	MH services are managed by Local Mental Health Authorities. 6 are state run and are part of DMHSAS; 9 are non-profit lead agencies, under contract with DMHSAS. DD services are managed through regional offices. SA services are managed by local non-profit lead agencies under contract with DMHAS.	MH and SAS are together on the state level (DMHSAS), however, they are administered by separate local service systems. DD is separate on both levels.	The botl

Historical Utilization and a Normative Model of Demand

OVERVIEW

The focus of the following discussion will be to use historical patterns of utilization of inpatient and outpatient public mental health services to project a normative state-wide target for state psychiatric hospital bed capacity. The recommended target will be 1621 beds, which PCG believes the State of North Carolina, working with community service providers, can achieve within five years.

PCG's Phase I report noted the dearth of information available to support modeling of bed demand based on consumer need. PCG followed an alternate approach that we believe makes the best use of the available data, is most directly actionable, and will be most easily enhanced as superior information becomes available. The result is a simultaneous top-down and bottom-up approach.

The top-down approach refers to a comparison of overall mental health bed capacity and admissions data in North Carolina to nine other selected states: Illinois, Kentucky, Massachusetts, Michigan, Missouri, Ohio, Pennsylvania, South Carolina and Virginia. The bottom-up approach is a variation on "best practice" benchmarking used in Total Quality Management. The "local best practice" model seeks to identify existing Area Programs whose combined historical performance might serve as a future target for the entire state.

The selected programs were profiled to establish that they did not differ substantially from the other programs in certain critical characteristics that were outside their control. The variance between the state-wide target hospital utilization rate and every other program's current performance levels was examined. The analysis highlighted those areas and services that require the most immediate interventions, and could help each program to devise detailed strategies by which they may achieve the Division's objectives over the next several years. This model is too primitive, however, to be prescriptive at the area program level.

Following publication of the Phase I report, PCG undertook a comprehensive assessment of North Carolina's community mental health, developmental disabilities and substance abuse service infrastructure. Using first-hand observation as well as statistical analysis, PCG determined that individual area programs varied widely in their capabilities to provide a full array of mental health services in the near- to mid-term. These capabilities and constraints will influence both the levels and the timing of area program utilization targets.

PCG does not, however, regard its 1621 bed target as a "floor". Indeed, further reductions might be justified if county programs more aggressively develop local alternatives to hospitalization, and if the state follows through in moving resources from the state hospitals to the counties where the clients are being served. We believe that the 1621 bed target reasonably reflects PCG's understanding of the interests and desires voiced by local mental health professionals and advocates. We also are cognizant of the likely impact of the Olmstead decision, which will give strong support to consumers' obtaining more services in community settings.

Finally, this chapter offers a discussion of some of the potential ramifications of achieving North Carolina's target state hospital bed capacity through a four hospital or a three hospital model.

General Approach – “Local Best Practice”

Statistical analysis reveals pronounced differences among North Carolina counties’ and Area Programs’ historical use of state psychiatric hospitals and alternative mental health treatment facilities. In 1998, clients residing in the median county used 9,470 state hospital bed days per 100,000 general population. The 5th and 95th percentile counties, however, used 3,820 and 20,007 bed days, respectively. Looking at Medicaid mental health spending (only about half of which was paid to the Area Programs), the median was \$45 *per capita* general population, while the 5th and 95th percentiles were \$20 and \$135. Median area program total funding *per capita* (including Medicaid and all other revenue sources) was \$119, while the 5th and 95th percentiles were \$84 and \$156.

We may conjecture that these differences are due, in part, to random variation; to measurement error; to differences in disease prevalence, diagnosis and detection; to citizens’ service-seeking behaviors and ability to pay as well as other cultural and economic influences; to providers’ accessibility and outreach efforts; to practitioners’ treatment philosophies and treatment objectives; and to the availability of skilled care and the service capacities of alternate venues. Devising valid quantitative indexes that would enable us to reliably estimate the relative contributions of each of these effects is extremely difficult.

A further complication arises if these statistics are to be used in developing normative expectations for the future performance of hospitals and area programs : determining the degree to which any of these factors are actually within the programs’ control. Still, quantitative analysis offers the only rebuttal to arguments of exceptionalism. For the sake of argument, we might agree that some unique considerations influence decisions in every one of North Carolina’s counties and programs. The thrust of our analysis, then, is to empirically gauge the limits of these arguments ; to use available data to isolate the factors that seem to be outside the purviews of local policy-makers and clinical decision-makers; and to focus on variations in service utilization and treatment practices that remain unexplained.

The availability of data – and the quality of the available data – are always a constraint. For this analysis, PCG was able to combine data from multiple sources at both the summary and atomic levels. Summary data on service recipients and expenditures by type of service were obtained both from North Carolina’s Division of Medical Assistance (DMA) and from the U.S. Health Care Financing Administration. Pioneer cost-finding data were provided by North Carolina’s Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS). Inventories of medical facilities were supplied by the Division of Facility Services. Demographic and economic data were obtained from the U.S. Census Bureau. State psychiatric hospital admission and discharge records were provided by DMHDDSAS. Medicaid claims and enrollment files were made accessible by DMA. These data always were combined at the lowest practical level. For example, for state hospital patients whose admissions records included Medicaid ID’s (which we know to be a subset of all Medicaid eligibles treated in the hospitals), PCG was able to assemble reasonably complete service histories.

These data lend themselves to a number of potential analytic approaches. From among these, PCG selected methodologies that we believe are most generalizable, most actionable, and most easily enhanced as superior information become available. Three approaches that we did not use deserve passing mention. The Division of Facility Services (DFS) develops the State Medical Facility Plan, which projects state-wide bed needs for psychiatric inpatient services and substance abuse detoxification inpatient and residential services. Using inventory data from the state Licensure and Certificate of Needs Sections, population data from the Office of State Planning and utilization data from HCIA, DFS psychiatric inpatient services projections focus on short-term psychiatric beds in

North Carolina's four mental health planning regions. Bed need is determined basically by extrapolating current beds *per capita* forward based on expected future populations.

Another method for estimating bed demand might have begun with epidemiological estimates of disease prevalence. The U.S. National Institute of Mental Health's Epidemiological Catchment Area Study, in fact, has studied the Durham area in depth. There are a number of practical difficulties with applying this approach to our analysis, however. Epidemiological prevalence estimates of mental illness invariably produce numbers that are orders of magnitude higher than the number of patients who receive treatment in the public system. The precision on these estimates is not claimed to be high. A recent U.S. Department of Health and Human Services estimate of the 12-month prevalence of serious mental illness among persons 18 and older in North Carolina fell between 186,000 and 357,000 at the 95% confidence level.

Also, diagnostic data in the state hospital system may be incomplete and possibly skewed, making benchmarking and case mix adjustment highly problematic. According to the electronic admissions records, for example, Broughton Hospital admitted almost no one in 1998 who was dually diagnosed with mental illness and substance abuse – an implausible finding. An analysis of primary and principle diagnoses commonly associated with serious and persistent mental illness (SPMI) shows a twenty-fold difference (between the 5th and 95th percentiles) in hospital days used by SPMI clients per 100,000 general county populations. (The difference at the 10th and 90th percentiles is six-fold.) The most plausible explanation for these variations is inconsistent coding.

A third method for estimating bed demand could be based on determination of appropriateness of care, measuring who among current inpatients are hospitalized inappropriately, and who among current outpatients are strong candidates for hospitalization based on uniform standards of treatment. In addition to the extreme costs and intrusiveness of such an approach, PCG believes that it might not address the right question. The 1998 hospital efficiency study, for example, conducted by a private firm for DMHDDSAS, identified a few client cohorts (*e.g.*, adolescents, long-term geriatric, substance abuse) among current inpatients who might be better served in different venues. While PCG acknowledges the need for transition services to address the needs of newly discharged clients who may have been inappropriately hospitalized, medium- to long-term bed demand is not likely to be accurately characterized as what remains after short-term ameliorative action.

Instead, PCG has elected a top-down and bottom-up approach. The top-down approach refers to a comparison of overall mental health bed capacity and admissions data in North Carolina to nine other selected states: Illinois, Kentucky, Massachusetts, Michigan, Missouri, Ohio, Pennsylvania, South Carolina and Virginia. North Carolina's inpatient adult bed capacity, at 32.3 beds per 100,000 adults, was 23% above the peer group average. North Carolina's rate of admissions per 100,000 adults, at 243, was the second highest in the group and exceeded the average more than two-fold. This analysis is insufficiently detailed to establish a bed capacity standard in itself; however, it does provide an independent test of the reasonableness of the results of our bottom-up approach.

PCG's bottom-up approach for proposing normative levels for future utilization of state psychiatric hospitals is a variation on "best practice" benchmarking used in Total Quality Management. The "local best practice" model seeks to identify existing area programs whose combined historical performance might serve as a future target for the entire state. These were not specifically the lowest utilizers of the state psychiatric hospitals. They are programs who are generally regarded as well-run by key-informants in the provider and consumer communities.

The selected programs were profiled to establish that they did not differ substantially from the remaining programs in certain critical characteristics that were outside their control. A tentative state-wide target was then set at the historical utilization levels of the selected programs. This level was

about 30% below the current state-wide average. Finally, the distance between the tentative state-wide target and every other program's current performance levels was examined. The analysis highlighted those areas and services that require the most immediate interventions, and could help each program to devise detailed strategies by which they may achieve the Division's objectives over the next several years.

DMHDDSAS Hospital Admission/Discharge Statistics

On the following pages are shown three years of state psychiatric hospital episodes, with additional detail on FY98. There are three reports: long-term adult mental health; short-term adult mental health; and substance abuse. Each report begins with one page of state-wide and regional summaries, followed by two pages of area-program-specific data.

Long-term stays and their total and average days-of-stay are based on any adult (ages 21-64) mental health (based on admission/commitment status) episodes (either continuing or already discharged) of at least 31 days with one or more days falling within FY96-FY98. Short-term stays are based exclusively on complete (discharged) adult mental health episodes of 30 days or less with one or more days in FY96-FY98. Substance abuse stays may be of any length and any age group.

Episode statistics can reveal the cumulative effects of long-standing admission and discharge policies and practices. The episodes themselves may have begun as much as a decade or more ago, however. FY98 statistics represent the intersection of these episodes and the fiscal year and are thus more useful for understanding the average daily census and bed capacity requirements.

Stays (episodes) and days are compared on each line to the size of the general population as well as to the estimated number of people living below the poverty line. Poverty is known to be correlated both to serious mental illness and to a propensity to seek public services. We can see, for example, that after adjusting for differences in regional rates of poverty, the utilization of state hospital bed days in the northern part of the state was 80% higher (47777 vs. 26658) than in the south-central region. (The raw rates (5511 vs. 3423) were 60% apart.)

These reports and others at the county level of detail were shared informally with DMHDDSAS staff, independent health care researchers in North Carolina, area program staff, and consumer advocates. In the discussions that followed, PCG attempted to elicit first-hand knowledge of area programs operations and environments. Statistics were examined for face-validity, and potential information gaps or recent changes in programs were noted. A number of programs among the lower utilizers of long-term and short-term inpatient adult mental health services were identified as "well-run". It was agreed that substance abuse programs were so diverse in their capabilities that inpatient utilization statistics were unrevealing as to quality-of-care.

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Long-term adult Mental Health by Region

Region	Number of Counties	Long-Term Stays	ALOS	Population	LT Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Poverty
State	100	6100	247	7,544,360	80.9	1506848	19973	355753	4715	984,564
E (Cherry)	33	1134	421	1,530,458	74.1	477228	31182	111647	7295	265,675
N (Umstead)	18	2697	146	1,739,895	155.0	394381	22667	95886	5511	200,694
S (Dix)	16	967	330	1,803,989	53.6	319460	17709	61750	3423	231,638
W (Broughton)	33	1302	243	2,470,018	52.7	315780	12785	86470	3501	286,557

Notes:

- Mental health admissions based on admission/commitment status
- Long-term episodes having at least one day in fiscal years 1996 through 1998
- Long term stays > 30 days
- ALOS and total days (but not stays or FY98 days) are computed only for complete episodes
- Episodes and days are non-cumulative; these are separate admissions, not unduplicated clients
- Adult admissions only: ages 21-64 on date of admission
- Excludes visiting patients and outpatients; includes transfers-in

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Long-term adult Mental Health by Area Program

Region	Area Program	Number of Counties	Long-Term Stays	ALOS	Population	LT Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Pove:
E	Albemarle	6	63	709	111,996	56.3	44695	39908	6821	6090	16,81
	Duplin-Sampson	2	65	624	98,270	66.1	40571	41286	6643	6760	18,56
	Edgecombe-Nash	2	129	309	143,341	90.0	39922	27851	13247	9242	24,87
	Halifax	1	31	101	55,182	56.2	3119	5653	2883	5225	13,96
	Lenoir	1	60	536	59,024	101.7	32143	54457	4797	8127	11,56
	Neuse	4	111	533	170,250	65.2	59135	34734	10525	6182	24,46
	Onslow	1	55	194	148,324	37.1	10660	7187	4400	2966	23,13
	Pitt	1	114	211	123,155	92.6	24024	19507	9147	7427	24,13
	Roanoke-Chowan	4	53	696	72,609	73.0	36890	50806	8197	11289	16,85
	Southeastern	3	178	342	255,840	69.6	60886	23799	18417	7199	37,43
	Tideland	5	79	820	91,017	86.8	64798	71193	9914	10892	18,37
	Wayne	1	114	290	114,246	99.8	33067	28944	9544	8354	19,07
	Wilson-Greene	2	82	333	87,204	94.0	27318	31326	7112	8156	16,41
N	Alamance-Caswell	2	280	132	144,333	194.0	37052	25671	9822	6805	14,73
	Centerpoint	3	433	153	366,318	118.2	66149	18058	16145	4407	38,29
	Crossroads	3	183	248	215,069	85.1	45316	21070	7631	3548	22,18
	Durham	1	550	134	200,219	274.7	73514	36717	20194	10086	24,82
	Guilford	1	591	139	388,519	152.1	81978	21100	19209	4944	45,45
	O-P-C	3	290	199	188,245	154.1	57583	30590	9648	5125	19,12
	Rockingham	1	167	93	89,510	186.6	15478	17292	5398	6031	11,45
	V-G-F-W	4	203	85	147,682	137.5	17311	11722	7839	5308	24,61

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Long-term adult Mental Health by Area Program (cont'd)

Region	Area Program	Number of Counties	Long-Term Stays	ALOS	Population	LT Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Pove
S	Cumberland	1	131	203	295,053	44.4	26644	9030	9745	3303	44,25
	Davidson	1	44	277	142,512	30.9	12182	8548	2055	1442	14,82
	Johnston	1	39	257	106,918	36.5	10009	9362	3842	3593	14,22
	Lee-Harnett	2	83	190	132,867	62.5	15797	11889	4568	3438	19,43
	Randolph	1	46	341	124,444	37.0	15669	12591	3181	2556	11,07
	Sandhills	5	134	556	194,809	68.8	74556	38272	6547	3361	30,49
	Southeast Regional	4	108	400	231,690	46.6	43253	18669	8420	3634	52,42
	Wake	1	382	318	575,696	66.4	121350	21079	23392	4063	44,90
W	Blue_Ridge	4	166	234	242,241	68.5	38860	16042	11327	4676	31,58
	Catawba	1	31	126	131,256	23.6	3912	2981	2742	2089	12,07
	Cleveland	1	64	174	91,410	70.0	11121	12166	4500	4923	11,70
	Foothills	4	184	286	231,271	79.6	52584	22737	10777	4660	25,49
	Gaston-Lincoln	2	121	167	240,149	50.4	20170	8399	8113	3378	26,13
	Mecklenburg	1	188	291	624,464	30.1	54801	8776	17056	2731	68,06
	New_River	5	86	292	154,021	55.8	25093	16292	5936	3854	22,71
	Piedmont	4	221	256	409,928	53.9	56575	13801	11749	2866	40,44
	Rutherford	2	46	295	76,251	60.3	13574	17802	4521	5929	9,48
	Smoky_Mountain	7	110	212	160,260	68.6	23283	14528	6015	3753	26,20
Trend	2	85	186	108,767	78.1	15807	14533	3734	3433	12,65	

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Short-term adult Mental Health by Region

Region	Number of Counties	Short-Term Stays	ALOS	Population	ST Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Poverty
State	100	15311	9.2	7,544,360	202.9	141083	1870	50686	672	984,564
E (Cherry)	33	4282	9.3	1,530,458	279.8	39718	2595	14005	915	265,675
N (Umstead)	18	2329	10.4	1,739,895	133.9	24252	1394	9847	566	200,694
S (Dix)	16	4360	7.2	1,803,989	241.7	31523	1747	10839	601	231,638
W (Broughton)	33	4340	10.5	2,470,018	175.7	45590	1846	15995	648	286,557

Notes:

- Mental health admissions based on admission/commitment status
- Short-term episodes having at least one day in fiscal years 1996 through 1998
- Short term stays <= 30 days
- ALOS and total days (but not stays or FY98 days) are computed only for complete episodes
- Episodes and days are non-cumulative; these are separate admissions, not unduplicated clients
- Adult admissions only: ages 21-64 on date of admission
- Excludes visiting patients and outpatients; includes transfers-in

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Short-term adult Mental Health by Area Program

Region	Area Program	Number of Counties	Short-Term Stays	ALOS	Population	ST Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Pove:
E	Albemarle	6	199	10.0	111,996	177.7	1998	1784	818	730	16,81
	Duplin-Sampson	2	198	10.1	98,270	201.5	1992	2027	670	682	18,56
	Edgecombe-Nash	2	602	8.3	143,341	420.0	4974	3470	1867	1302	24,87
	Halifax	1	87	9.3	55,182	157.7	806	1461	249	451	13,96
	Lenoir	1	184	9.6	59,024	311.7	1761	2984	641	1086	11,56
	Neuse	4	461	9.1	170,250	270.8	4191	2462	1270	746	24,46
	Onslow	1	301	8.6	148,324	202.9	2581	1740	1061	715	23,13
	Pitt	1	336	10.3	123,155	272.8	3453	2804	1117	907	24,13
	Roanoke-Chowan	4	144	11.5	72,609	198.3	1656	2281	451	621	16,85
	Southeastern	3	722	9.3	255,840	282.2	6688	2614	2559	1000	37,43
	Tideland	5	388	8.7	91,017	426.3	3388	3722	1337	1469	18,37
	Wayne	1	345	9.8	114,246	302.0	3367	2947	1056	924	19,07
	Wilson-Greene	2	315	9.1	87,204	361.2	2863	3283	909	1042	16,41
N	Alamance-Caswell	2	257	10.1	144,333	178.1	2604	1804	1027	712	14,73
	Centerpoint	3	263	11.3	366,318	71.8	2973	812	1101	301	38,29
	Crossroads	3	288	9.6	215,069	133.9	2778	1292	1155	537	22,18
	Durham	1	493	10.1	200,219	246.2	5000	2497	1908	953	24,82
	Guilford	1	419	11.1	388,519	107.8	4631	1192	1859	478	45,45
	O-P-C	3	252	10.6	188,245	133.9	2661	1414	1125	598	19,12
	Rockingham	1	194	10.4	89,510	216.7	2021	2258	972	1086	11,45
	V-G-F-W	4	163	9.7	147,682	110.4	1584	1073	700	474	24,61

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Short-term adult Mental Health by Area Program (cont'd)

Region	Area Program	Number of Counties	Short-Term Stays	ALOS	Population	ST Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Pove:
S	Cumberland	1	382	9.7	295,053	129.5	3699	1254	1544	523	44,25
	Davidson	1	217	6.5	142,512	152.3	1414	992	524	368	14,82
	Johnston	1	83	8.9	106,918	77.6	739	691	159	149	14,22
	Lee-Harnett	2	227	8.5	132,867	170.8	1921	1446	673	507	19,43
	Randolph	1	233	7.8	124,444	187.2	1827	1468	536	431	11,07
	Sandhills	5	462	8.3	194,809	237.2	3816	1959	1172	602	30,49
	Southeast Regional	4	258	10.5	231,690	111.4	2718	1173	708	306	52,42
	Wake	1	2498	6.2	575,696	433.9	15389	2673	5523	959	44,90
W	Blue_Ridge	4	591	9.9	242,241	244.0	5824	2404	2188	903	31,58
	Catawba	1	70	11.1	131,256	53.3	779	593	240	183	12,07
	Cleveland	1	278	10.0	91,410	304.1	2781	3042	876	958	11,70
	Foothills	4	626	10.4	231,271	270.7	6521	2820	2046	885	25,49
	Gaston-Lincoln	2	523	11.0	240,149	217.8	5734	2388	2266	944	26,13
	Mecklenburg	1	340	11.5	624,464	54.4	3926	629	1229	197	68,06
	New_River	5	243	10.2	154,021	157.8	2469	1603	855	555	22,71
	Piedmont	4	823	10.3	409,928	200.8	8515	2077	3151	769	40,44
	Rutherford	2	133	10.5	76,251	174.4	1397	1832	443	581	9,48
	Smoky_Mountain	7	510	10.5	160,260	318.2	5345	3335	1948	1216	26,20
Trend	2	203	11.3	108,767	186.6	2299	2114	753	692	12,65	

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Substance Abuse by Region

Region	Number of Counties	Subst Abuse Stays	ALOS	Population	SA Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Poverty
State	100	7381	20.1	7,544,360	97.8	148543	1969	54470	722	984,564
E (Cherry)	33	50	12.0	1,530,458	3.3	598	39	238	16	265,675
N (Umstead)	18	4243	22.1	1,739,895	243.9	93687	5385	38475	2211	200,694
S (Dix)	16	1451	12.5	1,803,989	80.4	18069	1002	8947	496	231,638
W (Broughton)	33	1637	22.1	2,470,018	66.3	36188	1465	6810	276	286,557

Notes:

- Substance abuse admissions based on admission/commitment status
- Episodes having at least one day in fiscal years 1996 through 1998
- All ages
- ALOS and total days (but not stays or FY98 days) are computed only for complete episodes
- Episodes and days are non-cumulative; these are separate admissions, not unduplicated clients
- Excludes visiting patients and outpatients; includes transfers-in
- Potential inconsistencies in use of diagnosis codes. In FY98, the number of admits with MH/SA dual diagnoses (in principal Dx, first prim each facility was:
 - Cherry 396
 - Umstead 531
 - Dix 469
 - Broughton 4

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Substance Abuse by Area Program

Region	Area Program	Number of Counties	Subst Abuse Stays	ALOS	Population	SA Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Pove:
E	Albemarle	6	4	11.0	111,996	3.6	44	39	0	0	16,8
	Duplin-Sampson	2	6	6.0	98,270	6.1	36	37	7	7	18,5
	Edgecombe-Nash	2	6	5.5	143,341	4.2	33	23	0	0	24,8
	Halifax	1	1	9.0	55,182	1.8	9	16	9	16	13,96
	Lenoir	1	2	6.5	59,024	3.4	13	22	0	0	11,5
	Neuse	4	4	32.3	170,250	2.3	129	76	53	31	24,46
	Onslow	1	2	6.0	148,324	1.3	12	8	2	1	23,13
	Pitt	1	4	11.5	123,155	3.2	46	37	21	17	24,13
	Roanoke-Chowan	4	1	6.0	72,609	1.4	6	8	0	0	16,8
	Southeastern	3	9	12.0	255,840	3.5	108	42	71	28	37,43
	Tideland	5	11	14.7	91,017	12.1	162	178	75	82	18,37
	Wayne	1	.	.	114,246	0.0	0	0	.	0	19,0
	Wilson-Greene	2	.	.	87,204	0.0	0	0	.	0	16,4
N	Alamance-Caswell	2	470	24.4	144,333	325.6	11476	7951	4239	2937	14,73
	Centerpoint	3	300	25.2	366,318	81.9	7560	2064	2822	770	38,29
	Crossroads	3	184	15.0	215,069	85.6	2758	1282	1425	663	22,18
	Durham	1	873	22.2	200,219	436.0	19354	9667	8307	4149	24,82
	Guilford	1	682	24.8	388,519	175.5	16912	4353	5464	1406	45,45
	O-P-C	3	769	21.4	188,245	408.5	16429	8727	7262	3858	19,12
	Rockingham	1	588	20.5	89,510	656.9	12082	13497	5181	5788	11,45
	V-G-F-W	4	377	18.9	147,682	255.3	7117	4819	3775	2556	24,61

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Three-year statistics: DMHDDSAS Client Admission/Discharge data

Substance Abuse by Area Program (cont'd)

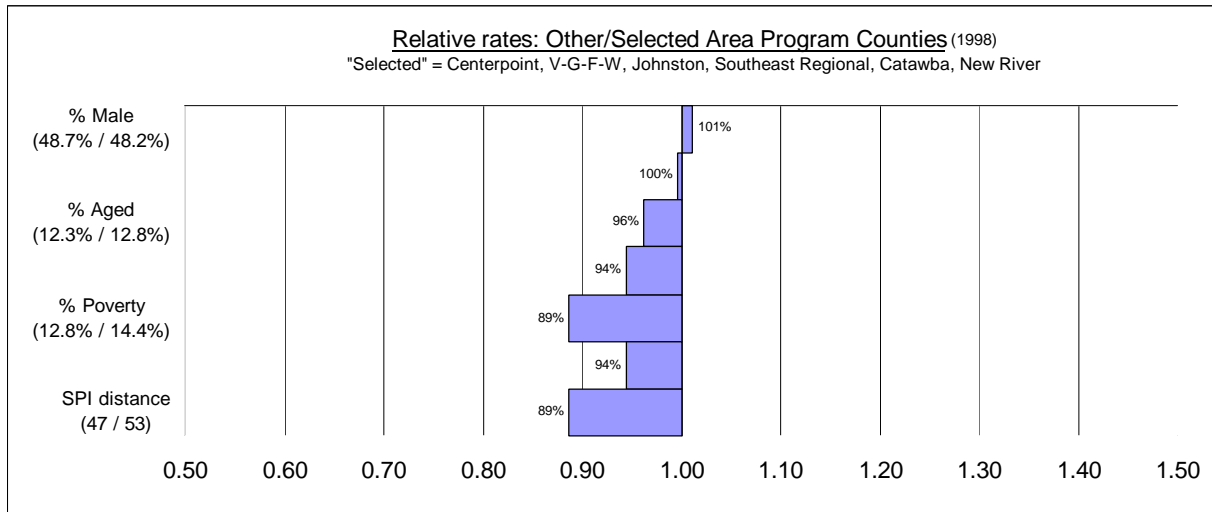
Region	Area Program	Number of Counties	Subst Abuse Stays	ALOS	Population	SA Stays /100k	Days of Stay	Days /100k	Days in FY98	FY98 Days /100k	Pove:
S	Cumberland	1	20	14.1	295,053	6.8	281	95	63	21	44,25
	Davidson	1	62	6.5	142,512	43.5	401	281	203	142	14,82
	Johnston	1	45	20.1	106,918	42.1	905	846	165	154	14,22
	Lee-Harnett	2	252	15.9	132,867	189.7	4008	3017	2056	1547	19,43
	Randolph	1	218	13.9	124,444	175.2	3030	2435	2240	1800	11,07
	Sandhills	5	239	14.3	194,809	122.7	3428	1760	2224	1142	30,49
	Southeast Regional	4	15	12.5	231,690	6.5	188	81	3	1	52,42
	Wake	1	600	9.7	575,696	104.2	5828	1012	1993	346	44,90
W	Blue_Ridge	4	237	13.9	242,241	97.8	3303	1363	1143	472	31,58
	Catawba	1	19	55.6	131,256	14.5	1056	805	11	8	12,07
	Cleveland	1	90	16.7	91,410	98.5	1502	1643	346	379	11,70
	Foothills	4	346	11.3	231,271	149.6	3905	1688	1069	462	25,49
	Gaston-Lincoln	2	190	12.5	240,149	79.1	2383	992	738	307	26,13
	Mecklenburg	1	76	185.0	624,464	12.2	14049	2250	596	95	68,06
	New_River	5	71	18.2	154,021	46.1	1290	838	192	125	22,71
	Piedmont	4	238	19.2	409,928	58.1	4568	1114	1540	376	40,44
	Rutherford	2	105	10.9	76,251	137.7	1146	1503	344	451	9,48
	Smoky_Mountain	7	189	9.6	160,260	117.9	1815	1133	518	323	26,20
	Trend	2	76	15.4	108,767	69.9	1171	1077	313	288	12,65

“Selected” programs vs. “Others”

Based on historically low utilization of state psychiatric hospitals in any or all of the above service categories, and taking into consideration the advice of key informants (composed of state mental health professionals and advocates), PCG assembled and profiled panels of “well run” programs who offered full arrays of local services. Separate panels were not constructed for each service type or client cohort, but an attempt was made to choose broadly qualified programs. It was understood that not every “selected” program would set a high standard in every category of service. The “local best practice” approach stresses the use of “real” programs rather idealized composites in order to set targets that are demonstrably achievable.

Selecting from a list of “well run” programs, panel membership was manipulated in an attempt to construct an aggregate that fairly represented the remainder of the state in economic terms, regional affiliation, urban/rural composition, racial characteristics, age mix, and other factors. Excluded from the final panel were individual counties with a rich array of local services like Mecklenburg, who, though they were low utilizers of the state hospitals, were considered to be too unique. The final “selected” panel was composed of six area programs. From the north, Centerpoint and V-G-F-W were chosen; from the south central region, Johnston and Southeast Regional; from the west, Catawba and New River. No eastern region candidates for “selected” programs were identified by PCG’s key informants.

The chart below is used to compare the “others” with the “selected” programs.



It can be seen that county populations of the “other” programs are 48.7% male, as compared to the “selected” programs, which are 48.2% male. The ratio of these two rates is 101%. The population percentages of youths are also nearly identical, and the “other” population has only slightly fewer aged as a percentage of the total. These are not tests of statistical significance; they are indicators of validity and generalizability. The “other” counties have slightly fewer non-white citizens. There seems to be a somewhat greater apparent difference in the proportion of the population living below

the poverty line. (The implications of this finding, if any, for subsequent analysis are not yet clear.) The “other” and the “selected” counties are surprisingly close in metropolitan status. This was determined by tagging the populations of 25 counties identified by the U.S. Census Bureau as Level A or B Metropolitan Statistical Areas. (Level A or B MSAs, which are often composed of multiple counties, must have a population of 250,000 or more. North Carolina’s MSA’s are: Charlotte/Gastonia/Rock Hill; Fayetteville; Greensboro/Winston-Salem/High Point; Hickory/Morganton/Lenoir; and, Raleigh-Durham/Chapel Hill.) We also note that the “other” county populations, though slightly less urbanized, are generally a few miles closer (as the crow flies) to their regional state psychiatric institutes.

Hierarchical Analysis

Before comparing the ways in which different programs serve their clients, it is standard practice to perform case-mix adjustment. Ideally, this adjustment recognizes inter-program differences in clients’ clinical conditions, family support, etc. It projects how each program might treat a “standard” population. We have noted above, however, PCG’s concerns about the unreliability (that is – non-comparability from program to program) of available diagnostic information on state hospital clients. We therefore have approached the problem slightly differently.

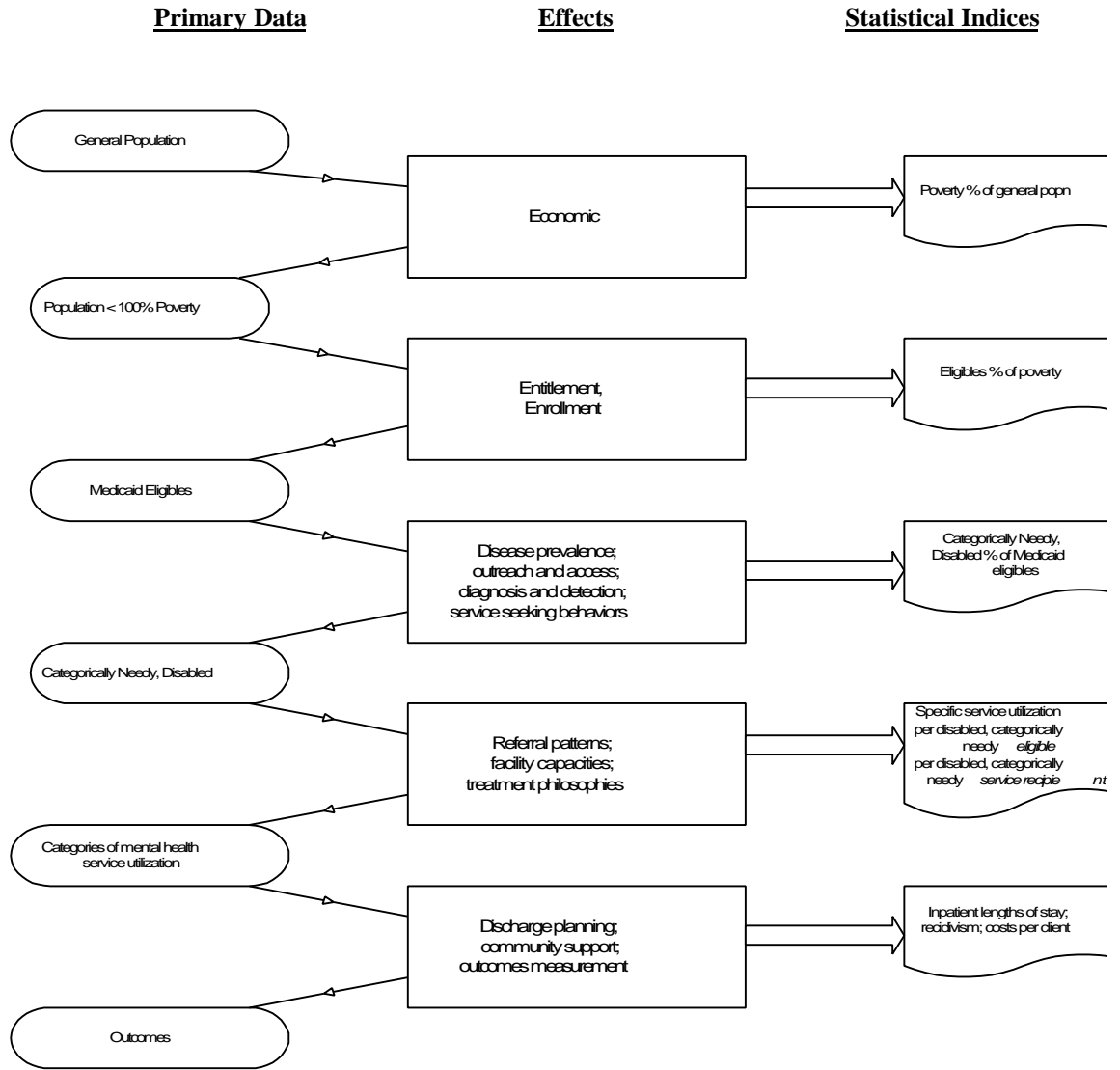
The chart on the next page illustrates many of the influences on service utilization. Poverty, for example, is known to correlate both with the prevalence of serious mental illness and with the likelihood that sufferers will seek care in the public system. Poverty can be indexed as the proportion of the general population of each county that is living below the poverty line. It is known to vary from county to county, but to the extent that we examine only the poor population in each county, we will have accounted for some of its influence on behavioral health services utilization.

In North Carolina, Medicaid eligibility is set at 100% of the poverty line. We know, however, that the proportion of the poor population who are enrolled in Medicaid varies widely from county to county. This may be due to any number of factors, some of which might be unavoidable and others of which might need improvement. The availability of insurance, however, could be a powerful influence on service-seeking behaviors or of providers’ willingness to offer services. Thus, to the extent that we examine only Medicaid enrollees, we will have mitigated somewhat the influences of poverty and insurance.

Among Medicaid enrollees, the Categorically Needy population may be regarded as a fairly stable sub-group. Those Categorically Needy Medicaid recipients who have qualified as Disabled are also a stable cohort. One third of North Carolina’s adult (ages 21-64) Categorically Needy and Disabled Medicaid recipients received some mental health services in FY98. We may suppose that many or most of these mental health service recipients are among the seriously mentally ill, most of whom would be known to the area programs and some of whom would be candidates during their treatments to receive inpatient psychiatric care. We know, for example, that those Categorically Needy and Disabled Medicaid recipients diagnosed as schizophrenic comprise 58 cases/100,000 general population in both the “selected” and “other” programs.

If we profile the ways in which different area programs have served the adult Categorically Needy and Disabled in their counties, we may gain a greater understanding of the differences in their mental health treatment philosophies and resources. We hope, too, that this subset of services and clients may serve as “tracers”, indicating patterns that may be generalizable to programs’ other systems of care.

Hierarchical Analysis of Historical Behavioral Health Care Utilization for Future Demand Estimates and Capacity Requirements



Hierarchical Analysis of Historical Behavioral Health Care Utilization for Future Demand Estimates and Capacity Requirements

Observations

- North Carolina’s counties exhibit wide variation in poverty rates.
- North Carolina’s counties exhibit wide variation in rates of Medicaid enrollment as a percentage of individuals living below the poverty line.
- Among North Carolina’s Medicaid population of ages 21-64, the proportion who are classified as Categorically Needy and who are eligible for Aid to the Disabled varies widely from county-to-county.
- The proportion of Categorically Needy, Aid to the Disabled Medicaid enrollees, age 21-64, who receive any mental health services varies widely from county-to-county.
- The use of private and public inpatient facilities by Categorically Needy, Aid to the Disabled Medicaid eligibles ages 21-64 who received any mental health services varies widely from county-to-county.

Implications

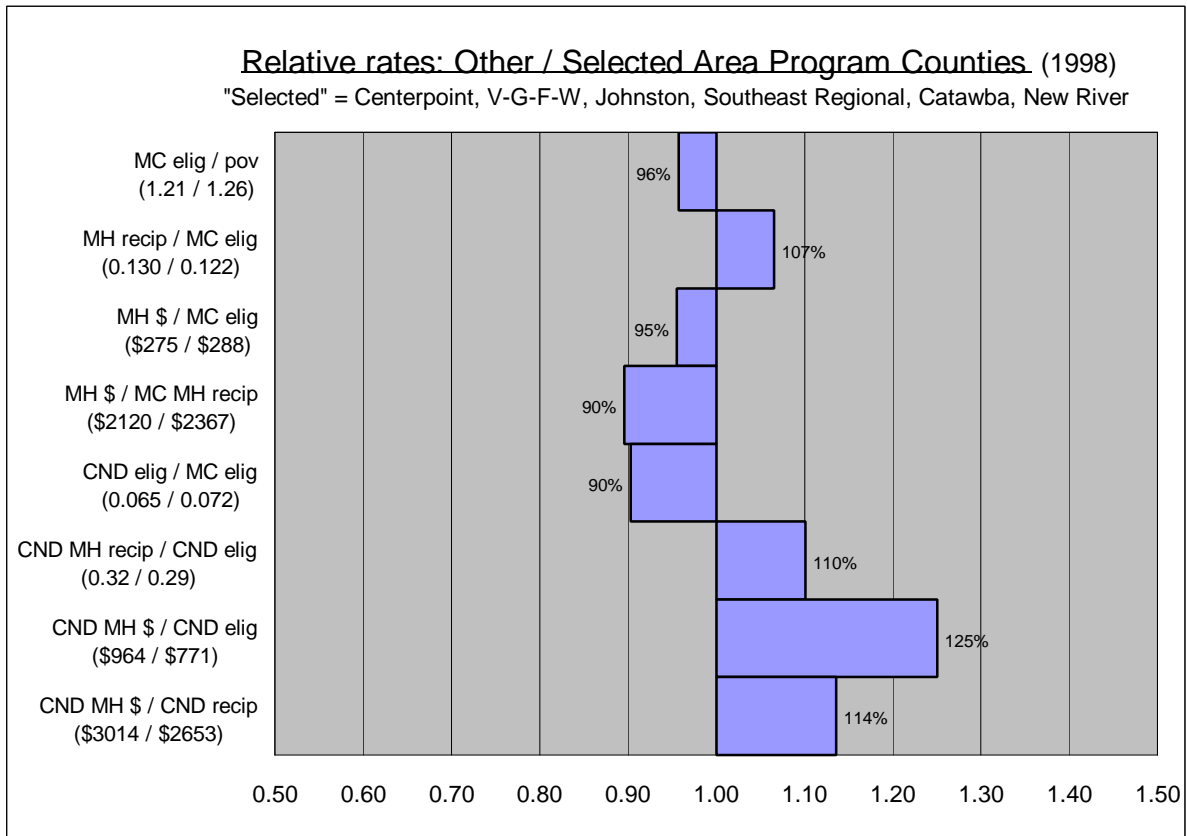
- Higher rates of poverty are known to be associated with mental illness (at the Census Tract level)². Estimates are useful for differentiating future service demand (and treatment) from historical service receipt.
- Lack of insurance is a potential barrier to access for people having serious mental illness.
- This phenomenon may reflect differences in service and detection, administrative practices, or other factors often used for projecting utilization rates, such as the variation in relative population size.
- Though the aid category “Aid to the Disabled” includes more eligibles than those suffering serious mental illness, the prevalence of serious mental illness to be a function of population. If that is so, then the number who receive services could be a reflection of referral patterns. County-to-county variations in the rates of inpatient utilization could, likewise, reflect any of these factors or treatment philosophies, etc.
- This finding suggests not only differing placement in different facilities, but also that mental health programs in counties (or their Area Programs) may exercise different inpatient acute or long-term care.

Conclusion: Estimates of future demand and capacity for inpatient and outpatient mental health services should be coordinated with anticipated responses of the provider community. In particular, the policies under consideration that might influence future capacity include standardization of clinical assessment, the basic benefit package, and service quality .

² Kessler, *et al.*, “A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness”, Mental Health, United States, 1998, SAMHSA

We must note, of course, that Medicaid does not pay for all of the services that would be needed by adult Medicaid eligibles: most obviously, treatment in the state psychiatric hospitals, and other residential services are not covered. PCG has combined, where possible, state hospital data with Medicaid data, using the Medicaid ID when it appears on clients' admission records. We recognize that these ID data are incomplete, but we have no reason to believe *a priori* that they are biased towards either the "other" or the "selected" programs. North Carolina clearly has multiple opportunities to better inform policy-makers and clinical decision-makers in the future through better record-keeping.

The chart below compares the "other" with the "selected" programs on a number of factors that might correlate with service utilization. By the time we get to the bottom, we hope to have isolated as many of those factors as possible.

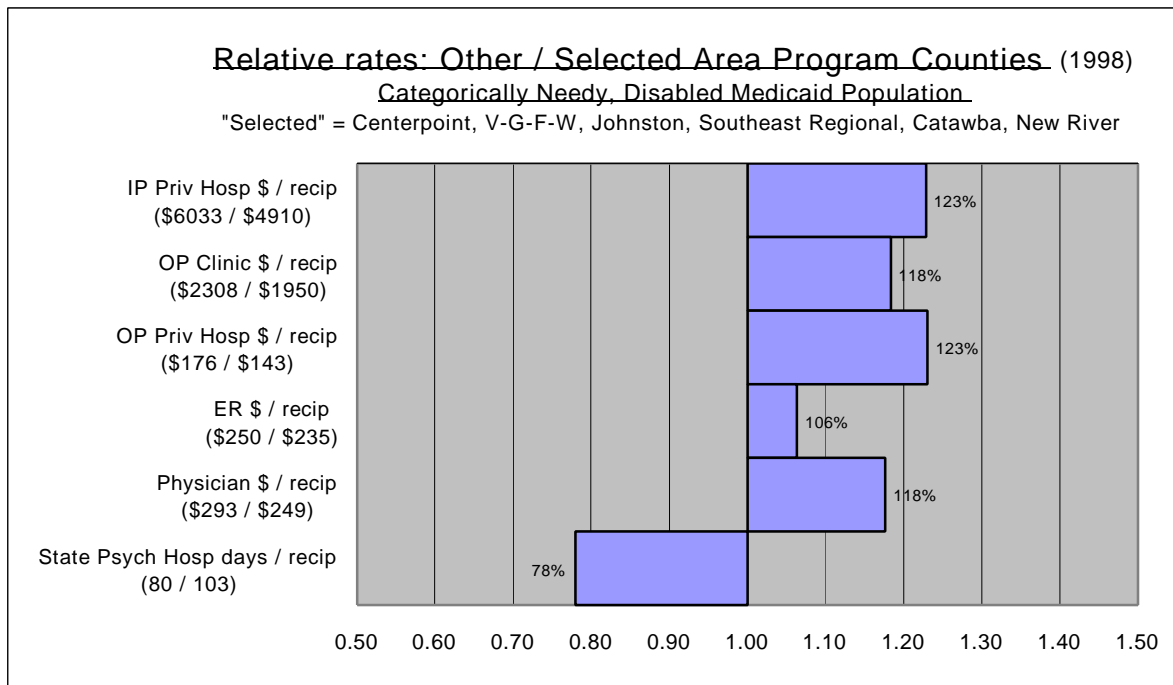


The number of all Medicaid enrollees in the "other" programs is 1.21 times the number of people in the general county populations living below the poverty line. This rate is 96% as high as 1.26, the rate of those enrolled in counties served by the "selected" programs. The fraction of all Medicaid eligibles who received any Medicaid-reimbursed mental health services during the year was 0.130 for the "others", 0.122 for the "selected", a relative difference of 10%. The Medicaid expenditures on these services, however, were 5% lower (\$275 vs. \$288) for the "others". When we examine the level of Medicaid mental health expenditures only on those clients who received services, the "others" spent about 10% less per recipient (\$2120 vs. \$2367). So far, we suggest that these differences are nearly a "wash" – that the "other" and the "selected" program counties are well matched.

The remaining lines of the chart refer to Medicaid services provided to Categori- cally Needy and Disabled (“CND”) adults. Here we are starting to see some substantial apparent differences between the “others” and the “selected”. Some of these differences can be attributed to the larger fluctuations that we would expect to see in smaller populations. We are not attempting to establish statistical significance, however. We are using these measures in order to:

- validate or to challenge decision-makers’ and providers’ perceptions of the way the system is presently working;
- trigger discussion of how area programs have defined their roles within the more general public mental health mission; and
- validate that the historical performance of the “selected” area programs was due to factors under their control and are within the capabilities of the rest of the state.

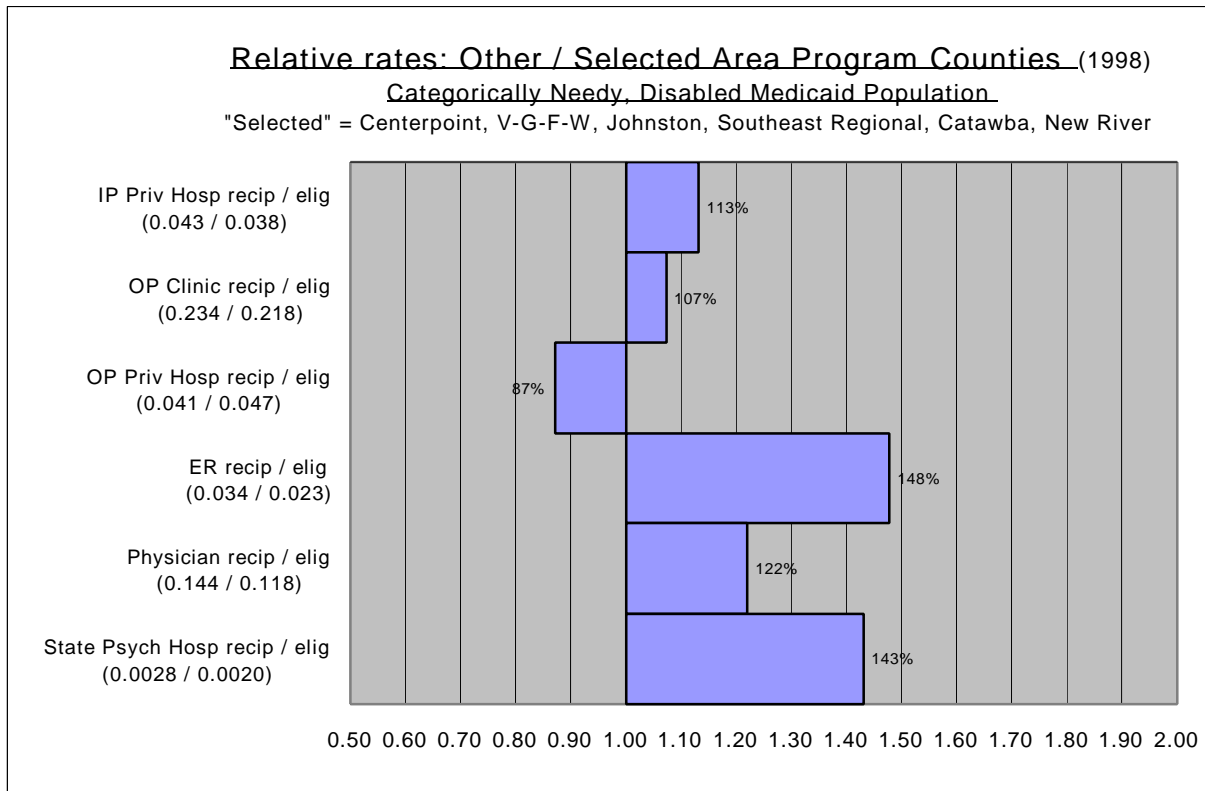
We see in the chart the fraction of Medicaid eligibles who were Categori- cally Needy and Disabled in the “other” group were 0.065, vs. 0.072 in the “selected”. About one third of these people received some mental health services in the year. In the “other” program counties, about 10% more people were served and each of these people received 14% more costly Medicaid mental health services, so Medicaid mental health expenditures per CND eligible (including those who received no services) were 25% higher. This finding would be consistent with the expectation that higher utilizers of the state psychiatric hospitals might be higher utilizers of Medicaid-reimbursed services. It would be inconsistent with the expectation that higher utilizers of the state psychiatric hospitals had substituted inpatient services for Medicaid-reimbursed outpatient services in the same year. The following chart elaborates somewhat on the rates of utilization of different types of Medicaid services.



The first five lines of the chart show consistently higher utilization of five major types of Medicaid-reimbursed services by CND residents of the “other” counties who received each of the services. The last line refers only to those CND clients who were identifiable on state hospital admissions records.

“Other” county residents used only 78% as many state hospital services as “selected” county residents. This finding might be counter-intuitive, but, absent reliable diagnostic information, we cannot tell from this limited profile whether comparable clients had shorter stays, or whether the “others” used the hospital for short stays as well as long stays.

The next chart potentially sheds some light on this question.

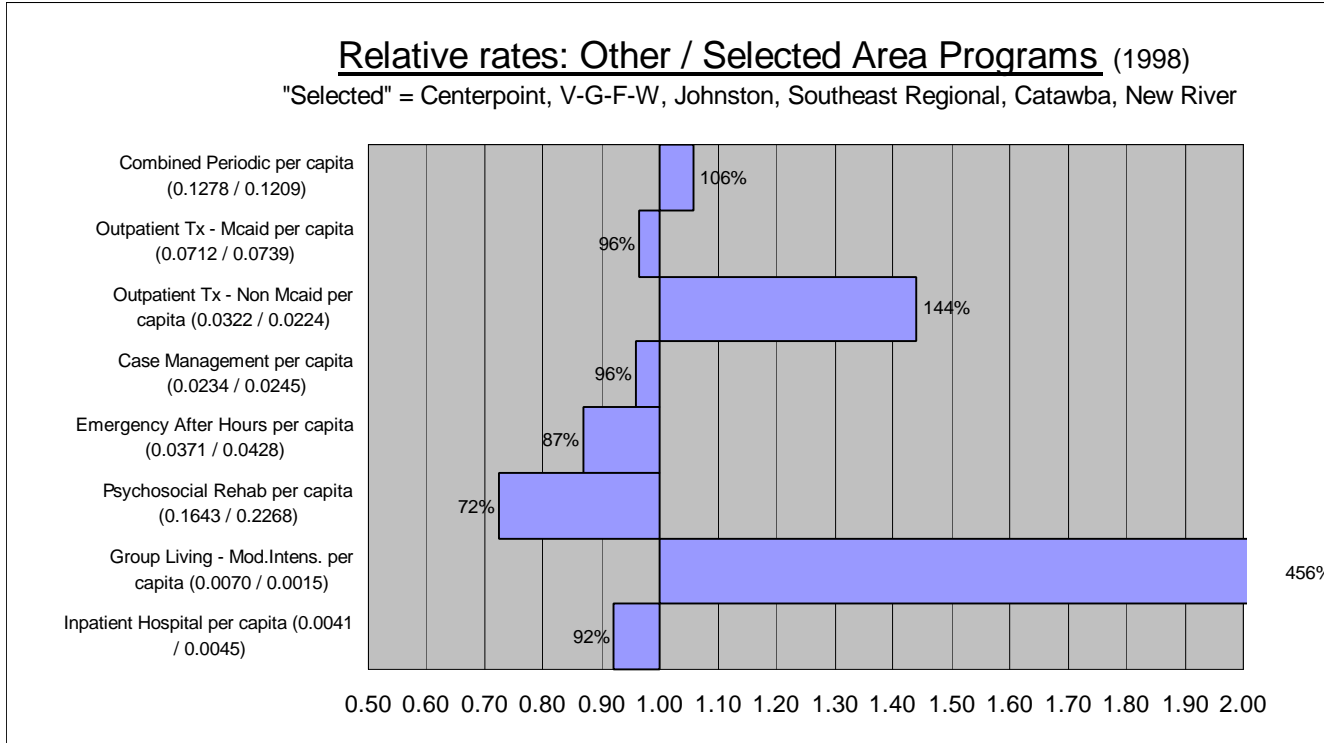


Looking at the bottom line first, we see that adult CND eligibles from the “other” counties were 43% more likely to use the state psychiatric hospitals than were those from the “selected” program counties. The remaining lines show that for four out of five Medicaid-reimbursed service types, residents of the “other” counties were more likely to receive services and (from the previous chart) those who did receive services used more services than their counterparts in the “selected” counties. For example, the combined effect of inpatient private hospital utilization is one-third more hospital days for CND eligibles in “other” counties.

Pioneer Data

The Pioneer cost finding data give another perspective on the delivery of community adult mental health services. Obviously, these do not include any services to area program clients that were provided by and directly billed by other vendors. Medicaid direct billings are one example. Still, if the data tell a similar story, we will have made a stronger case for the validity of the measures.

Analyzing cost finding data requires two important caveats. First, not every program offers every type of service. Moreover, not every program may define service types in exactly the same way. The latter point is reinforced by our observation that reimbursement rates for the same “service” may vary by orders of magnitude.



For adult mental health, Combined Periodic services constituted 35% of program reimbursements. Outpatient treatment-Medicaid constituted 23%, and outpatient treatment-non-Medicaid constituted 9%. Case management represented 6%; Emergency After Hours services were 3%; Psycho-social rehab was 6%; Group Living (Moderate Intensity) 2%; and inpatient hospitalization was 5%.

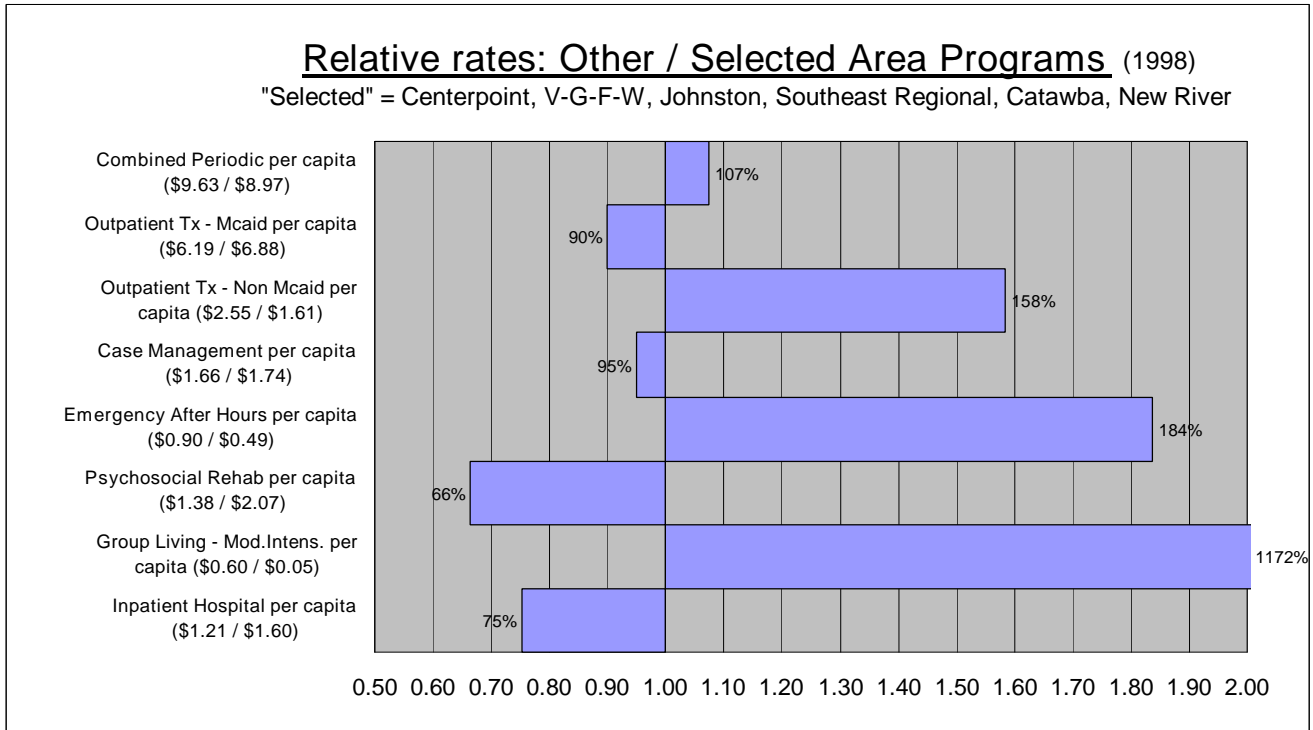
A comparison of *per capita* (general population) adult mental health units of service by service type reveals wide differences between the “others” and the “selected” programs.

The following chart shows *per capita* reimbursements by service type.

The differences in these two profiles result from differences in reimbursement rates. Most dramatic are: Emergency After Hours services, which are reimbursed at \$24.30/hour for the “other” programs, but only at \$11.48/hour for the “selected” programs; and Group Living (Moderate Intensity), which is reimbursed at \$84.86/day for the "other" programs, but at \$33.00/day for the “selected” programs.

The “other” programs appear to provide far more non-Medicaid outpatient treatment, somewhat less psychosocial rehab services, and almost five times the number (at twelve times the cost) of moderate intensity group living services.

Both of these profiles, we believe, are highly skewed by our decision to exclude “special case” Mecklenburg from the “selected” programs, which placed it among the “others”.



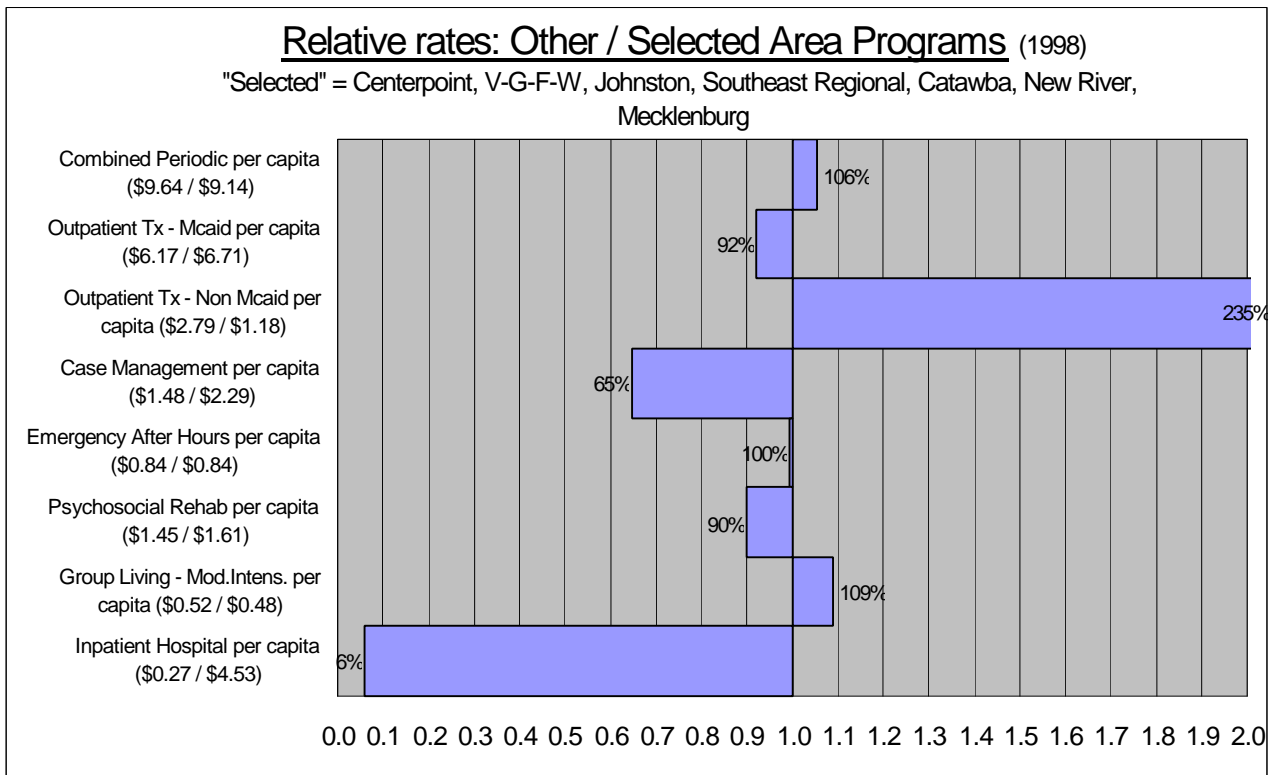
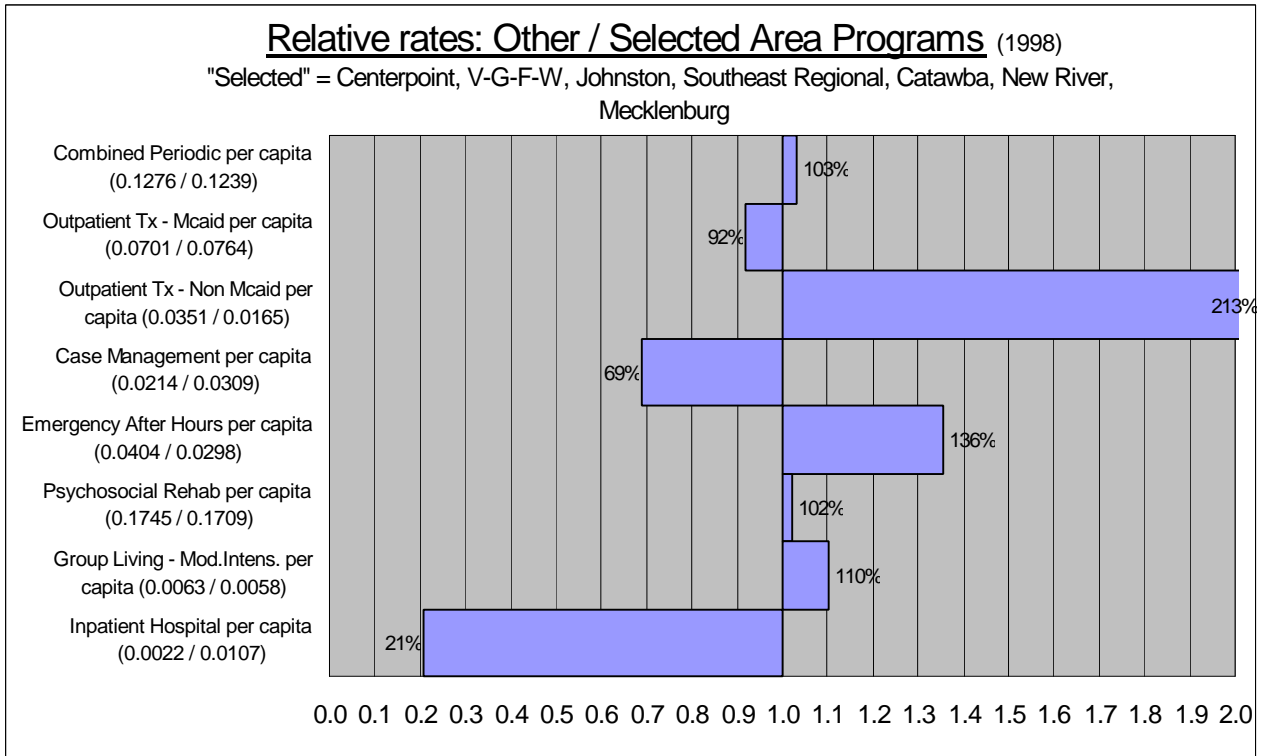
Adding Mecklenburg to the “selected” group produces the two charts on the following page.

Outpatient Treatment-Non-Medicaid is now over twice as frequent in the “other” vs. the “selected” programs. Case management services in the “other” programs are now clearly lower than in the “selected”. Emergency After Hours services now have reversed, with far more in the “other” programs than in the “selected”. Psychosocial Rehab and Moderate Intensity Group Living are now more closely matched. Strikingly, inpatient hospital utilization in the “other” programs is only 21% that of the “selected”, a result of Mecklenburg’s very high use of those facilities.

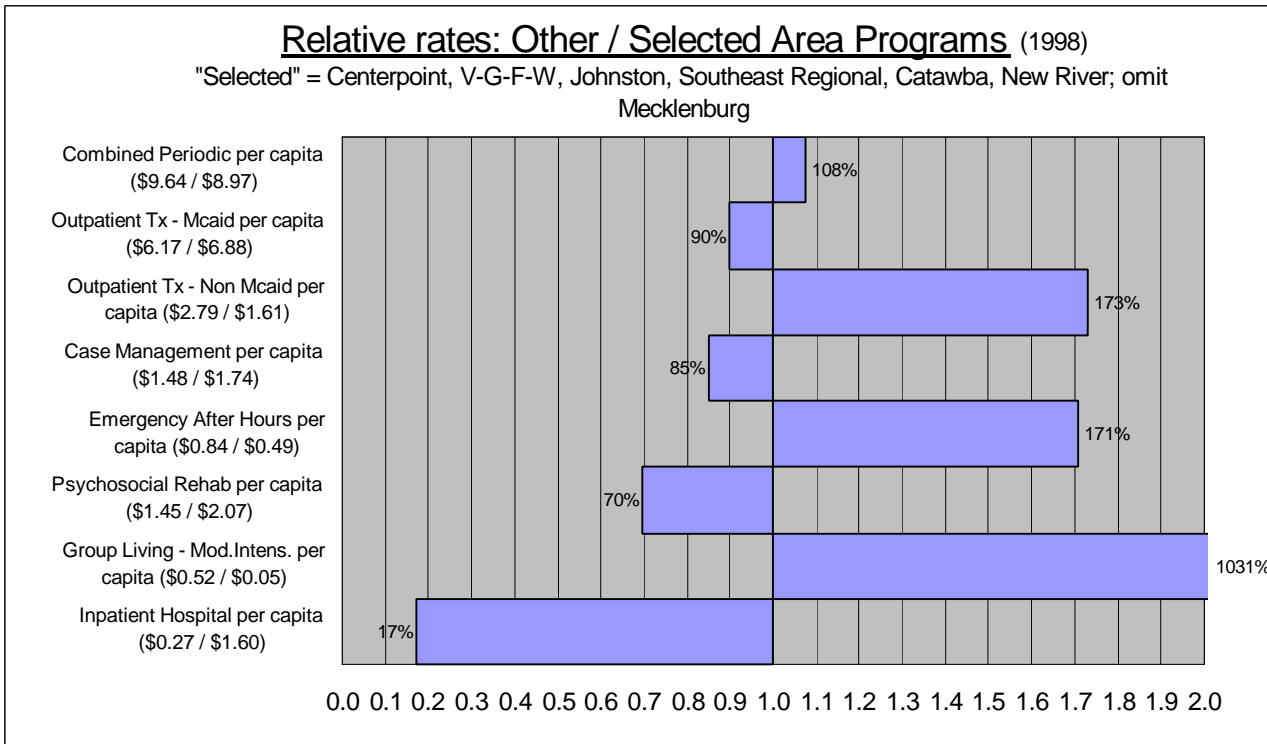
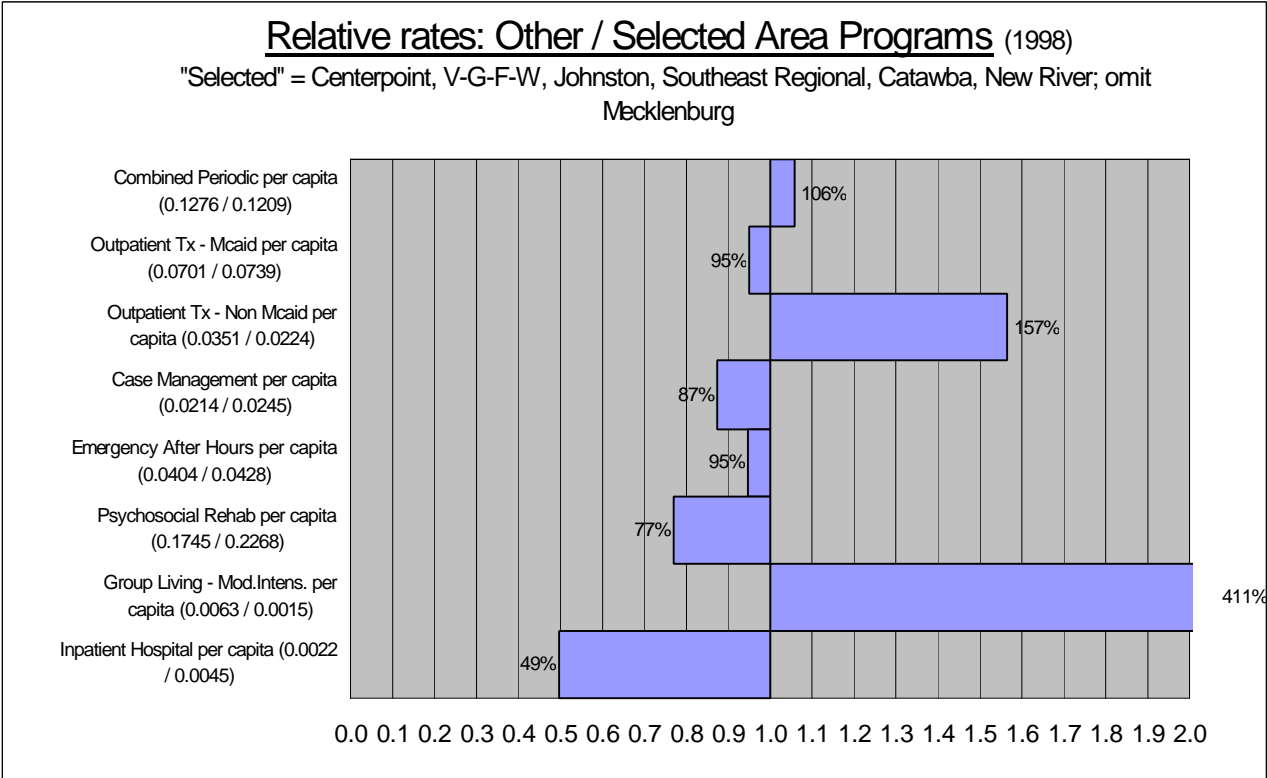
When Mecklenburg is excluded from both the “selected” and the “others”, the results are those shown on the subsequent page. Except for inpatient hospital utilization, this looks quite like the original set of charts. Clearly, the choice of whether or not to include Mecklenburg among the “selected” programs, where it significantly alters the overall service utilization profile, would reflect a value judgement as to the superiority (and generalizability) of one service model over the other.

The “other” programs use about 50% more non-Medicaid outpatient treatment, about 50% less inpatient private hospital treatment, and over four times as much of moderate intensity group living as the “selected” programs. The inpatient rate, which would seem to be counter-intuitive, translates to 228 fewer private hospital inpatient days/100,000 for adult mental health. However, the “other” programs’ use of the state psychiatric hospitals for adult mental health was 2,116 days/100,000 *higher* than the “selected” programs. The combined effect is that “other” programs consume 31% more private plus state days/100,000. These findings reinforce those on the Categorically Needy and Disabled Medicaid population, who were one-third more likely to be hospitalized in “other” program counties than in “selected” program counties.

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND



2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND



Bed Demand Calculation – Stage 1

PCG contrasted historic state psychiatric hospital utilization by the “selected” and “other” programs for seven service cohorts: short-term and long-term youth mental health, short term and long term adult mental health, short term and long term geriatric mental health, and substance abuse. The age criteria (*i.e.*, adults were between 21 and 64 years of age) were determined at admission. Similarly, mental health and substance abuse were based on admission/commitment status. The threshold between short-term and long-term stays was set at 30 days.

	Meck	Other	Selected			Reduced	Percentage
Population	624,464	5,782,011	1,137,885	Rate	Bed-days	"Book"	Reduction
FY98 Days / 100,000				Difference	Difference	Population	
Short-term youth MH		156	71	85	4,915	13	50%
Long-term youth MH		982	587	395	22,839	63	36%
Short-term adult MH		790	331	459	26,539	73	54%
Long-term adult MH		5081	3948	1133	65,510	179	19%
Short-term geriatric MH		21	18	3	173	0	12%
Long-term geriatric MH		1860	1339	521	30,124	83	25%
Substance abuse		811	612	199	11,506	32	21%
Total						443	

For each cohort, PCG computed the amount by which bed days in FY98 would have fallen if the “other” programs (excluding Mecklenburg) had used the hospitals at the same rates as the “selected”. That calculation is shown below.

For each service cohort, the utilization rate difference is noted. The rate difference is multiplied by the “other” general population to produce a bed-days difference. Dividing by 365 yields the reduced book population, which is the average daily census (resident population) plus the population on leave. Using the book population allows us to focus principally on the referral/admission decision process, rather than on concurrent utilization review or discharge planning.

Impact Analysis – Stage 1

The following page illustrates the impact of one of these utilization targets – long-term adult mental health – on each area program. Of course, the impact depends entirely upon the mechanism that is used to implement the new standard. One such implementation is chosen here.

In FY98, the “selected” programs utilized 3948 days/100,000; the “others” utilized 5081 on average. It can be shown that if each area program whose utilization rate exceeded 4520 days/100,000 were reduced to that level, the new average rate for the “other” programs would be 3948 – our target rate. Because some of the “selected” programs would also experience small reductions, their new average rate would fall slightly to 3846. Combining county-specific target utilization days, and re-introducing Mecklenburg to the calculation, brings the new state-wide target utilization rate to 3832.

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Stage 1 Long Term Adult Mental Health Admissions

Region	Area Program	Population	Days FY98	Days98 / 100k	Target Rate	Target Days	Target / Days98
E	Albemarle	111,996	6821	6090	4520	5062	74%
E	Duplin-Sampson	98,270	6643	6760	4520	4442	67%
E	Edgecombe-Nash	143,341	13247	9242	4520	6479	49%
E	Halifax	55,182	2883	5225	4520	2494	87%
E	Lenoir	59,024	4797	8127	4520	2668	56%
E	Neuse	170,250	10525	6182	4520	7695	73%
E	Onslow	148,324	4400	2966	2966	4400	100%
E	Pitt	123,155	9147	7427	4520	5567	61%
E	Roanoke-Chowan	72,609	8197	11289	4520	3282	40%
E	Southeastern	255,840	18417	7199	4520	11564	63%
E	Tideland	91,017	9914	10892	4520	4114	42%
E	Wayne	114,246	9544	8354	4520	5164	54%
E	Wilson-Greene	87,204	7112	8156	4520	3942	55%
N	Alamance-Caswell	144,333	9822	6805	4520	6524	66%
N	Centerpoint	366,318	16145	4407	4407	16145	100%
N	Crossroads	215,069	7631	3548	3548	7631	100%
N	Durham	200,219	20194	10086	4520	9050	45%
N	Guilford	388,519	19209	4944	4520	17561	91%
N	O-P-C	188,245	9648	5125	4520	8509	88%
N	Rockingham	89,510	5398	6031	4520	4046	75%
N	V-G-F-W	147,682	7839	5308	4520	6675	85%
S	Cumberland	295,053	9745	3303	3303	9745	100%
S	Davidson	142,512	2055	1442	1442	2055	100%
S	Johnston	106,918	3842	3593	3593	3842	100%
S	Lee-Harnett	132,867	4568	3438	3438	4568	100%
S	Randolph	124,444	3181	2556	2556	3181	100%
S	Sandhills	194,809	6547	3361	3361	6547	100%
S	Southeast Regional	231,690	8420	3634	3634	8420	100%
S	Wake	575,696	23392	4063	4063	23392	100%
W	Blue_Ridge	242,241	11327	4676	4520	10949	97%
W	Catawba	131,256	2742	2089	2089	2742	100%
W	Cleveland	91,410	4500	4923	4520	4132	92%
W	Foothills	231,271	10777	4660	4520	10453	97%
W	Gaston-Lincoln	240,149	8113	3378	3378	8113	100%
W	Mecklenburg	624,464	17056	2731	2731	17056	100%
W	New_River	154,021	5936	3854	3854	5936	100%
W	Piedmont	409,928	11749	2866	2866	11749	100%
W	Rutherford	76,251	4521	5929	4520	3447	76%
W	Smoky_Mountain	160,260	6015	3753	3753	6015	100%
W	Trend	108,767	3734	3433	3433	3734	100%

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

These impacts, when collected by region, produce the following results.

Region	Population	Days FY98	D98 / 100k	Target Rate	Target Days	Target / Days98	Reduced "Book"
E	1,530,458	111647	7295	4369	66872	60%	123
N	1,739,895	95886	5511	4376	76141	79%	54
S	1,803,989	61750	3423	3423	61750	100%	0
W	2,470,018	86470	3501	3414	84326	98%	6
State	7,544,360	355753	4715	3832	289089	81%	183

A similar impact analysis can be performed on short term adult mental health admissions, with the following regional results.

Region	Population	Days FY98	D98 / 100k	Target Rate	Target Days	Target / Days98	Reduced "Book"
E	1,530,458	14005	915	330	5051	36%	25
N	1,739,895	9847	566	324	5634	57%	12
S	1,803,989	10839	601	316	5703	53%	14
W	2,470,018	15995	648	289	7126	45%	24
State	7,544,360	50686	672	312	23513	46%	74

When these impacts are collected for all seven service cohorts by region, the results are shown below.

	E		N		S		W		State	
	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"
Short-term youth MH	40%	5	48%	4	57%	2	58%	3	50%	14
Long-term youth MH	54%	20	53%	24	61%	21	95%	1	63%	66
Short-term adult MH	36%	25	57%	12	53%	14	45%	24	46%	74
Long-term adult MH	60%	123	79%	54	100%	0	98%	6	81%	183
Short-term geriatric MH	100%	0	89%	0	99%	0	71%	0	87%	1
Long-term geriatric MH	62%	42	82%	14	92%	5	72%	30	74%	91
Substance abuse	100%	0	69%	32	100%	0	100%	0	78%	32
Total Book Reduction		215		140		42		64		461
6-30-98 Book Population		549		614		430		526		2119
Percent Reduction		39%		23%		10%		12%		22%
FY98 Ave Daily Residents		507		492		328		515		1842
MGT Operating beds		661		513		429		632		2235
Bed Capacity Reduction		259		117		45		77		486
Future Bed Demand		402		396		387		555		1741

A clear region-specific pattern begins to emerge. Significant recommended reductions in adult long-term mental health bed demand in the eastern region are consistent with MGT's recommendation for closure of nursing facility units, particularly at Cherry Hospital. PCG also recommends deep reductions in demand for short-term adult mental health beds at Cherry. Other regions, however, whose utilization of long-term adult mental health beds was unexceptional, are encouraged to cut their short-term adult mental health bed demand in half.

Because the bed demand calculation focuses on hospital *admissions*, reductions in demand affect the *book* populations, which include the resident population plus those clients on leave. (The reductions shown here sum to 461 rather than 443 as in the first table. The reason is that small reductions were achieved even among the "selected" programs when they were held to the same standard as the "others". For example, target long-term adult mental health days at V-G-F-W were set 15% below their FY98 actual utilization.)

Statistics published by DMHDDSAS reveal substantial apparent differences in leave policies among state hospitals. (For simplicity's sake, each region is here assumed to be served exclusively by the one hospital primarily responsible for that catchment area.) Though book population is reported for just a single point in time (here, June 30, 1998), average daily residents in FY98 compared to the book population varies from a low of 76% at Dix in the South Central region, to a high of 98% at Broughton in the West. Cherry and Umstead are 92% and 80%, respectively.

Hospital occupancy rates, the average daily residents as a proportion of total operating beds, also vary widely, from a low of 76% at Dix (including 59 pre-trial evaluation, clinical research and deaf beds) to a high of 96% at Umstead. Cherry and Broughton are 77% and 81%, respectively.

To calculate the reduction in bed capacity at each hospital (*i.e.* in each region), the prescribed percentage reduction in the book population was applied to the total number of operating beds reported by MGT, thus preserving the book-population-to-operating bed ratio at each hospital in FY98: 83% at each of Cherry and Broughton, 100% at Dix, and 120% at Umstead. This approach favors Umstead, reducing bed capacity by *less* than the reduction in book population, and may need to be revisited.

The computed capacity reductions were subtracted from the MGT total operational beds in FY98 to arrive at projected future regional bed demand. (We note that, since the MGT report was published in March 1998, Cherry has reduced the number of operational nursing facility beds by nineteen, bringing its total current capacity to 642. Dix has added seventy-two beds to its forensic treatment unit, bringing its total current capacity to 501.) Because the bed utilization, hospital bed capacities and bed reductions used by PCG were all contemporaneous to FY98, our future bed demand projections are unaffected by recent changes in hospital capacity.

Practical implications and limitations of the Stage 1 Bed Demand Calculation

The stage 1 bed demand calculation demonstrates that state-wide psychiatric hospital bed capacity can be safely reduced by nearly 500 beds merely by promoting "best practice" as it is currently performed in six well-run programs in North Carolina. The hierarchical analysis which preceded it established the unexceptional nature of the "selected" group in contrast to the "others", except for their patterns of treatment. The Pioneer cost-finding data analysis profiled the difference in service mix between the "selected" and the "others", suggesting several possible mechanisms for substitution of alternative services for state psychiatric hospital inpatient care. The relatively higher utilization of private inpatient hospitalization by the "selected" programs, however, suggests the need for further analysis of how the "selected" programs have used inpatient care, including admission criteria, treatment objectives and discharge criteria.

The 22% reduction in total beds accomplished through the stage 1 calculation is comparable to the 23% amount by which North Carolina was found earlier to exceed the average of nine peer-group states for adult bed capacity. Thus, the top-down and bottom-up analyses have converged.

The mechanism selected to illustrate the impact of these reductions – reduction of the heaviest hospital utilizers to a statewide maximum target – affected the Eastern region disproportionately to the rest of the state. It may be both epidemiologically and administratively justifiable to first address the most serious over-utilizers. This approach achieves the maximum statewide impact while focusing effort on the smallest number of programs. It may not, however, adequately address opportunities for improvement of treatment and referral practices elsewhere in the state, as evidenced by the wide statistically-unexplained variations among programs.

PCG's hierarchical analysis highlighted numerous programs that seem to have underperformed in outreach, accessibility, enrollment of Medicaid eligibles, provision of a full range of services, and other factors that are believed to correlate with demand for mental health treatment. These programs might be encouraged to *increase* the number of clients served and the number of services used. Some of the new clients could require inpatient services. The increased inpatient volume is expected to be small, but is exceedingly difficult to estimate. Among the imponderables is the question of whether increased outreach would result in the delivery of more effective and more timely treatment to clients who would otherwise first encounter the system as emergencies.

Lastly, to ignore the positive lessons of the Mecklenburg area program would be an injustice to the rest of the state. First-ranked in county adult mental health appropriations *per capita*, the program is nevertheless only 18th out of 40 in total adult mental health spending *per capita*; thus, treatment modality decisions (*e.g.*, inpatient *vs.* outpatient services) in Mecklenburg may not be based on affluence disproportionate to the rest of the state, as is commonly attributed. Thus, we wish to incorporate some portion of Mecklenburg's experience into a somewhat more ambitious state-wide target.

Bed Demand Calculation – Stage 2

The stage 2 bed demand calculation begins the same as stage 1, except that Mecklenburg is included among the “selected” programs. The preliminary result is that state psychiatric hospital book population can be reduced by an additional 168 beds. For stage 2, however, PCG proposes a minor modification to the target implementation, described below, that would serve two purposes:

- all area programs would be encouraged to build up local capacities for community alternatives to state hospital inpatient services; and
- “surplus” capacity would be left in the system to absorb new demand from area programs expanding outreach, access, etc.

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

The stage 2 “other” vs. “selected” table is shown here.

Population	Other	Selected			Reduced	Percentage Reduction
	5,782,011	1,762,349	Rate Difference	Bed-days Difference	"Book" Population	
FY98 Days / 100,000						
Short-term youth MH	156	59	97	5,609	15	58%
Long-term youth MH	982	414	568	32,842	90	53%
Short-term adult MH	790	283	507	29,315	80	60%
Long-term adult MH	5081	3517	1564	90,431	248	27%
Short-term geriatric MH	21	12	9	520	1	39%
Long-term geriatric MH	1860	1130	730	42,209	116	35%
Substance abuse	811	429	382	22,087	61	43%
Total					611	

Impact Analysis – Stage 2

For stage 2, PCG proposes a different mechanism than was used in stage 1 for setting area program demand targets that are subsequently aggregated to project needed state psychiatric hospital bed capacity. The new approach attempts to broaden the focus to more programs, rather than just to those who historically were the highest utilizers.

In stage 2, each program exceeding the stage 2 “selected” program average rate is challenged to close 60% of the distance between its current level of utilization and that of the “selected” programs. For example, the long-term adult mental health target utilization rate for the “selected” programs, above, is 3517 bed days/100,000. Wake County, who were unaffected by the stage 1 target, would now be encouraged to reduce their long-term adult mental health utilization rate from 4063 to 3736.

The stage 2 long-term adult mental health impacts on area programs are shown on a following page. These impacts, aggregated to the regional level, are shown below.

Region	Population	Days FY98	D98 / 100k	Target Rate	Target Days	Target / Days98	Reduced "Book"
E	1530458	111647	7295	3826	58555	0.524	145
N	1739895	95886	5511	3861	67171	0.701	79
S	1803989	61750	3423	3307	59651	0.966	6
W	2470018	86470	3501	3236	79929	0.924	18
State	7544360	355753	4715	3517	265306	0.746	248

Collecting impacts for all seven service cohorts by region, as before, yields the following stage 2 results table. The calculation yields a theoretical level of 1573 beds, which is the difference between MGT’s 2235 bed count and the 662 bed capacity reduction recommended by PCG.

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

	E		N		S		W		State	
	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"	Target / Days98	Reduce "Book"
Short-term youth MH	35%	5	43%	4	52%	3	52%	4	45%	15
Long-term youth MH	43%	24	43%	29	47%	29	80%	6	50%	88
Short-term adult MH	33%	26	53%	13	49%	15	42%	26	43%	79
Long-term adult MH	52%	145	70%	79	97%	6	92%	18	75%	248
Short-term geriatric MH	75%	0	63%	0	63%	0	50%	1	60%	2
Long-term geriatric MH	51%	54	72%	22	80%	11	64%	40	64%	126
Substance abuse	100%	0	39%	64	69%	8	98%	0	52%	72
Total Book Reduction		254		211		72		95		630
6-30-98 Book Population		549		614		430		526		2119
Percent Reduction		46%		34%		18%		18%		30%
FY98 Ave Daily Residents		507		492		328		515		1842
MGT Operating beds		661		513		429		632		2235
Bed Capacity Reduction		306		176		66		114		662
Future Bed Demand		355		337		363		518		1573

PCG's adjustments for changes in system capacity that have taken place since the MGT report yield a 667 bed reduction from a current capacity of 2288 beds, or a net **1621** bed capacity. This level, we believe, will also accommodate potentially elevated demand resulting from expanded community outreach. The 667 bed reduction, of which approximately 480 would affect adult mental health, would bring North Carolina near the mean of the nine peer-group states used in PCG's top-down analysis, with four states – Illinois, Kentucky, Massachusetts and Ohio – having still fewer adult mental health beds per 100,000 adults.

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

Public Inpatient Care in Peer Group States

STATE ADULT BED UTILIZATION AND ADMISSION BY POPULATION
(State Hospital and State-RunCMHCs Only)

STATE	POPULATION 1995 Projected Census	% 18+	ADULT BEDS CAPACITY	ADULT ADMISSIONS	BEDS AND ADMISSIONS PER 100,000	
					INPATIENT ADULT BEDS	INPATIENT ADULT ADMISSIONS
ILLINOIS	11,830,000	73.58%	1601	8836	18.39	101.52
KENTUCKY	3,860,000	74.82%	648	5811	22.44	201.21
MASSACHUSETTS	6,074,000	76.42%	1084	1540	23.35	33.18
MICHIGAN	9,549,000	73.62%	NA	NA	NA	NA
MISSOURI	5,324,000	74.04%	1304	8158	33.08	206.95
NORTH CAROLINA	7,195,000	75.00%	1745	13138	32.34	243.48
OHIO	11,151,000	74.35%	1333	5587	16.08	67.39
PENNSYLVANIA	12,072,000	75.90%	4040	2256	44.09	24.62
SOUTH CAROLINA	3,673,000	74.30%	960	10362	35.18	379.70
VIRGINIA	6,618,000	75.64%	2483	8109	49.60	161.99
TOTAL	77,346,000	74.73%	15,198	63,797	26.29	110.37

Notes:

Illinois - The total Adult Beds figure excludes Chester, a stand-alone forensic facility

Michigan - Michigan has sent data, but PCG not yet received it

North Carolina - The total Adult Beds figures are from MGT's report, and the admissions data is from the FY 98 NC Psychiatric Hospitals Annual Statistical Report

South Carolina - The total Adult Beds figure excludes the ICF/MR at South Carolina State Hospital and the NGRI unit at William S. Hall Psych Institute.

(The total Adult Admissions data is estimated from proportion of child to adult beds)

The 1621 bed target should not be regarded as a “floor”. It is not tied to reductions in specific hospital Units. Nevertheless, PCG has modeled one of several ways in which the recommended bed reductions might be implemented. One such model consistent with the foregoing analysis might distribute the remaining beds as follows:

Youth	78
Adult Admissions	376
Rehabilitation	299
Adult Long Term	340
High Management	60
Geriatric Admissions	101
Geriatric Long Term	178
Nursing Facility	0
Nursing	0
Medical / Surgical	53
Pre-trial Evaluation	102
Research	12
Deaf	17
Tuberculosis	5

2.2 HOSPITAL UTILIZATION AND PROJECTED DEMAND

This implementation would clearly offer further opportunities for reductions in medical/surgical beds, the tuberculosis unit, and perhaps some of the remaining youth and geriatric beds. Some county programs, we expect, can and will go further than current “local best practice” in developing local alternatives to hospitalization.

Stage 2 Long Term Adult Mental Health Admissions

Region	Area Program	Population	Days FY98	FY98 days /100k	Year 1 days /100k	Year 2 Target Rate	Year 2 Target Days	Year 2 Target / Year 1
E	Albemarle	111,996	6821	6090	4520	3918	4388	87%
E	Duplin-Sampson	98,270	6643	6760	4520	3918	3850	87%
E	Edgecombe-Nash	143,341	13247	9242	4520	3918	5616	87%
E	Halifax	55,182	2883	5225	4520	3918	2162	87%
E	Lenoir	59,024	4797	8127	4520	3918	2313	87%
E	Neuse	170,250	10525	6182	4520	3918	6671	87%
E	Onslow	148,324	4400	2966	2966	2966	4400	100%
E	Pitt	123,155	9147	7427	4520	3918	4825	87%
E	Roanoke-Chowan	72,609	8197	11289	4520	3918	2845	87%
E	Southeastern	255,840	18417	7199	4520	3918	10024	87%
E	Tideland	91,017	9914	10892	4520	3918	3566	87%
E	Wayne	114,246	9544	8354	4520	3918	4476	87%
E	Wilson-Greene	87,204	7112	8156	4520	3918	3417	87%
N	Alamance-Caswell	144,333	9822	6805	4520	3918	5655	87%
N	Centerpoint	366,318	16145	4407	4407	3873	14188	88%
N	Crossroads	215,069	7631	3548	3548	3529	7591	100%
N	Durham	200,219	20194	10086	4520	3918	7845	87%
N	Guilford	388,519	19209	4944	4520	3918	15223	87%
N	O-P-C	188,245	9648	5125	4520	3918	7376	87%
N	Rockingham	89,510	5398	6031	4520	3918	3507	87%
N	V-G-F-W	147,682	7839	5308	4520	3918	5786	87%
S	Cumberland	295,053	9745	3303	3303	3303	9745	100%
S	Davidson	142,512	2055	1442	1442	1442	2055	100%
S	Johnston	106,918	3842	3593	3593	3548	3793	99%
S	Lee-Hamett	132,867	4568	3438	3438	3438	4568	100%
S	Randolph	124,444	3181	2556	2556	2556	3181	100%
S	Sandhills	194,809	6547	3361	3361	3361	6547	100%
S	Southeast Regional	231,690	8420	3634	3634	3564	8257	98%
S	Wake	575,696	23392	4063	4063	3736	21505	92%
W	Blue_Ridge	242,241	11327	4676	4520	3918	9491	87%
W	Catawba	131,256	2742	2089	2089	2089	2742	100%
W	Cleveland	91,410	4500	4923	4520	3918	3582	87%
W	Foothills	231,271	10777	4660	4520	3918	9062	87%
W	Gaston-Lincoln	240,149	8113	3378	3378	3378	8113	100%
W	Mecklenburg	624,464	17056	2731	2731	2731	17056	100%
W	New_River	154,021	5936	3854	3854	3652	5625	95%
W	Piedmont	409,928	11749	2866	2866	2866	11749	100%
W	Rutherford	76,251	4521	5929	4520	3918	2988	87%
W	Smoky_Mountain	160,260	6015	3753	3753	3612	5788	96%
W	Trend	108,767	3734	3433	3433	3433	3734	100%

Data needs

To enhance future bed demand analysis and to assist decision-makers in effectively managing future utilization, the Pioneer system must be upgraded or replaced with a system that can capture accurate, complete and consistent client-level, provider-level and encounter-level service data. One of the obstacles to a comprehensive analysis of the entire continuum of behavioral healthcare as delivered by North Carolina's area programs, state psychiatric hospitals, and other public and private facilities, is the need to piece together partial information from many sources. At this highly aggregated level, many significant analytic details are lost and, we suspect, many inconsistencies remain undetected. Any focus on a single service segment or on only a small group of service segments, in contrast to a client-focused longitudinal record, will be inherently limited.

PCG's analysis has attempted to mitigate these limitations by modeling not the individual elements of the service mix, *e.g.*, state beds, Medicaid local beds, indigent contracted beds, *per se*; rather, we have focused on two groups of programs, similar in many ways, but quite different in their historical utilization of the state hospitals. We then more closely compared and contrasted the contributory factors that we believed to be within the programs' control, and we challenged the "others" to emulate the best lessons from the "selected" programs, as these affect the entire continuum of care. To make this target "real", PCG did not artificially construct a hypothetical "ideal" program; nor did we build up bed demand projections using a purely abstract statistical model. The "selected" group are understood to be far less than ideal, capable of significant improvements in their own right, and certainly not meriting emulation in every detail.

Better information are needed to enable North Carolina's decision-makers to develop more sophisticated demand models in the future. PCG feels strongly that client-centered information is key to the improvement of the quality of care, and that North Carolina's Pioneer system lags other states in its ability to support such efforts.

OVERVIEW

In its Phase I report, PCG's discussion of Facility Construction and Renovation of the State Psychiatric Hospitals was concerned primarily with independent review and evaluation of a hospital efficiency study conducted in early 1998 by MGT of America, Inc. for the Department of Mental Health, Developmental Disabilities, and Substance Abuse Services. Our current report builds upon the findings of Phase I and estimates capital costs associated with several possible future construction options for modernizing North Carolina's state hospitals. In review, PCG's earlier findings were:

1. PCG concurred with MGT that building new efficient patient care facilities would likely be more cost-effective over time than renovating existing state hospital buildings, with the possible exception of Broughton.
2. PCG estimated new construction costs between \$297 million (for MGT's recommended 1,287 bed capacity) and \$494 million (for the then-current bed capacity of 2,236). Renovation costs were estimated between \$246 million and \$386 million for the same two capacity levels.
3. A hybrid "new construction/renovation" option was proposed as an alternative to either pure approach.
4. PCG judged that previous estimates of infrastructure maintenance, replacement and decommissioning costs were probably too low. Each of the four hospitals had significantly more real estate and significantly more building space than it actually needed to meet current bed demand.

FUTURE CONSTRUCTION OPTIONS

Following publication of the Phase I report, PCG undertook a comprehensive assessment of North Carolina's *community* mental health, developmental disabilities and substance abuse service infrastructure. Using first-hand observation plus statistical analysis of historical inpatient and outpatient service utilization patterns, PCG produced independent estimates for total future state hospital bed requirements. PCG's regional estimates sum to 1621 beds statewide – a 29% reduction from current capacity, but 26% more beds than MGT's recommended 1287 beds statewide.

PCG does not regard its 1621 bed estimate as a "floor". Further reductions might be justified if county programs aggressively develop local alternatives to hospitalization, and if the state follows through in moving resources from the state hospitals to the counties where the clients are being served. The 1621 bed estimate, we feel, represents a feasible five-year planning target that recognizes the best practices in some parts of the state and current capabilities and constraints of the community service system.

Three possible construction approaches for reaching the 1621 bed capacity were explored: new construction, renovation, and hybrid (renovation plus new construction) approaches. In Phase I of our study, PCG observed that a hybrid option might be most cost effective at Cherry and Umstead hospitals. After further analysis, this finding was confirmed. Both facilities have reasonably good infrastructures and require only "enabling" construction, infilling of courtyards and gut renovation of existing buildings. At Broughton Hospital, extensive renovation of the Avery complex is still the most cost effective approach, so a hybrid option (involving renovation plus new construction) was not explored. Dix Hospital will require new construction in an off-hill location for any level of modern patient care capacity. Infrastructure repair and modernization costs at Dix would be uneconomical, and new patient care construction would be difficult to integrate into the current hill-top complex. For that reason, a hybrid option was not explored.

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Because Dix Hospital has no patient care facilities that merit renovation, we have also analyzed a **potential construction scenario excluding Dix** in order to explore the financial feasibility of a three hospital system. We note that a three hospital system would be feasible from a patient access point of view in North Carolina, given the close proximity of the three hospitals.

A summary of the estimated construction costs for each construction option for the **four hospital model** is shown below. Bed counts are based PCG’s bed demand analysis and on the assumption that all four hospitals would continue to operate. Recommended options are shown in bold.

	Four-hospital model	Cost Per Bed
Cherry beds	333	
Option A: all renovation	\$50,415,515	
Option B: new construction/ patient units	\$72,342,895	
Option C: hybrid	\$63,191,117	\$189,763
Umstead beds	340	
Option A: all renovation	\$59,438,826	
Option B: new construction/ patient units	\$69,039,454	
Option C: hybrid	\$63,769,632	\$187,558
Dix beds	429	
Option A: all renovation	\$85,533,525	
Option B: new construction/ patient units	\$106,106,925	\$247,335
Option C: hybrid	N/A	
Broughton beds	518	
Option A: all renovation	\$106,256,688	\$205,129
Option B: new construction/ patient units	\$122,453,403	
Option C: hybrid	N/A	
Four Hospital Total, Recommended Options	\$339,324,362	\$209,459

Details of capital investment calculations for the recommended construction options for the four hospital model are shown on the following pages.

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Cherry Hospital

Option C.3: Re-use of existing buildings w/ major enabling new construction; four hospital model

Assumptions:

1. U Buildings courtyards will be infilled w/ new construction
2. The existing space will be gutted and fully renovated
3. The renovation/ new mix will be approximately 2/3 renovation to 1/3 new construct
4. In the maintain present No. of beds scheme, Woodard will continue in use also for residential use
5. In the reduced bed scheme, Woodard and Royster will be used for program and support space.
6. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/bed
7. The new power plant and chiller capacity will be fully used as is.
8. Moderate funding is provided for the kitchen, pending outcome of centralizing or outsourcing this service.

	total sf/bed	No./ beds	total sf	U Bldgs Extg sf	U Bldgs Infill (a.)	Total U Bldgs	Activity Center	Royster	McFarland	Woodard	Linville
Residential Units	650	333	216450	151643	64935	216578	39243	102586	24586	62995	228
Program Space	400	333	133200	59312	31665	90977	39243				
total	1050		349650			307555	39243				
Campus Infrastructure											
Mothball/ Unused				7400							
Demolition								102586		62995	228
Sale/ transfer									24586		
Construction Cost (d.) \$/sf				180	225		60	3.5		3.5	3.5
Total \$				39303900	21735000	61038900	2354580	359051	0	220483	800
Asbestos Removal (g.)				1419308	0	0	255080	666809	0	409468	1487
Infrastructure Credit (h.)											

- a. Courtyard infill yields 8,050 sf per floor
- b. Includes Boiler Plant, Laundry, Kitchen, Carpenter Shop, Warehouses 1 and 2, Garage, Paint, Grounds & Engine
- c. Miscellaneous outlying buildings including Residential Hall, Conference Center, Chapel, OT, Carwash, Human re
- d. New construction \$225/sf; total renovation (\$180/sf); major renovation (\$100/sf); minor renovation (\$65/sf); demc
Mothballing (\$1.50/sf per year for 30 year life or \$45/sf);
- g. Asbestos removal is budgeted at \$6.50/sf
- h. Credit for recent infrastructure improvements to chillers & boiler pla

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

John Umstead Hospita

Option C.3: Re-use of existing buildings w/ major enabling new construction; four hospital model

Assumptions:

1. Ward building courtyards will be infilled w/ new construction
2. The existing space will be gutted and fully renovated
3. The renovation/ new mix will be approximately 58% renovation to 42% new construction
4. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/t
5. The existing ward buildings are of concrete fireproof construction and in good shape
6. Structural modules are poor and will be addressed by the infill construction to create a functional footprint
7. The present boiler plant is in good condition and will be used as is.
8. Chillers are in poor shape and will be entirely replaced for the new/ reno facility
9. Asbestos is extensive throughout the existing buildings ceilings, flooring (in some cases) and piping insulation.
10. Moderate funding is provided for the kitchen, pending outcome of centralizing or outsourcing this service.
11. See Option C.4 for a three campus model for the state, assuming Dorothea Dix is closed as a mental Health campus.

	total	Ward Bldgs 29-36 Extg sf	Ward Bldgs 29-36 Infill (a.)	Ward Bldgs 29-36 Total	Barrett Bldg (e)	Activities Center	Admin Bldg	Ward Bldgs 37-54 Extg sf	Food Service
Residential Units	650 340 221000	162530	109559	272088.8	79425	49412	46509	339733	33
Program Space	400 340 136000	82890	55875	138765	79425				
total	1050 357000	162530	109559	272089	79425				
Campus Infrastructure							46509		33
Mothball/ Unused	-2810	0	0	0					
Demolition	-2676					49412		339733	
Sale/ transfer	-5486								
Construction Cost (d.) \$/sf	27088.33	180	225		25	3.5 as is		3.5	
Total \$		29255400	24650730	53906130	1985625	172942	0	1189066	836
Add for asbestos removal (g)		1056445	0		0	0	0	2208265	

- a. Courtyard infill yields 7,025 sf per floor; Ward Bldgs are carried at 18,725 per bldg
- b. Includes Boiler Plant, Service units between 29-43, Laundry, Warehouses and Utility Buildings
- d. New construction \$225/sf; total renovation (\$180/sf); major renovation (\$100/sf); minor renovation (\$65/sf); demolition (\$1.50/sf per year for 30 year life or \$45/sf).
- e. Barrett Building refit for new interior finishes, etc., carried at \$25/sf
- f. Food Service: carried \$25/sf for HVAC upgrade
- g. Carried 6.50/sf for asbestos removal

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Dorothea Dix Hospital

Option B.3: New construction for residential space/ re-use existing for program space; four hospital model

Assumptions:

1. Residential space will be all in new construction
2. The new construction cost budgeted by MGT study is \$38.4 million for reduced beds and \$53.1 million for present
3. Option B revised carries new construction at \$225/sf.
4. The existing space used for programs will be gutted and fully renovated
5. The renovation/ new mix will be approximately 2/3 new to 1/3 renovated space
6. The 30 year renovation cost budgeted by the MGT study is \$14.2 million for reduced beds and \$23.9 million for pr
7. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/bed
8. The existing patient care buildings are mostly of fireproof construction and range in condition.
9. The configuration and layout of the main patient buildings is poorly suited for patient care but marginally usable f
10. The present boilers are in good condition and can be re-used as is.
11. Chillers and distribution systems are in poor shape and will be entirely replaced for the new/ reno facility

	total	New	McBryde	Hargrove	Brown	Wright	Ashby	Service	E	
	sf/bed	No./ beds	Construct	Extg sf	Spruill	Lineberger	Cherry	Bldgs	L	
Residential Units	650	429	278850	278850	406885	77445	40562	73132	73150	242497
Program Space	400	429	171600		171600					
total	1050		450450		171600					
Campus Infrastructure										242497
Mothball/ Unused				235285						
Demolition					77445					
Sale/ transfer						40562	73132	73150		
Construction Cost (d.) \$/sf			225	180/ 45	3.5	as is	as is	as is	as is	
Total \$			62741250	41475825	271057.5	0	0	0	0	
Add for asbestos removal (g)			0	1115400	503392.5	0				
										T

- d. New construction \$225/sf (excluding major site and site utilities); total renovation (\$180/sf); major renovation (\$110/sf); demolition (\$3.50/sf) exclusive of asbestos, etc; mothballing (\$1.50/sf per year for 30 year life or \$45/sf);
- g. Asbestos removal carried at \$6.50/sf

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Broughton Hospital

Option A.3: Reuse of existing campus with all renovation, no new construction; four hospital model

- Assumptions:
1. All patient residential, activity and support space will be in existing buildings
 2. Renovation costs per MGT study are assumed to be the maintenance repair and renovation cost over the 30 year life
 3. Accordingly, the MGT study carried a total 30 year renovation cost of \$72 million for reduced beds and \$85.9 million for full beds
 4. "Capital Replacement" (exhibits 9-5 and 9-6) is assumed not to be applied against renovation costs at the campuses
 5. Existing space re-used for programs will be fully renovated as needed
 6. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/bed
 7. The existing patient care buildings are mostly of fireproof construction and range in condition
 8. The configuration and layout of the Avery Building complex is reasonably suited, with renovation, for inpatient medical services
 9. The present boilers are in good condition and can be re-used as is.
 10. Chillers and distribution systems are in poor shape and will be replaced for the new/ renovation facility
 11. Asbestos piping insulation is present throughout the utility distribution systems.

	No. sf/bed	total beds	total sf	Avery Bldg	Avery Admin/ ctr	Marsh Taylor, Beall rt/ot, voc	Jones Scroggs Harper	McCambell Hoey, Saunc Morrison	Misc Outlying Bldgs	Service Bldgs	Other
Residential Units	650	518	336700	261217	46815	88427	193281	112079	104492	179660	
Program Space	400	518	207200	0		21728	117798	67674			
total	1050		543900	261217		21728	193281	67674			
Campus Infrastructure					46815						179660
Mothball/ Unused						66699	0				
Demolition								44405			
Sale/ transfer									104492		
Construction Cost (d.) \$/sf				180 as is	180/ 45	180/ 45	180/ 3.5	as is	as is		
Total \$				47019060	0	6912495	34790580	12336738	0	0	0
Add for asbestos removal (g)				1697911	0	574776	1256327	288633			

- d. New construction \$225/sf (excluding major site and site utilities); total renovation (\$180/sf); major renovation (\$100/sf); demolition (\$3.50/sf) exclusive of asbestos, etc; mothballing (\$1.50/sf per year for 30 year life or \$45/sf);
- g. Asbestos removal primarily for piping insulation carried at allowance of \$6.50

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Three Hospital Model

PCG has noted that every state hospital has significantly more real estate and significantly more building space than it actually needs to meet current bed demand, and the present capacity of any three hospitals exceeds aggregate future statewide bed demand; thus, PCG sought to understand some of the implications of a **three hospital model**. The western portion of the state is clearly served by Broughton Hospital, but the eastern and central portions are served by three hospitals that all lie within 50 miles of Raleigh. For reasons that will be discussed further below, Dorothea Dix Hospital was selected for closure to illustrate one possible three-hospital scenario. Catchment regions for each of the remaining hospitals were redrawn to place each North Carolina county within the region of the nearest facility. The recommended 1621 state bed capacity was redistributed to these three facilities. Each hospital was then evaluated for the most cost-efficient, long-term capital investment option.

	Three-hospital model	Cost Per Bed
Cherry beds	465	
Option A: all renovation	\$66,818,732	
Option B: new construction/ patient units	\$97,335,408	
Option C: hybrid	\$88,110,339	\$189,485
Umstead beds	638	
Option A: all renovation	\$108,312,370	
Option B: new construction/ patient units	\$134,092,880	
Option C: hybrid	\$117,531,791	\$184,219
Dix beds	0	
Option A: all renovation	\$7,268,270	(closing costs)
Option B: new construction/ patient units	\$0	
Option C: hybrid	N/A	
Broughton beds	518	
Option A: all renovation	\$106,256,688	\$205,129
Option B: new construction/ patient units	\$122,453,403	
Option C: hybrid	N/A	
Three Hospital Total, Recommended Options	\$319,167,088	\$196,895

Details of capital investment calculations for the recommended options for the three hospital model are shown on the following pages.

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Cherry Hospital

Option C.4: Re-use of existing buildings w/ major enabling new construction; three hospital model

- Assumptions:
1. U Buildings courtyards will be infilled w/ new construction
 2. The existing space will be gutted and fully renovated
 3. The renovation/ new mix will be approximately 2/3 renovation to 1/3 new construct
 4. In the maintain present No. of beds scheme, Woodard will continue in use also for residential use
 5. In the reduced bed scheme, Woodard and Royster will be used for program and support space.
 6. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/bed
 7. The new power plant and chiller capacity will be fully used as is.
 8. Moderate funding is provided for the kitchen, pending outcome of centralizing or outsourcing this service.

			total	U Bldgs Extg sf	U Bldgs Infill (a.)	Total U Bldgs	Activity Center	Royster	McFarland	Woodard	Linville
	sf/bed	No./	ber/sf								
Residential Units	650	465	302250	218355	96600	314955	39243	102586	24586	62995	228
Program Space (e.)	400	465	186000	174684	77280	251964		0		50396	
total	1050		488250	218355	96600	314955	39243	48282		62995	228
Campus Infrastructure											
Mothball/ Unused								54304			
Demolition											
Sale/ transfer									24586		
Construction Cost (d.) \$/sf				180	250		65	180/ 45		180/100	1
Total \$				39303900	24150000	63453900	2550795	11134440		0 10331180	22885
Asbestos Removal (g.)				1419308	0	0	255080	313833		0 409468	1487
Infrastructure Credit (h.)											

- a. Courtyard infill yields 8,050 sf per floor
- b. Includes Boiler Plant, Laundry, Kitchen, Carpenter Shop, Warehouses 1 and 2, Garage, Paint, Grounds & Engineer
- c. Miscellaneous outlying buildings including Residential Hall, Conference Center, Chapel, OT, Carwash, Human res
- d. New construction \$250/sf; total renovation (\$180/sf); major renovation (\$100/sf); minor renovation (\$65/sf); demo Mothballing (\$1.50/sf per year for 30 year life or \$45/sf).
- e. This option does not allow for 400sf of program space per bed; reduced by availability of space to 305sf/bed
- g. Asbestos removal is budgeted at \$6.50/sf
- h. Credit for recent infrastructure improvements to chillers & boiler pla

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

John Umstead Hospita

Option C.4: Re-use of existing buildings w/ major enabling new construction; three hospital model

Assumptions:

1. Ward building courtyards will be infilled w/ new construction
2. The existing space will be gutted and fully renovated
3. The renovation/ new mix will be approximately 58% renovation to 42% new construction
4. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/t
5. The existing ward buildings are of concrete fireproof construction and in good shape
6. Structural modules are poor and will be addressed by the infill construction to create a functional footprint
7. The present boiler plant is in good condition and will be used as is.
8. Chillers are in poor shape and will be entirely replaced for the new/ reno facility
9. Asbestos is extensive throughout the existing buildings ceilings, flooring (in some cases) and piping insulation.
10. Moderate funding is provided for the kitchen, pending outcome of centralizing or outsourcing this service.
11. See Option C.4 for a three campus model for the state, assuming Dorothea Dix is closed as a mental Health campus.

			total	Ward Bldgs 29-43 Extg sf	Ward Bldgs 29-43 Infill (a.)	Ward Bldgs 29-43 Total	Barrett Bldg (e)	Activities Center	Admin Bldg	Ward Bldgs 44-54 Extg sf	Foc Servi
	sf/bed	No./ ber sf									
Residential Units	650	638	414700	305260	224174	529434	79425	49412	46509	196011	3
Program Space	400	638	255200	183156	134504	317660	79425	49412			
total	1050		669900	305260	224174	529434	79425	49412			
Campus Infrastructure									46509		3
Mothball/ Unused											
Demolition										196011	
Sale/ transfer											
Construction Cost (d.) \$/sf				180	225		25	60 as is		3.5	
Total \$				54946800	50439186	105385986	1985625	2964720	0	686039	8
Add for asbestos removal (g)				1984190	0		0	0	0	1274072	

- a. Courtyard infill yields 7,025 sf per floor; Ward Bldgs are carried at 18,725 per bldg; building 43 has an addition in lieu o
- b. Includes Boiler Plant, Service units between 29-43, Laundry, Warehouses and Utility Buildings
- d. New construction \$225/sf; total renovation (\$180/sf); major renovation (\$100/sf); minor renovation (\$65/sf); demolition (Mothballing (\$1.50/sf per year for 30 year life or \$45/sf).
- e. Barrett Building refit for new interior finishes, etc., carried at \$25/sf
- f. Food Service: carried \$25/sf for HVAC upgrade
- g. Carried 6.50/sf for asbestos remove

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Dorothea Dix Hospital

Option A.4: Eliminate Mental Health Uses at Dix Site; three hospital model

- Assumptions:
1. All patient residential, activity and support space will be in existing buildings
 2. Renovation costs are assumed to be the maintenance repair and renovation cost over the 30 year life of the improvement
 3. The MGT study budget for item 2 for the 30 year life of the improvements is \$33.9 million for reduced beds and \$76 million for new construction
 4. "Capital Replacement" (exhibits 9-5 and 9-6) is assumed not to be applied against renovation costs at the campuses
 5. Existing space re-used for programs will be fully renovated as needed
 6. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/bed
 7. The existing patient care buildings are mostly of fireproof construction and range in condition.
 8. The configuration and layout of the main patient buildings is poorly suited for inpatient mental health units
 9. The present boilers are in good condition and can be re-used as is.
 10. Chillers and distribution systems are in poor shape and will be entirely replaced for the new/ reno facility
 11. Asbestos piping insulation is present throughout the utility distribution systems.

		total		McBryde							
	sf/bed	No./ bec	sf	Buildings	Hargrove	Spruill	Brown	Wright	Ashby	Service	Usi
				Extg sf	Bldg (e)	Bldg	Hoey	Lineberger	Cherry	Bldgs	Oth
								Edgerton	Williams		
				406885	30981	46464	40562	73132	73150	242497	36
Residential Units	650	0	0								
Program Space	400	0	0								
total	1050	0	0								
Campus Infrastructure											
Mothball/ Unused											
Demolition				406885	30981	46464				242497	
Sale/ transfer							40562	73132	73150		
Construction Cost (d.) \$/sf				3.5	3.5	3.5 as is		as is	as is		3.5
Total \$				1424098	108434	162624	0	0	0	848740	
Add for asbestos removal (g)				2644753	201377	302016	0	0	0	1576231	
											Tot

- d. New construction \$225/sf; total renovation (\$180/sf); major renovation (\$100/sf); minor renovation (\$65/sf); demol Mothballing (\$1.50/sf per year for 30 year life or \$45/sf);
- g. Asbestos removal carried at \$6.50/sf

2.3 HOSPITAL REPLACEMENT/RENOVATION COST ANALYSIS

Broughton Hospital

Option A.4: Reuse of existing campus with all renovation, no new construction; three hospital model

- Assumptions:
1. All patient residential, activity and support space will be in existing buildings
 2. Renovation costs per MGT study are assumed to be the maintenance repair and renovation cost over the 30 year life
 3. Accordingly, the MGT study carried a total 30 year renovation cost of \$72 million for reduced beds and \$85.9 million for full beds
 4. "Capital Replacement" (exhibits 9-5 and 9-6) is assumed not to be applied against renovation costs at the campuses
 5. Existing space re-used for programs will be fully renovated as needed
 6. Residential space will occupy 650 sf/bed; support and program space will occupy 400 sf/bed
 7. The existing patient care buildings are mostly of fireproof construction and range in condition
 8. The configuration and layout of the Avery Building complex is reasonably suited, with renovation, for inpatient medical services
 9. The present boilers are in good condition and can be re-used as is.
 10. Chillers and distribution systems are in poor shape and will be replaced for the new/reno facility
 11. Asbestos piping insulation is present throughout the utility distribution systems.

	No. sf/bed	total beds	total sf	Avery Bldg	Avery Admin/ ctr	Marsh Taylor, Beall rt/ot, voc	Jones Scroggs Harper	McCambell Hoey, Saunc Morrison	Misc Outlying Bldgs	Service Bldgs	Enrollment
Residential Units	650	518	336700	261217	46815	88427	193281	112079	104492	179660	
Program Space	400	518	207200	0		21728	117798	67674			
total	1050		543900	261217		21728	193281	67674			
Campus Infrastructure					46815						179660
Mothball/ Unused						66699	0				
Demolition								44405			
Sale/ transfer									104492		
Construction Cost (d.) \$/sf				180 as is	180/ 45	180/ 45	180/ 3.5	as is	as is		
Total \$				47019060	0	6912495	34790580	12336738	0	0	0
Add for asbestos removal (g)				1697911	0	574776	1256327	288633			

- d. New construction \$225/sf (excluding major site and site utilities); total renovation (\$180/sf); major renovation (\$100/sf); demolition (\$3.50/sf) exclusive of asbestos, etc; mothballing (\$1.50/sf per year for 30 year life or \$45/sf);
- g. Asbestos removal primarily for piping insulation carried at allowance of \$6.50/sf

Bed distribution in a three hospital system

PCG recommends the closing of approximately 30% of the state psychiatric hospital system’s beds over the next five years, a net reduction of 667 beds. Working from MGT’s 1998 bed count of 2235, this reduction yielded a net capacity of 1573 beds. Adjusting our calculations for changes at Cherry, Umstead and Dorothea Dix hospitals that have taken place in the interim, PCG here recommends a 1621 bed system.

The 1621 bed demand forecast is not tied to reductions in specific hospital units; rather, it is computed from state-wide reductions in utilization rates for seven particular types of admissions: long- and short-term youth, long- and short-term aged, long- and short-term adult, and substance abuse. Nevertheless, we may estimate one of several ways that these reductions might be implemented. The remaining beds might be distributed as follows:

Youth	78
Adult Admissions	376
Rehabilitation	299
Adult Long Term	340
High Management	60
Geriatric Admissions	101
Geriatric Long Term	178
Nursing Facility	0
Nursing	0
Medical / Surgical	53
Pre-trial Evaluation	102
Research	12
Deaf	17
Tuberculosis	5

This arrangement would itself suggest further opportunities for reductions in medical/ surgical beds (53 beds), the tuberculosis unit (5 beds), and perhaps over time, some of the remaining youth and geriatric beds. Further reductions could occur if county programs aggressively develop local alternatives to hospitalization, and if the state follows through in moving resources from the state hospitals to the counties where the clients are being served.

In the three hospital model, beds that had been at Dorothea Dix Hospital were relocated to the three other hospitals. Those beds that are associated with the regional population were redistributed proportionately. Pre-trial evaluation beds and medical/ surgical beds, which are more of a state-wide resource, were moved *en masse* to Umstead. Research and Deaf Unit beds were reassigned to Cherry.

Dix, Umstead and Cherry hospitals all lie within 50 miles of Raleigh, so shifting capacity among them would have limited adverse impact on clients’ families. Each hospital is a teaching facility – Dix for UNC, Umstead for Duke, and Cherry for ECU – so relocation of facilities would be limited to travel inconveniences for a small number of professional staff.

It is important to understand 1621 beds to be a good model that can serve consumers from across the state. We believe that local interests and business conditions are aligned to respond vigorously to the state’s need for new local replacement services and transfer funds are made available. Targeted local feasibility analysis, in conjunction with projected savings from state hospital downsizing (Section 2.6) should demonstrate local expansion capacity.

Downsizing vs. Closing: Four vs. Three Hospitals

The decision to close a state hospital is not an easy one. Many factors are involved – some tangible, some very important, but not quantifiable. It is PCG’s experience that at least seven factors should be considered: access, operating costs, capital investment costs, community development opportunities, human resource issues, ongoing state resource commitment (the safety net) and state hospital campus options. PCG has considered all these issues and offers the following argument.

Access

As previously noted, three state hospitals are within 50 miles of each other. This does not necessarily reflect the pattern of users, as it disadvantages many in the more rural areas distant from all hospitals. However, the closing of one hospital does not create unique access problems, particularly if it is the one in the middle of the three, Dorothea Dix.

Operating Costs

As will be shown in Section 2.6, Dorothea Dix’s operating costs are consistently higher than the other three. Since this is the result of the hospital structure, service mix and overhead it is not sufficient reason for closure. Some of these variables can be changed by policy and management practices. More significant, however, is the fact that in the three hospital model, the annual operating cost per bed is \$103,591 (2% less than current costs), while in the four hospital model operating costs rise to \$117,658 (10% higher than current costs). This 12% operating cost spread yields \$17.3M in annual expenses, or \$13.2M net of third party receipts. This difference is likely to grow since the management efforts to contain costs in a four hospital downsizing process are significantly more difficult than in a three hospital/closure model.

Capital Investment

It has been clearly demonstrated that the three hospital model will save the state at least \$20 million in capital expenses. No consideration has been made for the marginally higher maintenance and repair costs of a four hospital system, nor the major replacement costs as major equipment wears out, waiting to be replaced.

Community Development Opportunities

The presence of local medical schools and their teaching facilities, community general hospitals, and the very active Wake and Durham Counties and adjacent mental health programs, make the closure of Dorothea Dix a more feasible choice from a community service development point of view.

Human Resource Issues

Many state hospitals in rural areas provide the most significant employment opportunities for the surrounding communities. The location of Dorothea Dix in the Raleigh-Durham area make it feasible to consider employment alternatives for state staff, either to other state buildings and departments or to the private sector.

State Resource Commitment/Safety Net

State hospitals, whether well run, maintained and capitalized, or not, present a very significant public commitment to a “safety net” for persons with serious mental illness. Closing one is a significant and potentially threatening event unless it is accompanied by several commitments from the state:

- the replacement beds in other hospitals are as good, or better, as the ones that closed;
- that replacement services in the community are high quality and accessible;
- that the closing process is planned carefully and managed closely; and
- that there is clear accountability to the mental health community for the resources saved by hospital closure.

The State should be prepared to meet the first three commitments. The fourth presents a challenge that can be met by the creation of a special transfer account – the “Dorothea Dix Mental Health” transfer account described in Section 2.7. Public accountability can be used to ensure the use and amount of the transfers for their intended purposes.

State Hospital Campus Redevelopment Options

Dorothea Dix Hospital presents the richest re-use possibilities of any state hospital over the coming years. The multi-use of the large campus has already established many precedents. Many other new ideas of benefit to the State and the mental health community can be considered for the campus.

In conclusion, the three hospital model, with Dorothea Dix closing, offers the state and the users of its mental health services the most attractive and cost-effective option for improving the quality of care at the state hospitals and for maximizing investments in community services.

AREA PROGRAM MENTAL HEALTH SERVICES

OVERVIEW

This chapter of the report focuses entirely on the structures and programs utilized and the services delivered to individuals in need of mental health (MH) and substance abuse (SA) services. (A similar analysis that relates to services for individuals with developmental disabilities is found in another section of the report.) The chapter has been developed with an appreciation for the history of the service system and recent efforts to change parts of it. Our job, as we see it, is to go a step further than previous studies in reviewing the system comprehensively and making systems level recommendations to facilitate major organizational and service shifts.

The first section, *Background*, reviews previous analysis of North Carolina's state- operated psychiatric hospitals (MGT) and responses to that study to establish a starting point for our efforts. The second part of that section, *Provision of Services in Context*, is a brief large system analysis that looks at service delivery from the point of view of utilization and spending. Numerous comparisons among the various sub-populations and between North Carolina and other states serve as orientation for the detailed analysis later in the chapter. In the next section of the report, *Observations and Findings from Site Visits*, we begin to develop a focus for systemic change through a synthesis of data that we gathered in directly observing the functioning system. This analysis requires an understanding of the service system's primary component parts - DMHDDSAS, Area Programs, and state institutions - as well as an overall understanding of the functioning of the whole in providing needed services to consumers. Service system strengths are highlighted and recommendations for changing key elements of the service delivery system are advanced throughout the section. The final section, *Transforming the Service System*, makes the case for major systemic change through a comprehensive process of defining specific target populations and matching benefit packages. The development of a standardized statewide acute care and evaluation benefit package is viewed as a necessary first step in this process.

BACKGROUND

In the Phase I report, PCG presented its findings concerning the potential movement of some groups of individuals out of state hospitals and into community treatment. However, it did not focus on the specific steps necessary for North Carolina to develop and provide those services. This Report provides the additional assessment that is necessary to understand and quantify the potential service needs of the populations to be transitioned to the community and the State's ability to develop the necessary resources. The two main findings in the Phase I report regarding Community Service Options are:

1. *Many of the individuals currently residing in North Carolina's four state hospitals, in all levels of care, could be treated in the community if services were available. This includes services for youth and elderly and individuals with substance abuse and co-occurring disorders.*
2. *North Carolina's mental health system does not currently have the capacity to respond to the specific needs of many of the populations targeted; proposals to move large numbers of individuals into the community are not currently realistic and do not constitute an appropriate plan.*

The major goal of Phase II is to assess specific aspects of community capacity to serve these individuals. This analysis is what provides us with the information to recommend changes in the service system, including determining the ideal number and location of future state hospital beds.

Individuals with Substance Abuse Problems

Current thinking on clinical best practice prioritizes community-based care over institutional care whenever possible for individuals with substance abuse disorders. In the absence of more appropriate community settings, state hospitals have often been called on to fill the void for services for these individuals. In North Carolina, as in most cases, state hospitals are not properly staffed or clinically prepared to play this role.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) responded to MGT's recommendation to move treatment for individuals with substance abuse disorders out of the state hospitals in their report, *Diverting Substance Abuse Admissions from the State Psychiatric Hospitals* (4/99). DMHDDSAS recognized the importance of treating substance abuse patients in the most clinically appropriate setting. However, a Department workgroup concluded that due to the general characteristics of this population, many general hospitals and other treatment programs are unwilling to accept those needing the most intensive services into their system. Existing community facilities are not currently staffed or trained to provide a medically managed level of care and most are not equipped to provide secure setting, seclusion or restraints to ensure the safety of patients or staff. The workgroup stressed that the savings projected by MGT in their analysis are largely based on the comparatively low cost of treating substance abuse in community detoxification facilities. These programs are a significantly less intensive level of care than that provided in state psychiatric hospitals. The Coalition for Persons Disabled by Mental Illness (CPDMI, 6/98) and the Mental Health Association of North Carolina (MHA/NC, 4/98) agrees with the DMHDDSAS position. Another major problem discussed by the Department is the lack of resources to provide continuity of care after the acute phase. Aftercare programs of various types (sober homes, halfway houses, therapeutic communities, day/evening treatment) are needed to serve this population and contain the "revolving door" nature of substance abuse disorders.

Geriatric Population

It appears that many of the geriatric population at the state hospitals require custodial and medical care more than psychiatric treatment. North Carolina currently has few community-based facilities that could serve the majority of the long-term geriatric patients living in state hospital nursing and long term units. The state facilities themselves are antiquated and not conducive to effective patient care.

The MGT report is comprehensive in describing the current services provided at the state hospitals, and makes a strong case for the need for more services at the community level. These services can be provided more cost efficiently in the community. According to the MGT report, during fiscal year 1996-1997, North Carolina spent \$37.5 million on Geriatric Long Term and Nursing Facility units at state psychiatric resources to care for these patients. Spending at community based nursing facilities costs generally 50% less than at the state hospital although it is doubtful that these programs would be able to care for the institutionalized population without additional resources and funding.

The DMHDDSAS, in its report *Specialized Community Based Alternatives for Some Geriatric Patients who are Currently Being Served in State Psychiatric Hospitals* (4/99), supports the recommendation that geriatric patients and patients suffering from Alzheimer's and other dementias would receive more appropriate treatment in the community. NAMI of North Carolina has a similar view (9/98). The report recommends that new types of specialized long-term care facilities be developed in the community to serve these populations. These proposed specialized facilities should not be a substitute for acute inpatient psychiatric treatment but a real alternative to state hospital custodial care. CPDMI agrees with MGT's recommendation, but points out the lack of existing community resources and funding and the amount of time it would take to develop such programs.

The complexity of this patient population, including individuals with complicated medical and psychiatric needs, requires a collaborative and detailed planning approach involving several health care disciplines. The North Carolina Psychological Association points out the need to develop clinical pathways for all patients when services are transferred into the community. The North Carolina Psychiatric Association stresses the need for a more comprehensive care management approach for all clients. Therefore, in order to implement these recommendations, careful analysis of multiple service delivery models must be developed, reviewed and discussed.

Youth Population

MGT's assumption that "children and adolescents could be better served in community based facilities" is based on the belief that this population can be better served when treated in settings closer to home, school and other local resources. PCG supports this assumption and general direction. Increased stigmatization, exposure to potential abuse by other patients, and inappropriate services for adolescents with substance abuse problems were among the primary issues cited for their recommendation to close all of the Youth Units in the state system. The state hospital programs, though, appear to perform numerous functions in treating children and adolescents, including acute evaluation, long-term treatment, incarceration and rehabilitation of juvenile offenders and treatment of adolescents with substance abuse problems.

Based on existing knowledge of how other states structure their mental health services for youth, PCG agrees that the child and adolescent services recommended by MGT could be provided effectively in community settings. It is among the tasks of PCG to assess and determine whether services are available in the community to provide care for this population. Other states have demonstrated that establishing a full continuum of community care can be effective in decreasing state hospital utilization. North Carolina has also embarked on several projects to re-structure service delivery for children in this manner. Both Carolina Alternatives and the Fort Bragg Demonstration Project have attempted to build community treatment capacity for children and adolescents with some success.

A work group commissioned by DMHDDSAS, comprised of agency personnel, provider representative, and consumer advocates does not support MGT's recommendation (*Mental Health Services for Children and Families: Report of the Futures Committee 4/99*) at least not in the short term. They feel that the state hospitals are necessary to treat adolescent patients whose needs greatly exceed the community based service capacity. In their view, the state hospitals serve as a safety net for young consumers and should not be removed.

Other stakeholders hold similar views. NC Psychological Association (9/99), NAMI (9/98), CPDMI (6/98) and MHA/NC (4/98) strongly disagree with MGT's recommendation to close all Youth Units. Citing the severe level of need of the children and adolescents in the state hospitals, the advocates also point to a lack of community based services ready to handle the needs of the population. But they do imply that some re-assessment of services was in order.

The unanimity of all stakeholders in this area is compelling. A closer look at the service needs of the individuals in the Youth Units is clearly needed as a first step, but it is extremely unlikely that more than a small percentage of this group could be appropriately treated and contained in existing community programming today. While replacement of some of the state hospital functions is desirable and possible over time, the programs, most agree, cannot be closed before new services are developed. This will require an extended period of development and significant additional resources.

Other Populations

Adult inpatients are the largest group of service utilizers in the state hospital system. An option not considered by MGT, mentioned in the PCG Phase I report, is the movement of a significant number of adult inpatients into specialized community programs developed for this purpose. Services required are of essentially two types: acute inpatient capacity in general hospitals and intensive community-based aftercare combining treatment, housing and vocational support.

Numerous other states have been successful in assisting community hospitals to develop inpatient programs for this population through favorable contractual arrangements and the provision of technical support and training. We believe it is a viable option for North Carolina though clearly there are many communities that currently have limited or capacity and/or interest in providing this level of care. Many communities close in proximity to state hospitals and those in more rural areas have traditionally used the state hospitals for the provision of acute care. This made sense because they were close and the best option available or, in the case of rural counties, because they simply did not have enough demand to support a functioning local program. Nevertheless, community-based acute inpatient programs can function more efficiently than large state hospitals and play multiple important roles. Assessment and triage among individuals with primary versus co-occurring substance abuse is an important additional function that enables the system to route an individual to the appropriate aftercare plan and provider.

Many individuals with more intensive ongoing needs can also be maintained in the community. Moving this population from state hospital "residence" involves developing an integrated intermediate and tertiary care continuum linking state hospital rehabilitation with Assertive Community Treatment (Santos, et.al, 1997) and other progressive community services. These innovative service packages have had demonstrable effect in reducing re-hospitalization and length of stay for individuals with severe mental illness. The North Carolina Council on Community Programs has pointed out to DMHDDSAS North Carolina's ranking as 7th among all states in the amount of people living in state facilities. PCG has overseen this reorganization in other states and will explore multiple options for North Carolina.

Next Steps

Phase I reports that some area programs have been more successful than others in developing an acute care continuum and effectively limiting the use of the state hospitals to intermediate and tertiary care. Working with other clients, PCG has observed an important state hospital dynamic that often comes with moving acute care to the community. In re-defining their mission to the provision of intermediate and tertiary care, state hospitals experience an upsurge in morale, professionalism and quality of patient care. State hospitals can be an appropriate, even good, choice for provision of certain types of care, especially for individuals requiring rehabilitation in a secure setting.

PCG's first report found support for the recommendations suggested in the MGT study. However, the ability to provide quality services in the community is contingent on the successful development and funding of local programs and services. As the North Carolina Council of Community Programs and other stakeholders emphasize, consumer choice is paramount in the delivery of quality services (8/99). Moving state hospital patients into the community is a huge undertaking that can only be accomplished by all parties coming together in the best interests of the patients.

The next section reviews the findings from the site visits that were conducted and the feasibility of developing these services based on these findings. This discussion is followed by recommendations for changing the service delivery system.

SITE VISIT OBSERVATIONS AND FINDINGS

Overview

The North Carolina mental health and substance abuse service system, like that of many states across the country, developed over a period of some forty years in response to numerous demands and changing federal, state and local initiatives. The initial focus of treating adults with mental illness has been expanded many times to include other populations requiring a variety of different types of services. North Carolina's Area-based system allows for greater local control of program development than one finds in states with highly centralized, state-operated systems. In some cases, local decision making and additional local funding have facilitated the development of local systems of care that respond most closely to the needs of the local citizenry. On a statewide basis, however, there appears to be great imbalance among Area Programs and disability groups and major gaps in the treatment continuum.

By far the most striking aspect of the North Carolina service system is the amount of variation from area program to area program. State funding and service quality and accessibility varies widely across Area Programs. For instance, in the funding area alone per capita spending varies from a high of \$93 to a low of \$27 per capita. Other than Willie M. services, discussed later, it can be safely said that few Area Programs (AP) look alike or that there are a few "types" which can be used to accurately group AP's based on some major determinant such as urban/rural, large/small, or east/central/west. If there is some underlying "genetic code," we did not find it in our visits to the eight sites. For instance, two AP's might resemble each other in their adult mental health services and be widely disparate in relation to substance abuse or child mental health.

Most of the AP's that we visited can be said to be similar in the types of services that are offered for adults with severe mental illness. All of the AP's operate medication clinics, outpatient counseling, some version of psychosocial rehabilitation (day treatment, clubhouse, drop-in center), and some supported housing. However, differences in accessibility, provisions for crisis stabilization and other urgent care, inpatient resources, use of the state hospitals, transportation, treatment of co-occurring substance abuse, use of assertive community treatment or other mobile services, and availability of supported employment make these programs look more different than similar overall. Also, few AP's offer any specialized assistance for the elderly.

Services for children and adolescents and individuals with substance abuse also vary greatly and, on the whole, are less well developed than adult mental health services. In fact, the similarities among AP's in these two areas are often related to what is missing rather than what exists. The exception to this is the Willie M. program, which has a defined set of benefits that is uniform across the state. In regard to child and adolescent services outside of Willie M., some capacity for outpatient services, including case management, counseling and medication consultation, exists at all AP's and all of the programs have some capacity for residential treatment. Few AP's routinely make child trained clinicians available for urgent assessment or provide an array of crisis stabilization and hospital diversion services. There are, however, several AP's that have developed a full continuum of care or excellent

program models in community based initiatives and in joint ventures with social services or juvenile justice. The range in capacity for provision of child services is very wide.

The range in AP capacity for provision of substance abuse services appears to be less broad than the range for child mental health services. Most of the substance abuse service system clusters at the “barely adequate” or below level. Few treatment systems maintain adequate capacity for those who are intoxicated, especially if there is also some accompanying behavioral problem. In addition, there is wide variation in the availability of intensive rehabilitation programming for either residential or intensive outpatient. Use of the state operated ADATC’s is inconsistent, and specialty programs for women, adolescents, and individuals with co-occurring disorders exist in few places. Inappropriate use of state hospitals for containment of individuals with substance abuse has been previously documented (MGT, March, 1998; DMHDDSAS, Unified System of Services Report, March, 1995).

Examples of Excellence: Model Programs Developed in North Carolina

Perhaps the most important outcome of the site visits is the initial identification of specific program models and services that provide or have the potential to provide excellent care as a component of a larger system of services. There are, in fact, many examples of good to excellent programming from our site visit AP’s and, we suspect, more examples in the 30 Area Programs that we did not visit. Not all AP’s offer the same services. The services they do provide, however, are a reflection of local priorities, interests and resources. Even initiatives that are funded poorly by the state, i.e. substance abuse, have some good models at the AP level. It should be noted at this point that our nominations are somewhat impressionistic in nature – we did not have time to perform anything resembling a quality audit on any of these programs. Nevertheless, the programs cited stood out as appearing well designed, organized, managed, and documented. The following chart summarizes our observations:

2.4 Area Program Mental Health Services

AREA PROGRAM	TYPE OF SERVICE	SIGNIFICANT FEATURES
Adult Mental Health		
<i>Blue Ridge</i>	Psychosocial Rehabilitation Program	Serves as safety net for entire AP region
	Geriatric Services	Consultation services to nursing homes with mentally ill residents are provided
<i>Wake</i>	Psychiatric Emergency Room	Serves as a safety net for entire AP region
<i>Centerpoint</i>	Medication Scholarships	Aids indigent customers in filling their prescriptions
	Continuum of Services	Respite, partial hospitalization, day treatment, ambulatory detox, and intensive outpatient programs are available
	Access Center	Serves as a safety net for emergency services
<i>Mecklenburg</i>	Emergency and Acute Care	Strong system in place to serve SPMI adults during the acute phase of their illness
	Geriatric	Wrap around services are provided to elderly psychiatric clients living at home or in rest homes
<i>Southeastern</i>	Geriatric	Community based locked long term care; home bound care; psychiatric consultation
Child Mental Health		
<i>Centerpoint</i>	Outpatient Team Structure	Team focuses only on acute situations and substance abuse
	Latino Services	Desire to further develop bilingual services to meet the needs of the large Hispanic population in the area
<i>Sandhills</i>	Community-based initiatives	Partnerships with other agencies (juvenile justice, social services, school systems) has secured funding for numerous innovative programs
<i>Blue Ridge</i>	Continuum	Reduced hospitalization through aggressive care management
	School based	Day treatment used as alternative to hospitalization
	Crisis stabilization	15 Therapeutic Foster Care Homes
	In-home	Intensive family preservation programs for families with runaway children
<i>Southeastern</i>	Juvenile Justice Initiative	Clinicians conduct specialized assessments of referred youth and provide consultation to juvenile justice counselors
	Treatment of Sexually Aggressive Youth	Specialized program being developed that will include group and family treatment for at risk youth

2.4 Area Program Mental Health Services

AREA PROGRAM	TYPE OF SERVICE	SIGNIFICANT FEATURES
Substance Abuse		
<i>Centerpoint</i>	Inpatient Service	A full continuum of services is provided such as medical and social detoxification beds
	WISH Program	Serves recovering women and their children by providing support services to allow for the mother to continue treatment
<i>Blue Ridge</i>	Locked detoxification	Treats dual diagnosis patients
<i>Wake</i>	Homeless Program	165 bed unit to be built to serve indigent, homeless males (the "Healing Place")
<i>Mecklenburg</i>	Cascade Services	44 bed detox and extensive treatment services for women and their children
	Continuum	Extensive network of private providers, particularly CMC
<i>Southeastern</i>	Urgent Care and Crisis Stabilization	10 bed detox program located adjacent to crisis station
	Women's Program	Women's recovery group
<i>Rockingham</i>	Intensive Outpatient Program	Treatment takes place at the local community college and daily transportation is provided
<i>Sandhills</i>	Sexual Offenders Program	Treats dual diagnosis patients

Willie M. Program: High Quality on a Statewide Basis

Against a backdrop of wide individual variation among site visited AP's, Willie M. services stood out as essentially uniform from one program to another: consistent in approach, service array, service standards, documentation, and methods of evaluation. This "anomaly" strikes us as an important feature of the current system to review because it presents a unique opportunity to understand and evaluate the impact and effect of a different set of structural assumptions and imperatives within the system of care. More accurately, it can be said that the Willie M. consent decree created a parallel universe or care system that functioned alongside the mainstream but adhered to a separate set of philosophical and operational principles. Our observations suggest that Willie M., as a statewide program, as well as individual Willie M. service units compare favorably to the appropriate reference group along a whole host of dimensions.

In one sense, this should not be surprising – in FY 98-99, spending on Willie M. clients was \$37,000 per client as compared to \$337 per client for the non-designated mental health populations. The superior funding supported a treatment environment with smaller client to staff ratios and more manageable overall workloads. One observable difference in many of the AP Willie M. units was the positive morale, unified sense of purpose and overall *esprit de corps* of staff in these programs. (In fact, on several visits, staff expressed a fear that the end of the consent decree would lead to erosion of the Willie M. program and they would become "... just another program like all the rest.") The increased spending was a major factor in explaining the differences observed. It appears certain, however, that increased resources alone were not the only evidence that convinced The Department of Justice to end its oversight of the program.

Willie M. is among the few programs that has a meaningful case specific and total program outcome evaluation component. Data about clients and their progress is grouped into six categories: behavioral, social, legal, residential, educational, and health. Data indicates that children who have been Willie M. clients longer than one year showed significant reduction in the rate of threatening, assaultive, and self-injurious behaviors compared to newly certified children.

Given the apparent success of the program, it is important to identify and understand the contributing factors. Foremost on this list is the consent decree itself. This resulted in ongoing oversight by the court and set the stage for the development of the following program components and characteristics:

1. **Clear responsibility and accountability.** Since the Department of Justice sued the state and not the counties or AP's, responsibility for the program is solely with the state. Willie M. is unambiguously a state-operated program. The state may contract directly with providers other than the AP to fulfill its obligation.
2. **Well-defined target population and eligibility determination process.** Terms of the consent decree established the definition of the eligible population and the state designed an independent process to safeguard consistency with the legal definition.
3. **Client centered philosophy and service development approach.** The program developed a unique philosophy and service mission built around the central element of client centered, non-institutional care. Staff are trained in this approach and individual care plans are reviewed routinely by state employed reviewers for appropriateness.
4. **Segregated Budgeting and Funding.** Financial resources for the program are allocated separately from DMHDDSAS budget. Willie M. service unit budgets are segregated from AP budgets and monitored closely to verify that resources are solely spent on provision of Willie M. services.

5. **Consistent monitoring and performance review.** The state employs regional staff to review cases and programs on a regular basis. Extensive clinical and outcome data are collected periodically on each child in the program through the Willie M. Services Assessment and Outcomes Instrument (AOI). This instrument allows Area Programs to evaluate in a quantitative way the progress and outcomes of Willie M. clients and the effectiveness of their local programs.

Site Visit: Major Findings

This section attempts to distill a series of important findings about the North Carolina service system from the information gathered during the individual Area Program service system reviews (site visits). Beginning as initial impressions along side a host of other thoughts, these issues have come to the fore because they represent core concerns and challenges of the present system. (Note: The order of presentation is not meant to imply a particular “ranking” of the issues).

ASSESSMENT

Finding 1: There is wide variability in accessibility and quality of clinical assessment across Area Programs. An argument can easily be made that initial clinical assessment, especially urgent assessment, is the most important component of any treatment system. It is clearly among the most important since its primacy in any episode of care is determinative of what happens next. In short, a good assessment puts the individual on a path to effective treatment; a bad assessment results in, at minimum, wasted time, energy, and money and possibly a truly terribly consequence. Despite the Division’s new assessment standard (July, 1999), we observed assessment practices that spanned the entire continuum from excellent to poor. Predictably, systems on the lower end of the continuum had most difficulty providing high quality assessment to children, in rural locations, and during night and weekend time periods. Provision of high quality assessment requires access to treatment professionals with specific expertise in the patient population working within a standardized process based on accumulated knowledge (e.g. best practice).

Expert urgent assessment is especially important to a system with limited resources and many competing needs. As the first point of intervention, the emergency clinician plays a primary role in determining future allocation of resources. Successful intervention at this critical moment can make all the difference in a situation which is “at the boiling point”, but crisis intervention and diversion is no easy task. In fact, it is often much easier and simpler to hospitalize than provide intensive services immediately to an individual in crisis. Hospitalization, however, is anywhere from 2 to 4 times as expensive as an alternative treatment plan.

In looking to the future, assessment also plays a critical role in assuring that individuals with the greatest need receive the highest intensity (and cost) services and that this targeting of services is uniform across the state. Any attempt to manage utilization bases its system on the assumption that a competent assessment has been done. The utilization management system and the decisions that come from it are only as good as the individual case information that is used when decisions are made. Utilization management decisions based on non-standardized assessments will ultimately fall short in their attempt to rationalize the system of care.

Recommendation 1: The recently issued standard for assessment developed by DMHDDSAS should be adopted for statewide use and incorporated as a condition of participation in the contracting process. Implementation of the standard should be monitored through the Council On Accreditation process or periodic audits by state employed/contracted reviewers. Considerable training resources must be made available to meet the new standard of care for assessment.

SUBSTANCE ABUSE

Finding 2: Services for acute substance abuse are particularly lacking statewide leading to the inappropriate use of state hospitals as the “default” treatment setting. Most AP’s simply do not have the capacity to treat individuals who are intoxicated and display behavioral control problems. While there is wide variability at the Area Program level, in general, the service system for the adult mental health population is considerably more developed than the system for individuals with substance abuse. Individuals with severe mental illness are universally considered a priority population and can access at least some (though not necessarily adequate) community-based services in any part of the state. The same thing cannot be said for individuals with severe substance abuse disorders. The SA system is really a “hodgepodge” of services, not a continuum in any real sense. Acute care for individuals is especially difficult to access if they exhibit aggressive or self-injurious behavior. More often than not, these individuals are sent to a state hospital that provides “security” but little in the way of focused treatment. Access to aftercare for is also highly variable and often inadequate. Given the nature of substance abuse disorders and the high rate of relapse, aftercare is essential.

Given the difficulty in providing acute care for substance abusing individuals, it was surprising to discover that the state’s Alcohol and Drug Abuse Treatment Centers (ADATC) often do not provide the level of intensive services (medically monitored/managed detoxification and rehabilitation) needed for the most difficult populations. While the services currently provided at ADATCs are certainly needed, it would be possible for these services to be duplicated in the community. DMHDDSAS has recently begun to redefine the role and transform some of the ADATCs to serve the acute population (*Diverting Substance Abuse Admissions, DMHDDSAS, April, 1999*). In the interim, state hospitals remain crowded with individuals with primary addictive disorders. Not only is this poor treatment for those individuals, but it is also distracting to the hospitals’ attempts to provide mental health care to those with mental illness. This does not even begin to address the prevalence and treatment of individuals with substance abuse disorders in prisons and jails.

Two other areas of notable paucity in the substance abuse continuum are services for individuals with co-occurring disorders and intensive community services for adolescents. The prevalence and needs of individuals with co-occurring illnesses have been documented nationally. The National Alliance for the Mentally Ill estimates that as much as 50 percent of the mentally ill population also has a substance abuse problem. The drug most commonly used is alcohol, followed by marijuana and cocaine. These individuals, estimated at somewhere between 40-70% of all individuals with a diagnosed major mental illness, are receiving treatment services, probably in very significant amounts, that do not address the complexity of their needs. Suffice it to say that the site visits saw very little in the way of specialized programming for this population. Adolescents fared only slightly better and some specialized outpatient services have been developed in some AP’s. Still, resources to provide intensive, non-hospital treatment are sorely lacking.

Recommendation 2: The development of a continuum of care for individuals with substance abuse and addictive disorders is a top priority for DMHDDSAS and the State of North Carolina. This process should begin with the development of acute care capacity at the ADATC's and in community hospital settings. In addition, specialty programming and/or additional services for individuals with co-occurring disorders within current treatment settings is a statistical and clinical imperative since so large a portion of the traditional target population are affected. Providing intensive services for adolescents creates the possibility of heading off the vicious downward spiral of addiction and is cost-effective in the long run. Training the workforce to accurately assess and then treat these populations will require a clear commitment of resources.

STATE HOSPITALS

Finding 3: The role of the State Mental Institutions is unclear and varies from Area to Area.

Public mental hospitals in North Carolina are expected to serve as the "safety net" for individuals with a variety of needs and nowhere else to go. This will likely remain true to some extent just as it has in other states. However, in North Carolina, there are great disparities in how AP's utilize the state hospitals and the significant resources required to keep them going. In some locations, state hospitals are the primary resource for acute psychiatric care; some AP's use the state hospitals for treatment of individuals who are intoxicated and unstable; some AP's use the state hospital for long term care only; and some AP's rarely use the state hospitals at all. Various attempts by DMHDDSAS to alter this chaotic pattern have had little success. A division mandate to refuse admission to individuals with presenting problem of primary substance has been all but disregarded. A recent division report identified 2,054 substance abuse admissions out of a total of 3,592 total admissions, a staggering 57%, to the state facilities.

Of course, just "closing the doors" is no solution. These individuals present real problems and need treatment *somewhere*. The appropriate questions are what type of treatment, in what type of setting, with what expected outcome? While the state facilities might be able to develop good clinical programs for all the various demands presented, there are compelling reasons to divide these responsibilities. On the clinical side, provision of service closer to home facilitates integration with family, local aftercare services and other community resources. On the administrative side, proximity is at least a partial condition for the development of AP accountability and cost-effective alternatives to inpatient care. Finally, efficacy, the delivery of positive treatment outcomes, is most likely to occur in treatment programs that **specialize** in particular areas.

A re-definition of the role of the state hospitals, we suggest, will both change the way the current system operates and re-vitalize the hospitals themselves. Our view is that state hospitals will continue to play a major role in an integrated service system as the ultimate "safety net" for individuals with intermediate and long term care needs and for society as the secure location for treatment of the forensic population. Within a restricted set of expectations, state hospitals can, over time, develop competent treatment programs for special populations requiring extended rehabilitation, including those with co-occurring disorders (e.g. Massachusetts, Pennsylvania, New Hampshire).

Achieving this type of major change in the service system requires the development of a multi-year plan to build community capacity as the state hospitals reduce their size and focus on their newly defined mission. DMHDDSAS has taken a first step in this direction by converting some ADATCs to acute care facilities. Additional efforts to create alternative acute care destinations for individuals with primary substance abuse such as conversion of the remaining ADATCs and community hospital initiatives will be necessary to address this sizable population. However, given the size and impact of the substance abuse population on the state hospitals, this appears to be the best path because it addresses two major problems at the same time. The "Assessment and Acute Care Benefit Package" discussed in the next section addresses this issue.

Recommendation 3: DMHDDSAS should re-define the role of the state hospitals as intermediate and long term care facilities. A major part of this change will be a strategy for development of acute care capacity in community settings. A variety of structures will likely be needed to accomplish this transition including conversion of all ADATCs to acute care, development of partnerships with the new County Programs utilizing former state hospital buildings, partnerships with community hospitals and other intensive care providers, and development of innovative hospital alternative programs in the provider network. Significant funding for these ventures should become available as the state hospitals serve fewer individuals (see Section 2.6). However, funding for start-up capital will surely be needed.

SPECIAL POPULATIONS

Finding 4: Populations with special needs are frequently under-served including dual diagnosed (MH/SA) clients, children and adolescents and elderly. Lack of existing resources and specially trained staff makes it difficult for the AP to service populations other than the traditional target group, adults with severe mental illness. The approach has been to shift the responsibility of care to the state hospitals. North Carolina, like every other state in the country, faces competing demands for resources from numerous “special” groups, all of who demonstrate legitimate need and a host of other issues that complicate their care. Just listing the different sub-groups of needy populations requires several pages in the DMHDDSAS redesign initiative document. Within the adult population, individuals with co-occurring disorders represent a sizable cohort requiring special programming. Other identifiable groups include the homeless population, individuals with mental illness and developmental disabilities, individuals with developmental disabilities and substance abuse disorders, incarcerated individuals with mental illness or substance abuse disorders, victims of physical and sexual abuse, deaf individuals and more. Accessible services for individuals of hispanic origin are also an imperative given the growth in that sector of the population.

Children and adolescents (outside of the Willie M. population) appear to constitute an under-served population also. While services for the Willie M. population have been much improved over a relatively short period of time, this targeted allocation of resources has, in many places, created a two-tiered system. Children and adolescents who do not qualify for Willie M. have much more limited access to care. As previously stated, there is great variability in access to a continuum of care for children and adolescents across the state. Many AP’s have difficulty providing urgent assessment by child trained clinicians, hospital diversion services such as day treatment or crisis respite, home-based care, and even basic family and behavioral treatment by qualified professionals. Every Area Program is attempting to figure out what to do with youthful sex offenders and adolescents abusing substances. The cost of providing residential care for the sex offender group alone has prompted a close review by DMHDDSAS and the Office of Juvenile Justice (Services for Youthful Sex Offenders, September, 1999). DMHDDSAS currently estimates that it spends over \$3M per year on out of state residential facilities and total state cost including those in training schools, those funded through Medicaid and those funded by DSS is much higher. A DMHDDSAS pilot program proposal for some 75 youth is projected to cost around \$4.4M; that same program for all identified youthful offenders (both adjudicated and non-adjudicated) would cost roughly \$65M.

The treatment of children and adolescents is complicated by competing departmental responsibilities and resource concerns. Since, the needs of children and adolescents often cross departmental boundaries (e.g. the Departments of Social Service, Juvenile Corrections, Special Education and local educational authorities), coordination and cooperation are crucial to the outcome of a child’s care

Critically, the needs of North Carolina's senior citizens have received little attention. Few AP's operate specialty services for elders although the population of individuals over 65 years of age is growing rapidly and is estimated to increase by 65% by the year 2020 (Specialized Community Based Alternatives for Some Geriatric Patients Who Are Currently Being Served in State Psychiatric Hospitals, April, 1999). Planning and programming must take into account a variety of special issues and conditions presented by this group. Among the issues to contend with are limited mobility, social isolation, behavioral symptoms with multiple etiology, and physical infirmity. Services required include clinical support to nursing homes and other care environments, home-based care (medication), substance abuse services, psychopharmacology consultation, and several levels of specialized residential facilities. Relocation of elderly individuals currently in the state hospitals will certainly not be possible without the development of these services.

Recommendation 5: North Carolina should adopt a process of defining specific target populations and benefit packages that match the needs of the targeted group (see "Transforming the Service System"). Two groups that are clear priorities for the state are elderly and dually diagnosed individuals currently residing in state hospitals (children are discussed in the next recommendation). Movement of these individuals will require the development of new community based capacities and structured living environments of various types. DMHDDSAS should immediately begin the process of developing pilot programs with skilled nursing facilities, other residential service providers, innovative community programs such as assertive community treatment providers, to gain experience and determine the optimal mix of services for this long term institutionalized group. Training resources will be needed to implement any of these initiatives.

CHILDREN'S SERVICES

Finding 6: With the demise of Carolina Alternatives and the end of the Willie M. lawsuit, children's services are experiencing a major crisis in confidence and direction. The dominant forces shaping children's services during the better part of the 1990's were the lawsuit and consent decree that created the Willie M. program and the development and implementation of a Medicaid waiver that created Carolina Alternatives. As the new century begins, neither of these major initiatives remains fully intact. In evaluating the results and vestiges of these events, Children's Services must re-group and develop an action plan to pursue its mission. At this point, there does not seem to be a problem with the mission *per se*. The *Report of the Futures Committee* (1999) has developed a set of guiding principles to update the Child Mental Health Plan (1987) that is widely endorsed. Nevertheless, the dismantling of services at the provider level, especially in CA participating AP's, has resulted in a sense of confusion and disappointment that threatens to undermine the progress of the last five years.

The results of CA are not consistent, but the experience has certainly left "a sour taste in the mouths" of everyone involved. Two issues are most concerning. First, despite the overall failure of CA in the eyes of the Federal Authorities, our impression is that CA provided a powerful influence on service system development in the desired direction. In many areas, the enhanced service capacity and quality of care was impressive (Burns, et.al. 1999). In particular, flexibility in funding allowed many CA participating AP's the latitude to develop services for children and adolescents that were preventative, school or home based, and tailored to individual needs. CA participating AP's also developed competent child and family emergency/urgent care response and a variety of hospital diversion programs. These are exactly the types of services that are needed, especially if the state wants to reduce its reliance on state hospitals and other high cost residential facilities. Second, lost in the politics and "finger pointing" is the hard work of a lot of clinicians who rose to the occasion, invested themselves, and changed the service system over a few short years. In addition, CA became a cause that these clinicians embraced; the result being a

palpable “*esprit de corps*” seen rarely in public sector programs. North Carolina would be well advised to recognize these efforts in the hope that the spirit will somehow survive the poor “press” that their efforts have received.

Willie M. programs have thus far retained their sense of purpose and uniqueness, but express significant concern about the impact of the end of judicial oversight. There is a sense that they will become “just like everyone else”, presumably under-funded and overwhelmed, and swallowed up by competing demands for services that will “water down” the product. Their fears are not unrealistic. The advantages and lessons learned from the Willie M experience has already been noted. However, it is hard to imagine the system being able to afford quite the level of funding that currently goes into this group of children and adolescents given the needs of other groups of children and adolescents. Solving the riddle is no small task, but it would be a mistake to unravel the best local example of defining, treating, and monitoring/evaluating a specific “target population.” Its value goes beyond the direct care it provides as a working “model” for developing other initiatives. *It would be wiser to add new target populations (as opposed to expanding the definition itself) under the Willie M. process and umbrella than to dismantle the Willie M. infrastructure. The annual client turnover or aging out rate of about 20% presents an ample opportunity for this.* In this way, the success of Willie M. can be spread over a broader population consisting of multiple difficult to treat target populations. Increased efficiency and management of treatment should allow for a gradual reduction of per capita spending on traditional Willie M. clients and allow for increased access to resources for the new “Willie M.’s”.

Recommendation 6: North Carolina needs a new plan of action for caring for the behavioral health needs of children (and families) that builds on the experiences of Carolina Alternatives and Willie M. and institutes increased accountability for effectiveness and clinical outcomes. Specific recommendations include:

1. Develop local inter-agency partnerships for the care of children based on the concept of “joint total responsibility” for program outcomes. These programs should be supported by the respective state agencies and incentivized by funding allocated by the legislature for that specific purpose.
2. Expand the Willie M. program by adding new target populations to be served under that administrative process and umbrella, without increasing the total budget, building on the 20% annual aging out rate.
3. Continue to develop alternatives to hospitalization and long term residential placement through the expansion of model programs for emergency assessment and crisis intervention, crisis respite, home-based family treatment, and school based intervention
4. Promote early identification and intervention in children at risk for severe emotional disturbance, sexual offenses, and substance abuse. Utilize findings from “*The Great Smoky Mountains Study*” (Costello, et.al., 1996) to appropriately target high risk groups.
5. Provide specialized training for individuals working with children, adolescents and families.

TRANSFORMING THE SERVICE SYSTEM

The current system suffers from a lack of clarity about what specifically it is trying to accomplish. This is not to say that no policy exists because in fact many do. Both state and federal policies and guidelines play a major role and must continue to play a major role in guiding the efforts of the service system. Nevertheless, there is currently no statewide system that defines who will be served with what resources and in what way. In this section, we recommend two major interventions to address these issues.

One change recommended is the development and implementation of a standard acute care benefit package covering both mental and substance abuse disorders. This benefit is intended to create statewide accessibility to a range of basic services for any individual requesting evaluation, urgent and emergent care, and/or brief outpatient and aftercare. The proposal suggests that every County Program would make these services available as a condition of contracting with the state. Coverage for mental health and substance abuse disorders is essentially equivalent.

A second major systemic intervention recommended is the practice of defining “Target Populations,” service packages, and resource allocations in the design of the state’s behavioral health plan. In a fashion similar to Willie M., Thomas S. and elements of the Pioneer system, the state would specifically allocate funds for the development of specific benefit packages for it’s highest priority groups and monitor effectiveness of these services in achieving pre-determined outcomes (improvements in functioning) for the population.

Defining Populations and Services - Background

Clarification of what populations to serve with what programmatic and financial resources is a necessary but complex task in numerous ways. Any attempt to move in this direction will spur political activism among constituency groups advocating for their specific needs. Further complicating this issue is the fact that the current system is under-funded for the population it serves now: it is certain that there is significant unmet need wherever one looks. One need look no further than the state’s jails and penitentiaries to find an easily identifiable group of individuals with untreated mental health and especially substance abuse treatment needs. Other examples of untreated or inappropriately treated groups include individuals with co-occurring mental health and substance use needs, homeless individuals, children and adults with developmental disabilities and substance abuse or mental illness, children of individuals with severe mental and addictive illness, and many others. This list has not even begun to touch on the need for and advisability of prevention services.

Moving towards clarification of populations and resources will reveal several poorly kept secrets:

- (1) despite its attempts, the Division (DMHDDSAS) has extremely limited capacity within the present system to implement an approach of this type,
- (2) even if it had more authority, the Division would not be able to back up its edicts with financial resources, and
- (3) in the current system, rationing of care among different populations occurs continuously and idiosyncratically at the Area Program level guided by local forces and the individual priorities of county and program leaders.

One way to understand the present system and its lack of accountability is to view it as an “unspoken agreement” among the three main players – the General Assembly, the Division, and the Area Programs. The General Assembly says to the Division, “you have to make do with what we can give you and make sure that each of the main advocacy groups feels prioritized.” The Division says to the AP’s, “you must provide all these services to all these groups, but we can only give you this much money.” And the AP’s say to the Division and the General Assembly, “we’ll do the best we can with what you give us, but there is really no way, so don’t bother to hold us accountable.” Of course, it is not this simple. Federal regulators and lawsuits, maverick counties, accreditation bodies, and consumer advocates expect delivery of quality services, track spending closely, and, increasingly insist on receiving real data about the impact of these services. The end result is that the “conspiracy” is broken, but there is still no clear forward path.

Defining Populations and Services -Toward a Sound Foundation for a Re-Designed System

In a system with finite resources, it is imperative to use those resources in the most effective and efficient way possible. The current system attempts to provide services to meet the needs of virtually every person who presents for care and to continue to provide care as long as the person makes him/herself available. While some AP’s have succeeded in instituting utilization management systems to try to conserve precious resources, many AP’s have not, and besides, most of the situations presented do warrant clinical intervention of one sort or another.

In a system with no agreement on who the priority populations are or what the scope of services should be, the result is a spreading or “sprinkling” of resources over a broad range of people, problems, and personal life circumstance. The system is often neither effective nor efficient because the services offered are not appropriately timed, targeted, or intensive enough to produce the degree of change and improved functioning that resolves the issue or problem that the person originally sought help for. Because of this, the system always functions marginally and reactively rather than proactively and progressing toward pre-determined goals and objectives. Higher functioning AP’s have responded to this vacuum of direction by charting a singular course that allows them to function in a rational way. These individual attempts are laudable and adaptive for the AP yet create a state system that varies tremendously from one place to another. A citizen of North Carolina who moves within the state has no idea what services will be available. In fact, some citizens have moved after finding better services in other places.

The task of defining and prioritizing populations and services is an extremely difficult one that engenders more emotion than many other public policy debates because of the personal impact that its decisions will have. However, we regard the present policy of either trying to be all things to all people or leaving those decisions to each county or AP as far more problematic. In the recent past, North Carolina was able to develop a specific service system that effectively addressed the needs of a group of people and monitor it closely. Although the discipline was foisted upon DMHDDSAS and the state by a court order, the experience of developing the Willie M. (and Thomas S.) system has been good training for the next round of necessary changes.

In summary, defining populations and services (and resources) is the necessary pre-condition for creating a rational system that monitors itself effectively and uses that information to continually improve. It allows the system to evaluate components and sub-populations, create meaningful standards of care based on clinical evidence and best practice for that specific group, and measure progress of the system against a sensible baseline of similar programs and populations.

Recommendation 7: North Carolina must develop a process to define specific target populations and develop benefit packages or continuum of services that fit with the needs of individuals in each group. In addition, funding for these Target Population benefit packages should be budgeted independently and each allocation of resources should also include a statement specifying service delivery requirements, specific outcomes expected, and monitoring procedures.

Universal Access to Evaluation and Acute Care: Mending the Holes in the “Safety Net”

Access to high quality assessment services and acute care is highly variable from one AP to another and often within each AP depending on the time of day that a consumer presents for care, the age of the consumer, and the type of care one requires. This is a central and defining problem for both the consumer him/herself, and the system as a whole for two main reasons:

1. The initial evaluation determines the initial treatment plan. A poor evaluation can and often does result in inappropriate referral or placement, undue personal strain, and inefficient use of resources. North Carolina needs to implement a statewide standard such as that developed by DMHDDSAS (Clinical Guideline Series for Area Programs: II. Client Assessment, July, 1999) that assures the availability of qualified assessment for all disability groups at any time of day.
2. A situation requiring acute care is compelling. A system that is unprepared to efficiently and effectively address urgent and emergent events is always reacting to the moment, shunting other priorities aside to deal with the crisis, or quickly transferring this responsibility elsewhere. Under the present system in North Carolina, many AP's rely on the state hospitals for the provision of acute care. At best, this is an inefficient practice. Moreover, the use of the state hospitals for individuals with substance disorders is clearly inappropriate.

Recommendation 8: PCG recommends the development of a standard “Evaluation and Acute Care” benefit package available to every North Carolinian through any County Program. The following services subject to statewide medical necessity criteria, constitute a new model for consistent assessment and acute care, state-wide. Such a benefit is essential to reduce reliance on the state hospitals for acute care. It may need to be phased in over several years, although some county programs are capable of meeting this requirement today.

Assessment Services

- Up to three sessions (50 minutes each) for individual and/or family assessment by a masters prepared clinician privileged in specific age and disability category of the consumer being evaluated
- One session (up to 50 minutes) initial psychiatric evaluation
- Psychological testing, if indicated, to clarify eligibility for intensive services

Acute Care Services – Mental health

- Urgent assessment by a masters prepared clinician privileged in specific age and disability category of the consumer being evaluated; available twenty-four hours per day, 365 days per year
- Up to 15 days inpatient treatment, or
- Conversion of unused inpatient benefit to hospital alternatives on a two for one basis (IE. two days of alternative for every one day of hospital). Covered services include: crisis stabilization bed, observation/holding beds and respite care, day treatment, intensive in-home services, therapeutic foster care
- Initial psychiatric consultation and up to six medication follow-up visits
- Eight individual or family outpatient sessions, or
- Conversion of unused individual outpatient benefit to group treatment on a two for one basis.

Acute Care Services – Substance Abuse

- Urgent assessment by a masters prepared clinician privileged in substance abuse; available twenty-four hours per day, 365 days per year
- Up to 5 days of medically monitored inpatient detoxification (ASAM level III.7)
- Up to 10 days of clinically managed residential treatment (ASAM level III.5)
- Conversion of unused inpatient and residential days on a two for one basis (ie. two days of non-inpatient care for every day of inpatient or residential care) to intensive community services including intensive outpatient, partial hospital, day treatment, evening treatment
- Initial psychiatric consultation and up to six medication follow-up visits
- Eight individual or family outpatient visits, or
- Conversion of unused individual sessions to group treatment on a two for one basis (ie. two group visits for every unused individual visit)

There are many issues that will have to be resolved in implementing this benefit package and we will not attempt to do that here. However, some further clarification of key issues is in order:

Access – Essentially, we do view this benefit as an “entitlement” – it must be available to every resident of North Carolina through every County Program regardless of ability to pay. Additionally for individuals with insurance coverage:

- A. We recommend amending the State Medicaid Plan to closely mirror the service package described above.
- B. Individuals with private insurance could be referred to their plan if the APME was not a network provider.

Contracting – Each County Program will be required to provide the benefit as a condition of receiving funds from DMHSAS.

Network - The County Program does not have to provide all of the services directly but must insure access to services through its network of providers.

Utilization Review/Utilization Management– County Program’s will provide services to consumers based on statewide medical/clinical necessity criteria established by DMHSAS. Each County Program will pre-authorize and manage service utilization for itself. DMHSAS will perform periodic audits to check for compliance with these standards and assess penalties for non-compliance.

Quality Management, Consumer Satisfaction, Outcome Evaluation – Each County Program will be responsible for developing and maintaining a quality management program that routinely assesses consumer satisfaction and reports outcome data consistent with state requirements.

Appeals and Grievances – Each County Program will adhere to the DMHSAS policy (to be developed) for timely resolution of consumer appeals and grievances.

Target Populations – Focused Specialty Care

This section discusses further restructuring of the delivery of mental health and substance abuse services through the process of defining target populations and matching service or benefit packages. While the “Evaluation and Acute Care” benefit (EACB) is a package of services that anyone can access, only individuals meeting the definition of a specific target population are eligible to receive specialized, extended care. County Program’s currently serve many individuals who require extended care and will likely become target populations including individuals with severe mental illness, difficult to manage older adults, Willie M.’s, women with substance abuse disorders, children with severe emotional disturbance, and others. However, the new proposal seeks to not only define the population, but also to define the treatment philosophy and service array that best addresses the needs of the particular group and monitor the effectiveness of those treatments. In this way, it is expected that service arrays will become better “targeted” to each groups’ needs and lead to more efficient use of resources over time. The Willie M. and Thomas S. programs serve as an initial guide in the development of these benefit plans and monitoring processes. In order to accomplish this, it is essential that meaningful clinical (diagnostic and behavioral) and functional criteria be developed to identify the “target” groups.

Recommendation 9: PCG recommends an annual review and modification of the benefit packages based on specific results of outcome evaluation data.

Implementing Targeted Specialty Care (TSC) Benefit Packages

PCG has not detailed the contents of Targeted Specialty Benefit (TSC) Packages since there are many issues that will have to be resolved in implementation. Indeed, the design and development of each package is complicated in itself. Some of the central issues that follow comprise an agenda to be worked on by the Division for planning the transformation of the system.

Defining TSC benefit packages – The design and development the TSC benefit packages are part of an evolving strategy to accomplish primary goals. These goals should include (among others):

- Decreasing dependence on state hospitals, particularly the development of long-term community alternatives for many of the clients using the 667 beds scheduled for closure.
- Prevention, early identification and comprehensive response to substance abuse in children and adolescents.
- Development of recovery-based models and services for individuals with severe mental illness, substance abuse or co-occurring disorders.

Access – TSC can only be accessed through the County Program clinical assessment process (which is accessible to anyone through the EAC). The County Program subsequently reviews each individual situation and makes a determination as to whether an individual qualifies for the TSC according to criteria developed by DMHSAS.

Services – Once an individual is admitted to TSC, he/she is eligible to any and all services defined in that package subject to medical/clinical necessity criteria. DMHSAS may wish to develop two (or more) levels of a specific TSC package to differentiate among groups who look similar diagnostically but differ functionally. For example, the TSC for Individuals with Serious Mental Illness may have a “Standard” package for individuals requiring a wide range of rehabilitative and recovery supportive services and an “Extended” package for individuals who require assertive community treatment, residential support, and other intensive services to support community tenure. Individuals moving to community settings after a period of state hospital residency would also be part of this group.

Contracting – Each County Program will agree to numerous service and reporting requirements as a condition of receiving funds associated with each TSC. In particular, the County Program will be required to deliver services according to each TSC plan and utilization criteria, respond to consumer appeals in a timely manner, and provide outcome data for statewide analysis.

Network – County Program’s may provide services directly or through contracts with local providers. However, the County Program is responsible for delivering the complete benefit and monitoring the quality of network services.

Utilization Review/Utilization Management – County Program’s will be responsible for certification of initial eligibility of all consumers into TSC’s consistent with statewide standards and for periodic monitoring of continued appropriateness for services under the TSC. DMHSAS will perform periodic audits to determine County Program compliance with TSC requirements.

Quality Management, Customer Satisfaction, Outcome Evaluation - Each County Program will be responsible for developing and maintaining a quality management program that routinely assesses consumer satisfaction and reports outcome data consistent with state requirements.

Appeals and Grievances – Each County Program will adhere to the DMHSAS policy (to be developed) for timely resolution of consumer appeals and grievances.

Monitoring and Managing the Behavioral Health System

Establishing and maintaining public confidence and willingness to fund the behavioral health system requires a well conceived, organized process for monitoring services and improving them over time (quality management). This process begins with the development of a set of basic standards (standards of care) and expectations for the delivery of care (clinical guidelines, performance expectations) and a set of methods for continually evaluating the services (outcome evaluation, consumer satisfaction). Because resources are limited, it is also imperative for the system to have a mechanism that guides the use of services and ensures that the resources are utilized in a manner consistent with the system's primary goals (utilization management). North Carolina has made progress over the last several years in developing and initiating a number of vehicles for monitoring various aspects of the service system. It has yet to consolidate these vehicles into a comprehensive approach that provides all levels of the system with the information and data needed to efficiently change and provide better service to the consumer.

While North Carolina has a great deal of company in this category, it is the absence of the "larger vision" that is most troubling. Despite serious efforts by DMHDDSAS to involve Area Program representatives, consumers, and other providers in numerous task forces and study groups to develop management vehicles, there is a strong sense of wasted time, duplication of effort, and lack of direction according to participants in the system. The overlap and timing of the "Area Program Accreditation" effort and the "Council on Accreditation" initiative stand out as the most egregious example. However, DMHDDSAS did not control many elements of the timing and has clearly attempted to provide coordinated direction over the past year in developing monitoring and management tools. The recently published "Clinical Guideline Series for Area Programs" and the "Mental Health Consumer Oriented Report Card" (second publication of results) are good examples of initiatives that show promise. Our observation is that Area Programs have been slow in supporting these initiatives and do not see them as essential to their local service system. In the future, County Programs and consumers need to be part of the process.

Clarifying Responsibility for Monitoring and Management

Attempting to clarify the respective roles and responsibilities of the County Programs and DMHSAS for monitoring and managing the service system requires some assumptions about structural elements of the system. The basis for this discussion is the County Program model (described in Section 2.1) with Acute Care and Targeted Specialty Care benefit packages (described in this chapter).

County Programs and DMHSAS should have specific responsibilities in each area under this model. In general, the DMHSAS is responsible for designing statewide initiatives and monitoring of county compliance, either directly (see Utilization Management) or through the Council on Accreditation (COA). County Program's are responsible for implementation of statewide initiatives and monitoring of their provider networks in all defined areas. Responsibilities in all areas will be defined in contracting process between DMHSAS and the Counties.

Recommendation 10: Responsibilities for monitoring and managing the system of care should be clearly designated to DMHSAS and the County Programs. The details are outlined on the following chart.

2.4 Area Program Mental Health Services

DOMAIN	DMHSAS	COUNTY PROGRAMS
<i>Standards of Care</i>	Development of all applicable standards	Implementation of standards throughout network
	Training	Internal monitoring
	COA monitoring	
<i>Utilization Management</i>	Specification of medical/clinical necessity guidelines	Prior approval of services consistent with statewide guidelines
	Specification of Target Benefit Packages	Monitor provider network
	Tracking of state-wide trends	Continued care reviews
	Provider comparisons	Eligibility determination for Targeted Specialty Care
	Periodic audit of County Program records	
<i>Appeals/Grievance</i>	Monitor compliance with Division of Insurance policies	Maintain system of appeals/grievances consistent with policies of Division of Insurance
	Track statewide trends	Track and respond to grievances in network
	Final authority on appeals	QI oversight of grievances and appeals
	COA monitoring	
<i>Quality Management</i>	Develop general guidelines	Develop specific County Programs and network quality management plan with Board of Directors involvement
	Implement DMHDDSAS QM	Monitor program compliance with QM initiatives
	COA monitoring	

2.4 Area Program Mental Health Services

DOMAIN	DMHSAS	COUNTY PROGRAMS
<i>Outcome Evaluation</i>	Design and develop statewide outcome evaluation project; establish benchmarks	Implement statewide process
	Track state trends	Collect data according to stated procedure
	Provide comparisons to County Programs	Utilize data in QM initiatives
	Provide data to clinicians	Utilize data to change treatment procedures
	Develop training modules for clinicians based on results	Provide training to staff as indicated
<i>Consumer Satisfaction</i>	Design and develop statewide consumer satisfaction process	Implement statewide process
	Provide meaningful comparisons	Collect data according to stated procedure
	Utilize data in statewide QM initiatives	Utilize data in network QM initiatives
<i>Clinical Guidelines</i>	Develop clear guidelines	Implement guidelines
	Modify and update guidelines as best practice evolves	Provide adequate clinical supervision and peer review
	Provide training to clinicians	Provide training to clinicians
	COA monitoring	Monitor network

Issues and Concerns: Consumer Involvement

The plan described here attempts to provide a comprehensive structure for managing the system of care with appropriate checks and balances at each level. There is deliberately very little redundancy built in because each of these responsibilities can be time consuming and costly; the idea is to manage the system not prevent it from focusing on its primary task. One way for the system to be true to its mission of service and make these management and monitoring tools relevant to the task is to include consumers and families in their development from the beginning and throughout. This is a basic assumption of the model proposed.

Recommendation 11: Consumers and families must be actively involved in leading the effort to manage and monitor the system at every level. Key areas of involvement include (but not limited to): initial process design with DMHSAS, County management, quality management efforts at all levels, grievance and appeals committees, and practice guideline advisory groups.

Issues and Concerns: The Role of the Council on Accreditation (COA)

DMHDDSAS has contracted with COA to play a major role in the monitoring of the system of care. The “responsibilities” chart has indicated COA coverage in four major areas including monitoring APME compliance with standards of care, clinical guidelines, quality management, and grievances and appeals. While these are areas that COA typically covers, outsourcing these responsibilities to COA will not work unless COA reviewers become totally fluent in North Carolina specific criteria in each area in addition to the basic COA standards. Otherwise, DMHDDSAS will have to conduct a redundant process.

A second issue pertains to network monitoring. Each APME will presumably contract with many additional providers and will be responsible for monitoring their efforts. What provisions has DMHDDSAS developed with COA to check APME monitoring of its provider network? This is a crucial issue since as much as 50% of all services are actually delivered by network providers.

The role of COA in monitoring the system of care should be reviewed in the context of any changes that are forthcoming from this report and the ensuing legislative process. COA can certainly be helpful in facilitating a cultural shift and is already conducting accreditation reviews. DMHDDSAS is in no position to perform this role at the present time. However, this may be an important function for DMHDDSAS to play directly in the long term.

Transforming the Service System: Implementation

At this point, the question becomes, “So, how do we get there from here?” There is, of course, no single answer. However, from our viewpoint, we see great utility in prioritizing implementation of the standardized Assessment and Acute Care Benefit Package (AACBP). AACBP fundamentally alters the relationship between the state and the county programs, establishes a “floor” expectation of service delivery throughout the state, and begins to address many of the most pressing issues that we noted throughout this chapter including the need to improve clinical assessment, address the overall weakness of the substance abuse continuum, and reduce the scope and size of the state hospitals.

Key system issues positively impacted by implementation of the Assessment and Acute Care Benefit Package (AACBP):

1. Initiation of new contracting process between County's and state that defines specific funding for specific services.
2. Initiation of statewide standardized assessment procedure as part of the contract. The DMHDDSAS standard as defined in the Clinical Guideline Series for Area Programs: II. Client Assessment (July, 1999).
3. Adoption of the assessment standard improves treatment quality for all disability groups by prescribing qualifications for clinicians and standard process for assessment that recognize specific needs of the population.
4. Adoption of the standardized assessment creates a foundation for effective utilization management of resources that is similar throughout the state.
5. AACBP establishes uniform expectations for responsibility for acute care in the community. This change is critical to the state's agenda to downsize the state hospitals.
6. Defining primary responsibility for acute care in the community creates an opportunity for the state hospitals to be re-defined as intermediate and tertiary care environments. This should lead to improved treatment quality at the state hospital programs that remain there.
7. AACBP establishes a basic benefit package for individuals with substance abuse disorders that is essentially equivalent to those available for mental disorders. This is a major step in recognizing and addressing the needs of the substance abuse population. In addition, through accurate assessment and development of additional acute care resources, individuals with acute substance abuse presentation will be routed to appropriate treatment venues other than the state hospitals.
8. AACBP establishes a mechanism for development and maintenance of non-hospital acute care service development. This part of the benefit supports the advances that many AP's made under Carolina Alternatives and allows the treatment system to more flexibly meet the needs of the individual. Reduction in use of inpatient services, including those at the state hospitals is expected as a result of this improved coverage.
9. AACBP establishes a basic expectation for provision of brief outpatient and aftercare that both ensures availability for individuals in crisis and, also, limits the state's responsibility for funding beyond the basic benefit unless the individual qualifies for inclusion in a Target Population.

While implementation of AACBP may seem overwhelming, it is our assessment that some County Programs, especially those with local inpatient resources, will be capable of immediate implementation. In other areas, pilot projects to develop acute hospital services could be started now with a timed implementation of the full AACBP. Certainly, pilot projects to improve access to acute substance abuse services will be necessary in many places as well. However, this development will be entirely consistent with the state's initiative to reduce the size of the state hospitals. Start-up funding for the pilots will undoubtedly be necessary, but much of the ongoing cost should come from savings from state hospital expenditures. Similarly, it is our assessment that most of the non-hospital cost is already in the system. The major new cost areas (other than inpatient) include additional funding to meet the assessment standard, new funding to develop acute diversion capacity and new funding to meet the substance abuse service requirements.

New Initiatives: Keeping the Momentum

PCG has become aware of a number of initiatives that DMHDDSAS has been engaged in recently. Although these initiatives may not be directly related to our previous recommendations, they represent serious efforts to address some of the findings in this report. Included among these are:

- development of standards for performance contracting;
- development of priority populations definitions and service requirements;
- use of ASAM criteria for patient placement;
- transition of ADATC's to Level 3.7 and the purchase of Level 4 services from acute care hospitals; and
- providing child mental health services directly in school settings.

These activities, and others, move the State in the right direction in establishing standards and innovative services in the community for target populations. These should be supported and moved ahead, and should not fall victim to the current lack of direction of the system.

On a different note, there has been continued newspaper stories in the closing or the anticipated closing of community residential and inpatient services. This could create an even bigger deficit to overcome in the future. *We urge DMHDDSAS to convene an immediate task force to assess the risk of losing the community beds (residential and hospital) and make recommendations to the Secretary of the Department of Health and Human Services within 30 days.*

PRIMARY FINDINGS ON FINANCES AND FINANCIAL OPERATIONS

NORTH CAROLINA IN A NATIONAL CONTEXT

On a per capita basis, North Carolina spending is comparable to both national averages and peer states; however, North Carolina spends a disproportionately greater amount of money on State hospital services compared to community-based services. This spending allocation reduces the amount of money Area Programs have to develop and manage locally provided services. Additionally, State funding policies encourages Area Programs to utilize State hospitals - the system's most expensive delivery alternative.

PCG's analysis shows that while aggregate per capita spending in North Carolina is comparable to the national average, funding of the services is not optimized. Unlike many other progressive states, North Carolina spends a disproportionate amount of money funding State hospitals as opposed to community-based services. This funding scenario drives high system costs by perpetuating a reliance on the system's most expensive delivery alternative, the state-run institutions. Nationally states are expanding community-based care by expanding funding, while concurrently decreasing funding of large, state-operated institutions. Additionally, the focus of other states on community-based services is consistent with the future direction established by a recent U.S. Supreme Court Olmstead ruling that emphasizes community placement of clients.

Data used in the following analysis of MH/SA spending in North Carolina and in other states across the country is based on data obtained from a report produced by the NASMHPD Research Institute entitled Funding Sources and Expenditures of State Mental Health Agencies, Fiscal Year 1997 Final Report. Additional sources of data were used in the analysis to confirm and normalize the data. The data should be used for comparison purposes only.

Total spending in North Carolina for the delivery of both inpatient and community-based mental health, substance abuse and developmental disability services exceeded \$1.2 billion in FY 98-99. The breakdown of total spending includes 45% designated for the mental health population, 8% designated for the substance abuse population and 47% designated for the developmentally disabled population. In FY 96-97, total mental health and substance abuse expenditures in North Carolina equaled more than \$532M, equivalent to \$73 per capita, compared to the national average of \$64 per capita. North Carolina's per capita funding for mental health services ranks the State 22nd nationally.

While comparison to national per capita spending is useful, the results can be potentially misleading due to the inclusion of significantly dissimilar demographic states. To maintain consistency with our Phase I Report, PCG identified a nine-state "peer" benchmark group. Consistent with the national comparison, North Carolina per capita spending is essentially the same as the peer group average of \$71 per capita.

2.5. Finances and Financial Operations

Total MH/SA Expenditures Per Capita for FY 96-97

	Total MH/SA Expenditures	Population	Per Capita
North Carolina	\$532M	7.3M	\$73
Peer States			
South Carolina	\$304M	3.7M	\$82
Michigan	\$950M	9.7M	\$98
Ohio*	\$699M	11.2M	\$62
Pennsylvania	\$876M	12.0M	\$73
Massachusetts**	\$642M	6.1M	\$105
Kentucky	\$166M	3.9M	\$42
Virginia	\$384M	6.6M	\$58
Missouri	\$359M	5.4M	\$66
Illinois	\$613M	11.9M	\$51
Peer State Average	\$576M	8.0M	\$71
National Average	\$332M	5.2M	\$64

*Ohio expenditures may not fully include substance abuse expenditures

**Massachusetts Substance Abuse figures obtained from MA Dept of Health's Internet Web page, www.state.ma.us since Substance Abuse is part of the Public Health Department.

NASMHPD Research Institute *Funding Sources and Expenditures of State Mental Health Agencies, Fiscal Year 1997 Final Report*

North Carolina differs from the peer group, though, in the distribution of funding between community-based services and state institutions. Of the \$532 million dollars in the MH/SA delivery system in FY 96-97, North Carolina spends approximately \$235M (44%) on inpatient services at the four State Psychiatric facilities and \$290M (55%) on community-based services at the thirty-nine local Area Programs (the additional 1% of expenditures is allocated to "Support Activities"). When expenditure distribution is compared to peer state and national averages, North Carolina spends less on community-based services. Specifically, North Carolina spends approximately 55% on community-based care compared to a peer state average of 59% and a national average of 62%. Some of the more aggressive peer states spend in excess of 65% in the community following the trend of moving patients into more appropriate settings and away from State institutions. Furthermore, as other states continue to move funds to the community since FY 96-97, North Carolina's expenditure pattern has remained consistent. This is evidenced by the fact that for FY 00, community-based expenditures remained at 44%. A funding distribution that is more heavily weighted towards inpatient care, such as North Carolina's, limits Area Programs from expanding community-based services because of limited funding. The data/statistics are not exact as obtaining consistently reported mental health funding data is nearly impossible; nevertheless, the data is compelling. Moreover, this data is consistent with our detailed analysis of the North Carolina's State hospital utilization and projected bed demand that demonstrates the need to downsize the State institutions. (Section 2.2) Due to the recent Olmstead Supreme Court ruling, additional funding will need to flow to the community to serve patients in the least restrictive community environment.

2.5. Finances and Financial Operations

The following chart breaks down, by State, spending between state institutions and community-based care.

I. FY 96-97 MH/SA Expenditures: Inpatient vs. Community-Based Services

	State Mental Hospitals*	Community- Based Services*
North Carolina	44%	55%
Peer States		
South Carolina	45%	48%
Michigan	32%	66%
Ohio	23%	74%
Pennsylvania	38%	61%
Massachusetts**	28%	64%
Kentucky	23%	77%
Virginia	56%	42%
Missouri	54%	39%
Illinois	37%	61%
Peer State Average	37%	59%
National Average	37%	62%

* Please note: percentages do not add up to 100% due to the additional funds allocated to “Support Activities”

** Massachusetts data does not include SA figures broken down into inpatient and community-based services

NASMHPD Research Institute *Funding Sources and Expenditures of State Mental Health Agencies, Fiscal Year 1997 Final Report*

In order for North Carolina to achieve the national state average of 62% allocated to support community-based expenditures, approximately \$38M would need to be moved from the State mental health hospitals to the community for locally based services. This funding would allow Area Programs to begin the development of community-based services to deliver care rather than relying on State hospitals. In the long term, developing community-based care would allow for a reduction in State hospital utilization and, ultimately, reduce system-wide costs. The majority of peer states are already in the process of moving clients from State hospitals into the community, an initiative that results in lower system costs and more appropriate levels of care as evidenced by the increased number of treatment options at the community level. Local providers in peer states are incentivized to limit inpatient services to those clients with acute needs and offer appropriate treatment alternatives including residential, day treatment and outpatient treatment programs to those clients in need of less severe levels of care. The success of this strategy depends heavily upon the State’s ability to ensure that funding follows the patient into the community to support the local delivery of service.

2.5. Finances and Financial Operations

State Funding

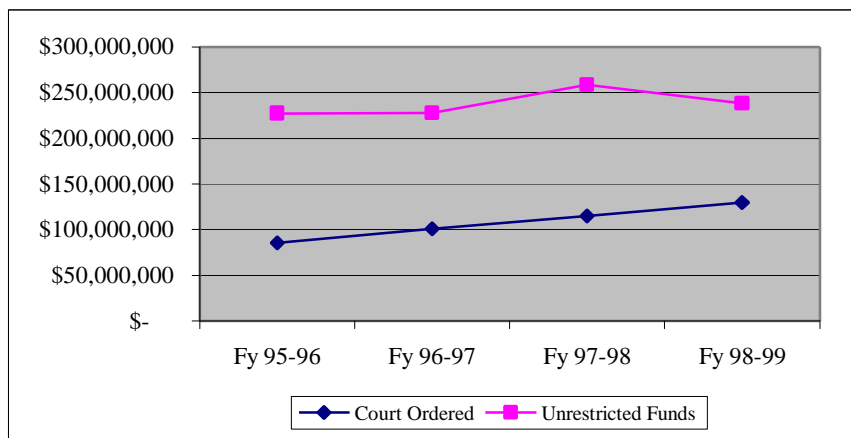
Over the last three years, the allocation of State funds to Area Programs for community-based services has increased. The increase, however, has primarily supported growth in court-ordered treatment programs that provide a high level of service to a limited number of clients. The funding for non court-ordered programs by the State has essentially experienced no growth over the same time period. Actually, from FY 97-98 to FY 98-99, unrestricted State funds decreased by nearly \$20 million. This directly decreased funding for indigent care because unrestricted State funds are the main source for indigent care revenue for Area Programs. Moreover, only a minimal amount of State funding has been targeted for substance abuse programs accounting for the limited availability of community-based programs across the State.

(State Expenditures in this section refer to the funds distributed by the State of North Carolina's DMHDDAS to the Area Programs. Approximately 80% of these funds are State appropriated dollars and 20% of the funds are federal dollars)

State expenditures at the community level have increased by approximately 8% over the last three years from \$364 million to \$392 million. Over 90% of the \$28 million increase was allocated to the two court-ordered programs, Thomas S. and Willie M. The remaining \$2M was used to fund expansion of the non-court ordered services. Accounting for inflation and population growth, the increase in non-court ordered funding to Area Programs has been minimal. (Please note the numbers in this section include State DD spending and will not correspond to the MH/SA numbers found in the *North Carolina in a National Context* of this Section.)

II. State Expenditures: Breakdown of Court-Ordered vs. Unrestricted Funds

III. Community-Based Expenditures



State of NC, Division of MH/SA/DD Area Program Fiscal Monitoring Reports

As stated previously, North Carolina spends a comparable amount per capita as other peer states and the national average. A large percentage of the monies, however, are allocated to serve specific populations based on previous court decisions. These funds are available for use by Area Programs to serve only a small number of clients. In FY 98-99, Willie M. funding totaled \$48 million of the Area Programs' State allocation, yet these funds were utilized to support approximately 1,600 eligible clients. Similarly, North Carolina spent a total of \$82 million serving the 1,569 designated Thomas S. clients receiving developmental disability services. Together, the two court-ordered treatment programs were allocated approximately 33% of the total State funding to support less than 1% of the clients served in the system.

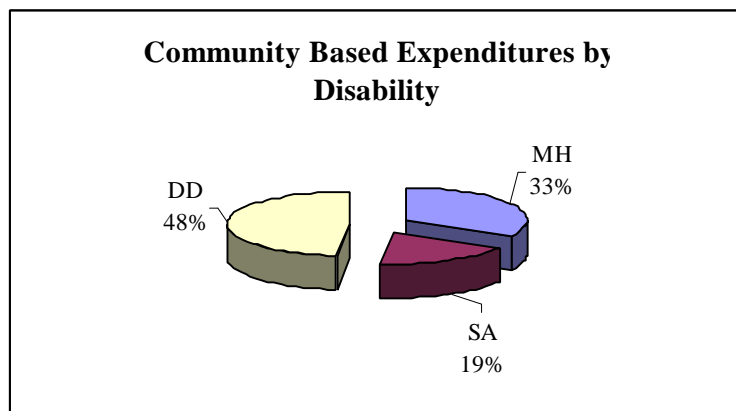
2.5. Finances and Financial Operations

State/Federal Dollars Allocated for Community-Based Services

	MH	Willie M	SA	DD	Thomas S
Clients Served FY 98-99	217,653	1,600	87,215	16,113	1,569
Total State Dollars	\$82M	\$48M	\$73M	\$108M	\$82M
% of Total State Allocation	21%	12%	19%	27%	21%

State of NC, Division of MH/SA/DD (1) *Annual Statistical Report of Area Programs* and (2) *Total Expenditures Worksheet*

Until the recent satisfying of the consent decrees, the State was ordered to fund a specific service continuum for clients who qualified for these programs. The large percentage of State funds spent on the court-ordered programs minimizes the impact State funds have on the local capacity to expand the provision of services to the non court-ordered groups. At the local level, Area Programs are faced with the difficulty of funding services for non court-ordered populations offering limited service continuums. In contrast, Willie M. and Thomas S. clients have access to a comprehensive set of benefits including high-end residential services and extensive step-down service offerings funded primarily through the State's allocation of funds.



* Willie M. and Thomas S. totals have been included in MH and DD totals respectively

State of NC, Division of MH/SA/DD: *Overview of DMHDDSAS Funding Worksheet*

Another critical aspect of State funding is the allocation between the service disciplines as a significant difference exists between the funding available for developmental disability, mental health and substance abuse services. Unarguably, in total funding, substance abuse is the poorest funded discipline accounting for the minimal continuum of care available in the community and the corresponding overuse of the State hospitals for this service. By using the court-ordered programs as funding streams and designating significant dollars to the DD population to fund costly services, the State has little money left to serve the remaining clients in the system. To compound the issue, services that are offered in the community are often not reimbursed by Medicaid leaving Area Programs to fund the services through County funds and the limited State funds to support the continuum of care.

2.5. Finances and Financial Operations

Another significant revenue source for the State, Disproportionate Share Funds for the state hospitals (IMD/DSH), produced approximately \$97M for North Carolina in FY 98-99. These funds have been generated by the State hospitals and have reverted to the General Fund. To date, the community mental health system has not benefited from this substantial funding source. Due to the recent Balanced Budget Act of 1997, DSH reimbursement will be decreasing over the next three years by an estimated \$15 million (Please see Section 2.6). One of the potential benefits of this Federal reimbursement change is that if the clients currently generating DSH payments are moved from the State hospitals to the community-based programs, regular Medicaid reimbursement can be earned. This could provide more appropriately based services for these clients along with additional revenue for the County Programs. Also, it will allow the mental health system to stay within its budget appropriation to finance the shift to community services, except for one-time bridge funds.

Area Program Budgets

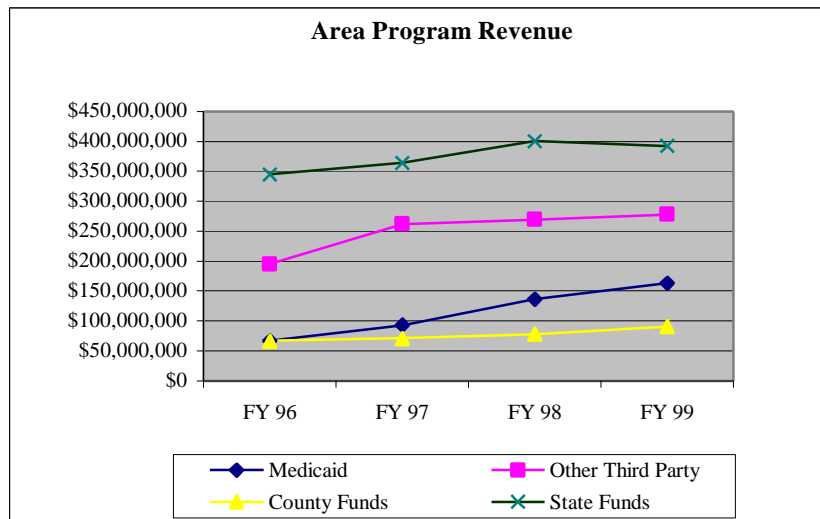
Over the last four years, Area Program expenses have increased more than revenue. The disparity between expenses and revenue has put many Area Programs in financially precarious positions. The limited availability of unrestricted funds to support services compels financial directors to reduce costs and continue to search for additional revenue enhancement opportunities. Additionally, there is significant variation in financial resources among Area Programs resulting in a multi-tiered system of care. The difference in financial resources is the single biggest factor in determining operational and clinical capacities of Area Programs.

The budget differential between Area Programs has and will continue to have a significant impact on the system's ability to support continued growth. The funding variance is the primary driving force in creating widely varying financial, operational and clinical capacities among Area Programs. Many Area Programs are simply "making do" with significantly less funds than others. As demands on service continuum expansion increases and the funds available to support the expansion diminish, the prospect for future system success is lessened unless all Area Programs receive proportionally equivalent local, State and Federal funding.

Area Program Budget Growth

Over the last four years, total revenue for the Area Programs has increased by more than 25% with a corresponding increase in total expenditures of 29% illustrating the vast changes in responsibility and complexity in the financial management operating structure. Much of the increase can be attributed to tremendous expansion in Medicaid billing with a greater influence placed on these funds to support local revenue budgets. While increases in budgets allow Area Programs to serve a larger number of clients, the resulting increases in the administrative and financial responsibilities adds administrative costs which may limit the Area Programs' ability to expand or even maintain current service continuum capacities.

2.5. Finances and Financial Operations



State of NC, Division of MH/SA/DD, FY 98-99 Area Program Quarterly Fiscal Monitoring Reports

As a percentage of total budget, the dependence on Medicaid revenue to support Area Program budgets varies widely ranging from 10% in VGFW to 54% in Southeast Regional. Of the 325,000 clients in FY 98-99, the services provided to only 75,170 or 23% of these clients were billed to Medicaid, yet Medicaid represents 76% of the fee-for-service revenue generated by the Area Programs.

Fee-For-Service Revenue Analysis

Fee-For-Service Revenue Sources	Revenue FY 98-99	% of Total Revenue
Client Fees	\$12.5M	6%
Medicaid-Regular	\$163.2M	76%
Medicaid CAP MR/DD	\$32.4M	15%
Medicare	\$3.0M	1%
Commercial Insurance	\$4.7M	2%
Total FFS Revenue	\$215.8M	100%

State of NC, Division of MH/SA/DD, FY 98-99 Area Program Quarterly Fiscal Monitoring Reports

Client fees, Medicare and commercial insurance revenue continues to decline at the community level despite efforts such as North Carolina Health Choice to enroll more people into commercial insurance plans. The lack of additional funding places a greater dependence on Medicaid to fund larger percentages of local budgets.

As mentioned in the *State Funding* part of this report, unrestricted State funding has remained stagnant forcing Area Programs to find additional revenue sources to serve the non-Medicaid population. County funding is one revenue source that has increased as Area Programs look to local government to support existing programs as well as new initiatives. Total County funding over the last four years has increased by 36% to a total of \$90.8M in FY 98-99. For some Area Programs, County funding represents a significant percentage of budgeted dollars providing additional capacity not available in all areas of the State. For example, in FY 98-99, Mecklenburg County appropriated \$26.5 million representing 40% of the Area Program's revenue budget. In contrast, other Area Programs receive little County funding ranging to as little as \$87,000 in Rutherford-Polk Area Program, representing less than 1% of the Area Program's total revenue budget. While County funding has increased, the

2.5. Finances and Financial Operations

net effect on the Area Programs' budgets remains somewhat limited as total county funds equal only 12% of the total revenue budget for FY 98-99.

The variance of County funding across the state is notable as 65% of the total county contribution statewide is designated for five Area Programs including Mecklenburg, Wake, Durham, Guilford County and CenterPoint Area Program with total contributions equaling \$58.1M. By removing the above five contributions from the system, the remaining county contributions total \$32M averaging less than 6% of the total budgets for the other Area Programs. In addition, County contributions statewide range from \$1 to \$43 per capita further illustrating the funding variance and one of the key challenges in the system.

Further analysis demonstrates that local funding varies significantly between single-county and multi-county Area Programs averaging \$21 and \$5 per capita respectively. Single-county Area Programs receive, on average, more than 24% of their budget from local funds while the multi-county Area Programs receive less than 5%. The largest single county contribution to an Area Program totals more than \$26 million representing approximately 40% of the budget. In contrast, the largest county contribution to a multi-county Area Program totals approximately \$5 million representing 17% of the budget. As a result, the multi-county Area Programs are incentivized to generate substantially more revenue through other sources such as Medicaid, Medicare and commercial insurance to subsidize the limited amount of local funding received.

IV. County Expenditures: Multi-County vs. Single County

	County Contributions	
	Per Capita	% of Budget
Multi-county	\$5	5%
Single County	\$21	24%
Statewide	\$12	12%

State of NC, Division of MH/SA/D Area Program Quarterly Fiscal Monitoring Reports

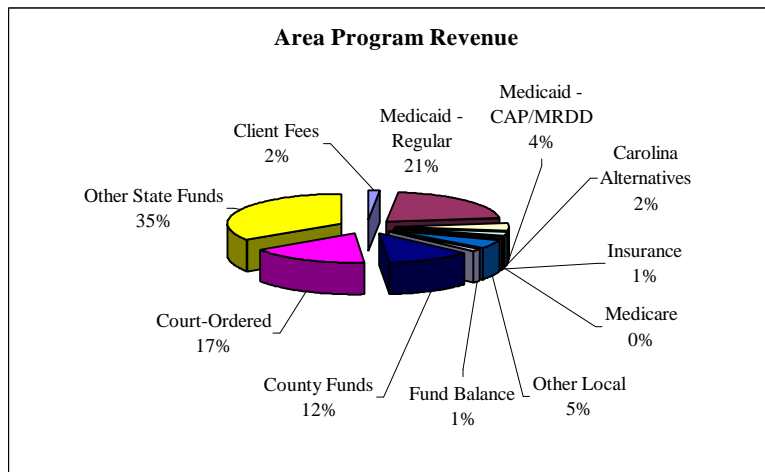
In general, North Carolina counties with single-county Area Programs operate more like a county department with integrated operations and a more direct link to the County Manager and his or her staff. The County exerts more influence over the local delivery of MH/SA/DD services thus contribute more money per capita than those counties participating in multi-county Area Program arrangements.

Due to unreported indirect contributions provided by the Counties, the actual contributions of Counties to the local Area Programs are significantly greater than the \$90.8 million dollars reported to the State on the *Quarterly Fiscal Monitoring Reports*. These indirect contributions include buildings, maintenance, land, accounting services, legal services, human resources, MIS technical support and others that help the Area Programs operate with a smaller administrative overhead than would be required by an independent entity. *Based on a small sample of Area Programs, an estimated additional 30% to 50% of the direct contributions (cash) are provided to the Area Programs by the Counties in the form of indirect services. This translates to an additional \$25 to \$45 million of indirect County Contributions currently used to support the local delivery system.* To compound the issue, the actual amount of County Contributions is further distorted by the practice of Area Programs reverting money back to their County's budget at year-end. The reverted County funds totaled more than \$6 million in FY 98-99. The current reporting mechanisms do not track all of this data making it difficult to determine the true amount of County support toward the community system.

2.5. Finances and Financial Operations

Area Program Revenue Breakdown

Area Program budgets are comprised of Federal, State and local resources generating funds through various allocation and fee-for-service methods. The budgets are heavily dependent upon Medicaid, State allocations and County Funds to support the local continuum of care. As the population and number of clients in need continues to grow, the Area Programs will rely more heavily on fee-for-service income through more efficient and effective methods of billing to support the treatment services provided at the community level.



State of NC, Division of MH/SA/D *Area Program Quarterly Fiscal Monitoring Reports*

More than a dozen funding streams currently exist across the State including, Federal, State and county contributions, Medicaid, Medicare, commercial insurance, client fees, Willie M., Thomas S., CAP MR/DD, Federal and State Block Grants as well as others. Multiple funding streams represent a challenge to Area Program management and require strong financial management capability. Despite large budget variations across Area Programs, management of the same number of funding streams is required putting stress on limited resources especially within the smaller Area Programs with limited staff and MIS capabilities. The system is intimidating and overwhelming as many restrictions and guidelines are placed on the various funding sources, complicating the system and increasing administrative time and cost. In addition, many of the funding streams, such as Medicaid, contain incentives that encourage Area Programs to modify service offerings in order to maximize revenue.

The multiple funding streams with restrictive mandates and perverse incentives have created a complex community-based environment with a difficult management structure and little fiscal accountability. Restrictive funding mechanisms are driving Area Programs to focus on using an appropriate provider of care based on the restrictive criteria rather than the most optimal care for the client. While multiple funding streams may be necessary to ensure dollars from multiple sources, the administrative integration and simplification of the management of these sources has not been realized.

2.5. Finances and Financial Operations

Carolina Alternatives represents North Carolina's first foray into a capitated behavioral health revenue stream with fewer restrictions placed on funding. According to HCFA and as evidenced by the recent dissolution of the State's 10 pilot programs, Carolina Alternatives was unsuccessful for various reasons. Based on the initial results as well as the potential paybacks resulting from this effort, HCFA is unlikely to permit a wide-scale capitated system in the near future; therefore, a fee-for-service Medicaid system with some restrictions is still necessary in the State.

The wide variance in Area Program budgets results in a disparate ability to serve clients as the smaller Area Programs expend a greater percentage of resources on administrative functions and less on the actual provision of services. The total revenue budget dollar generated per client served ranges from as little as \$1,100 in Duplin-Sampson and Smokey Mountain to as high as \$3,900 per client served in Piedmont Area Program. As illustrated in the table below, the larger Area Programs are able to gain economies of scale and serve more clients per budgeted dollar than smaller Area Programs. Administrative functions such as financial services, administration, MIS, human resources and others are allocated among a larger number of employees and departments resulting in lower administrative overhead percentages and higher dollar amounts available to spend on services.

Area Program Budgets	<i># of Area Programs</i>	Total Budget	# of clients served	Budget \$ per client served
Less than \$20M	25	\$308M	157K	\$1,967
Greater than \$20M	14	\$453M	168K	\$2,689
Statewide	39	\$761M	325K	\$2,342

State of NC, Division of MH/SA/D *Area Program Quarterly Fiscal Monitoring Reports*
FY 97-98 Area Program Expenditures based on FY 97-98 Actual Cost Finding

From reviewing data and discussions with Area Program Finance Directors, it appears that the administrative overhead amount varies greatly across Area Programs. One Finance Director of a small Area Program reported an administrative overhead percentage of approximately 20% to 25% while the Finance Director from a large Area Program reported figures in the 10% to 12% range. This significant difference corresponds to the finding mentioned above. Unfortunately, due to the inconsistent reporting of administrative costs among Area Programs, actual administrative percentages are not available for comparison purposes.

Despite the lack of accurate data on administrative cost in the system, the variance among Area Programs is significant. As the chart above illustrates, the administrative cost of managing an Area Program appears to be related to the size of the budget. As Area Programs expand, economies-of-scale are realized and less administrative costs are required to administer the programs. The smaller Area Programs must adhere to the same complex administrative requirements as the larger Area Programs despite possessing less administrative support such as staff and MIS capabilities driving up overall costs to the system. Based on a \$750 million system, for each percentage point decrease in administrative cost, the community will realize savings of \$7.5 million resulting in additional dollars available for service delivery.

Financial Pressure

The current complex MH/SA delivery environment places a significant strain on the financial operations of the Area Programs. The recent population growth in North Carolina and subsequent increase in the local client base combined with the ever-increasing restrictions placed on the existing funding streams has mandated more

2.5. Finances and Financial Operations

technical management of financial operations. Finance Directors have developed creative ways to reduce costs while exploring additional revenue enhancement opportunities; however, intense State reporting requirements, additional financial obligations and the reduction of unrestricted State funding has reduced the impact of these cost reduction and revenue generating activities.

To add to the financial pressure, the funds available to support the indigent population are diminishing. In FY 98-99, a total of \$526 million of service was reported through the State's Pioneer system. The State allocated a total of \$237 million of *unrestricted revenue* to the Area Programs leaving a balance of \$289 million to be reimbursed by other means. An additional \$183 million was generated through billing Medicaid, Medicare, private insurance and client fees leaving an additional \$106 million of non-funded services for the Area Programs to support the indigent care population. The non-funded dollar amount is actually probably higher due to underreporting of services by the Area Program to the State. At times, services provided by contracted providers are not reported through the Pioneer system. This actually leaves an even larger non-funded amount that Area Programs must cover and fund these services through county contributions.

	FY 98-99
Pioneer Reported Services	\$526M
Division Allocation (non court-ordered)	(\$237M)
1 st and 3 rd Party Funding Sources	(\$183M)
Total Non-funded Services	\$106M

Area Program Pioneer Allocations, FY 98-99 – North Carolina, Division of MHSADDSAS

As the funds available for the indigent population decline, Area Programs will be required to either cut services or serve fewer clients in order to maintain solvency. DMH has a limited capacity to expand the dollars available in the system with the General Assembly allocating funds for the delivery of MH/SA/DD services on an annual basis. With fewer unrestricted dollars available in the system, Area Programs will continue to struggle to deliver care to a larger population of clients with little growth in funding in the system.

Area Program Budget Cycle

The current budget cycle prevents Area Programs from accurately estimating revenue and expenditures due to the changing landscape of the system throughout the year. DMA's adjustment of reimbursement rates after the Area Programs have finalized the budget leaves the financial directors in a state of uncertainty. This is especially a concern where Medicaid reimbursement represents a large percentage of an Area Program's budget. As a result, Area Program Board members must approve a budget where revenue is not actually finalized, a difficult task to accomplish. Additionally, finalizing the method and allocation amount for Thomas S. and Willie M. well after the start of the fiscal year results in a similar effect on Area Program budgets. If rates and allocations are lower than expected, the Area Programs must move budgeted dollars from other programs to support the local continuum of care thus leaving less money to support indigent and other non court-ordered programs.

Medicaid Match Reserve Requirement

To further illustrate the financial strain at the community level, in FY 98-99 the Area Programs were required to pay a portion of the State's Medicaid Match Reserve obligation. The required match was

2.5. Finances and Financial Operations

\$74 million. The State appropriation was more than \$36 million leaving the Area Programs responsible for funding the remaining \$38 million from decreased allocation. Prior to FY 98-99, a “soft” match was employed by the State to cover the non-Federal reimbursement requirement. Due to the significant increase in Medicaid revenue, appropriate funds were not available to meet the non-federal match required for the federal funds. At that time, the Federal government insisted that a more definitive match process be implemented so Area Programs benefited by receiving 100% of the Medicaid rate paid for services rendered (previously the Area Programs were only reimbursed the Federal Share of the Medicaid rate). However, the impact was offset by a notable rate reduction for some Medicaid billable services. The result was a significant financial burden as Area Program Finance Directors had not budgeted for this financial liability, thus had difficulty finding additional revenue to fund the match obligation.

Previously, due to the “soft” match process employed by the State, Counties were not obligated to financially participate in funding Medicaid mental health expenditures. Effective July 1, 1999, legislation was enacted requiring counties to financially participate in the Medicaid match requirement.

Multi-County vs. Single County Response

The strategies employed to manage the financial issues in the system vary based on the size and structure of the Area Programs. Multi-county Area Programs receive less county reimbursement motivating the management to generate more revenue through more effective means of billing Medicaid and drawing down more third party reimbursement and additional State allocated funds. Despite receiving one-fourth of the average county contribution of a single county Area Program, multi-county Area Programs generate significantly higher State dollars and Medicaid dollars per capita resulting in more revenue available to support the local budgets.

Multi-County vs. Single County Revenue

	State \$ Per Capita	County \$ Per Capita	Medicaid \$ per Capita	Total Revenue per Capita
Single County Average	\$42	\$21	\$20	\$110
Multi-County Average	\$59	\$5	\$30	\$88

State of NC, Division of MH/SA/DD Area Program Quarterly Fiscal Monitoring Reports

The high administrative costs, however, required to support the extensive billing processes and to maintain consistent revenue growth limits the economies-of-scale desired by the Area Programs, thus restricting the impact that these funds have on the overall budget.

The lack of local revenue forces the multi-county Area Programs to more aggressively pursue additional revenue enhancement opportunities while maintaining tighter controls on cost. As growth in State funding evaporates, Area Programs will begin to focus more directly on alternative funding sources to support the local continuum of care.

According to Area Program mission statements, all clients should be served regardless of an ability-to-pay. This requirement puts pressure on individual Area Programs to make decisions regarding whom they should serve, who has the ability-to-pay and how much to designate as the client’s responsibility. The Area Programs’ fear of not serving a client in need causes over-utilization of the system especially by those clients who have coverage through non-public funds such as private insurance or self-pay.

2.5. Finances and Financial Operations

Cost Shifting to State Hospitals

One method of controlling costs in the community is the practice of referring clients to the State Hospital system rather than contracting with a local provider of inpatient care. Use of the State hospital system creates an unwanted incentive for Area Programs to utilize State Hospitals and not to expand community service options. Without the incentive, State Hospitals are essentially a “free” service since Area Programs are not charged for sending clients to these institutions.

When clients are referred from the community to the State Hospital System, transportation is the only cost that Area Programs incur, which is obviously substantially less than funding inpatient bed days. Conversely, if an Area Program uses a community-based alternative for a client, the Area Program must bear the cost for these services. Thus, as finances become increasingly challenged, Area Programs are incentivized to send more patients, especially indigents that have no funding sources, to State hospitals. This financing mechanism incentivizes Area Programs to utilize the system’s most expensive resource, State hospitals, as evidenced by the 13% increase in State hospital admissions over the last 4 years. Moreover, a client’s desire to receive locally based services will continue to be restricted in the future if Area Program finances continue to be strained.

During the past year, a few Area Programs have made a conscious decision to discontinue the operation of internal inpatient units and have begun relying primarily on the State Hospital System to reduce costs internally while continuing to support the inpatient needs for their clients. While the Area Programs are able to shift some costs to the State hospitals, the practice is an expensive solution for the system as a whole.

DMH has a bed allocation methodology in an attempt to control the number of State hospital admissions and incentivize Area Programs to manage the utilization of bed days. According to the allocation methodology, Area Programs are charged \$315 per bed day greater than the quota established by DMH. The utilization allocations, however, have not been updated since 1995 and Area Programs are never charged for overuse. As a result, the bed day allocations by DMH have no impact on the manner in which Area Programs serve clients. The unwanted end result is patient care overly directed by financial considerations rather than the best interest of the patient to receive appropriate care in an appropriate setting.

Area Program 1st and 3rd Party Funding Sources

Area Programs are funded by numerous sources including State, Medicaid, Medicare, commercial insurance, and self pay. Due to a general inability to generate significant dollars in self pay, Medicare and commercial insurance revenue, Area Programs rely heavily on Medicaid reimbursement. In FY 98-99, almost 1/3 of Area Program budgets were funded with Medicaid reimbursement; nevertheless, substance abuse services have not received a comparable Medicaid reimbursement level as the other two service continuums. Over the last four years, Area Programs' reliance on Medicare and commercial insurance revenue has decreased.

Medicaid Funding

Area Programs rely heavily on Medicaid funding to pay for services provided to Medicaid recipients seeking mental health and substance abuse treatment. Over the last four years, Medicaid represents the fastest growing segment of Area Program revenues increasing from \$67M in FY 95-96 to \$163M in FY 98-99, a 143% increase.

2.5. Finances and Financial Operations

Medicaid growth is partially responsible for the rapid expansion in the system, as Area Programs have used the funds to build service capacity to serve a larger number of clients. The growth does not come without a cost as Area Programs now face the added responsibility of monitoring documentation compliance and billing integrity. As more services are contracted to private providers and Area Programs serve more as managers of service, the issue of program compliance will become increasingly prominent and more difficult to control.

Another important issue related to Medicaid funding revolves around the disparity of funding for Medicaid vs. non-Medicaid clients. In FY 98-99, \$163 million was generated for services provided to 75,000 Medicaid recipients equaling \$2,173 per Medicaid client served as compared to approximately \$200 generated per non-Medicaid client served. The variance is creating a two-tiered system of care as Area Programs are incentivized to provide services to Medicaid clients and view others as potential "free care" funded by State and local contributions. Programs must fund the services provided to the non-Medicaid population by other means including billing Medicare, commercial insurance and self-pay as well as using other local, State and Federal funds not already restricted to target populations. As Medicaid revenues swell, the increasing responsibility of documentation and billing integrity has fallen to the Area Programs, adding additional administrative expense and complexity to the system.

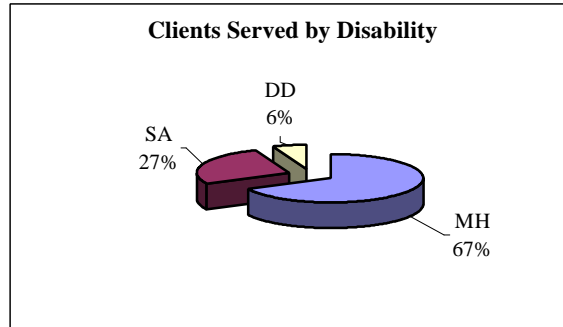
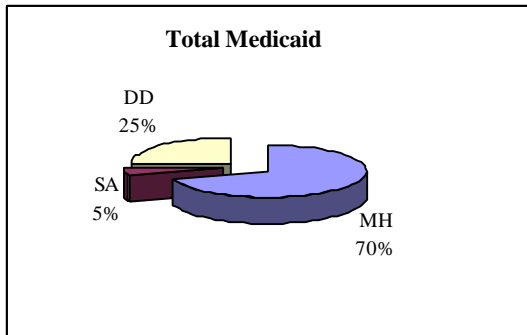
In general, the quality of clinical documentation as compared to standards/expectations set forth by DMH varies across the State. In the spring of 1999, DMH conducted a billing compliance review of all Area Programs to determine whether these agencies' record keeping supported the claims that were filed. DMH identified the quality service note documentation and staff privileging as the major issues resulting from the billing review. These audits of each Area Program will occur on an annual basis to ensure the integrity of the claims submitted to DMA. Overall, the increased focus has improved documentation across the state.

As Area Programs move more toward the contracting of care to private providers, the role of billing compliance will become even more complicated. Area Programs serve as the monitor of billing compliance for the contract providers, yet DMH establishes and interprets the standards while DMA controls the flow of funds. Over the last two years, Area Programs have put forth a substantial effort to improve the documentation practices of both internal clinicians as well as the contract providers. Some have developed specific compliance units responsible for reviewing claims and providing feedback and training as issues are found and documentation standards are refined. Other Area Programs conduct a 100% review of the service notes and other documentation requirements of the contract providers prior to billing Medicaid and/or paying the provider for services rendered. This extensive statewide effort is expensive to maintain yet represents a necessary cost to the system in order to ensure the integrity of the billing process.

In addition to the variance between Medicaid and non-Medicaid clients, Medicaid payments vary across disabilities. The better-defined service continuums in mental health and developmental disabilities generate significantly more dollars per client served than substance abuse.

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As illustrated below, 27% of the client population served receives substance abuse treatment, yet Area Programs receive only 5% of the total Medicaid payments to fund these services. Medicaid funding for substance abuse services has not accompanied the tremendous growth in the community system despite Medicaid becoming an increasingly significant part of the local funding of care.



North Carolina Area Programs Annual Statistical Report, State of NC, Division of MH/SA/DD Medicaid Paid Claims Report

A tremendous variance in Medicaid billing practices exists as the dependence upon Medicaid revenue forces many Area Programs to maximize the dollars generated by serving the Medicaid population. For example, Albemarle Area Program generated a total of \$10.4M Medicaid dollars in FY 98-99 by serving 1,443 Medicaid clients, an average of \$7,200 per Medicaid client served. In contrast, VGFW Area Program generates \$841 per Medicaid client served illustrating the vast differences in billing practices as well as the variance in level of services provided.

Multi-county Area Programs generate more revenue per Medicaid client than single-county Area Programs, \$2615 and \$2388 per Medicaid client served, respectively. The multi-county Area Programs receive less local funding and, on average, less State funding, forcing a more effective identification of Medicaid recipients and billing for Medicaid reimbursable services. To illustrate the current variance, the counties that compose Albemarle Area Program contain 13,500 Medicaid recipients. In FY 98-99 Albemarle, a multi-county Area Program, generated \$10.4M, averaging \$770 per Medicaid recipient in the county. In contrast, Lenoir, a single-county Area Program, with 10,608 Medicaid recipients generated \$1.1M Medicaid dollars equating to \$105 per Medicaid recipient in the county, a sevenfold difference from Albemarle. Multi-county Area Programs, on average, have been forced to implement better intake and billing practices allowing them to identify a greater percentage of Medicaid recipients and generate higher Medicaid reimbursement dollars per Medicaid recipient.

Medicaid Revenue Analysis

	Total Medicaid \$	Total Budget	% of Budget	Medicaid Recipients	Medicaid Revenue per Medicaid Recipient
Multi-County AP	\$5.5M	\$19.9M	28%	2,040	\$2,692
Single County AP	\$4.2M	\$18.9M	23%	1,748	\$2,423
Statewide Average	\$5.0M	\$19.5M	26%	1,927	\$2,614

State of NC, Division of MH/SA/DD Medicaid Paid Claims Report

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Additionally, often the relationship with the local Department of Social Services is not seamless enough to assist with the Medicaid identification process further magnifying the issue. Services provided to Medicaid recipients often go unbilled, and therefore unpaid; consequently the services become inappropriately subsidized by County and State dollars.

If each of the single-county Area Programs generated an equal amount of Medicaid reimbursement per Medicaid recipient to the average revenue generated per Medicaid recipient in the catchment area of a multi-county Area Program, an additional \$470K per single-county Area Program or \$7.1M of Medicaid funds would be realized.

Commercial Insurance Funding

Commercial insurance continues to become a less significant funding source for Area Programs. Cumulative over the last 3 years, commercial insurance reimbursement has actually decreased by \$2.4M. Despite serving a growing population, many barriers limit Area Programs' ability to effectively bill insurance. DMH and Area Programs have a limited knowledge base to improve the current performance. While commercial insurance constitutes less than 1% of total revenue for Area Programs, the funding source does represent a potential for increasing total revenue in the system. Specifically, four primary reasons limit commercial insurance reimbursement dollars:

1. Area Programs are not considered in-network providers for commercial insurance panels,
2. Many commercial insurance carriers do not offer mental health coverage benefits or offer benefits only in a limited capacity,
3. Area Programs are challenged to effectively obtain pre-authorization numbers and bill for services rendered,
4. Current MIS systems used by Area Programs lack the sophistication to track the individual requirements of each commercial insurance carrier.

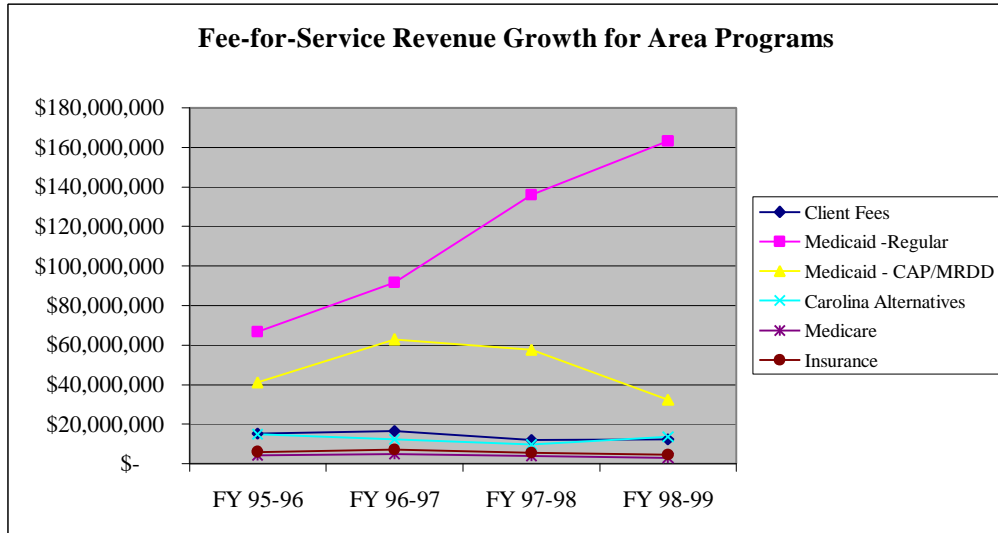
The following analysis illustrates the magnitude of this point. A one-month sample of commercial insurance denials for a large Area Program was approximately \$20,000 per month or \$240,000 per year. The primary denial reason was that the provider was not listed as in-network and the secondary reason being that the provider was not listed as in-network or not obtaining a pre-authorization number.

Despite these problems, Area Programs continue to provide services to commercial insurance clients, spending public dollars to serve clients who have private insurance resulting in fewer dollars available to serve indigent clients. In addition, a tremendous amount of internal resources are used in processing the commercial insurance billing and denials for minimal return on investment.

Additionally, even with improved billing practices, commercial insurance reimbursement may be offset as commercial insurance companies limit and even discontinue mental health coverage. Over the last few years, multiple States have enacted Mental Health Parity Laws in response to the Mental Health Parity Act of 1996. This action has helped stem the tide of commercial insurance carriers discriminating against mental health and substance abuse services.

Initially, North Carolina Health Choice (NCHC), the State's Federally sponsored CHIP program, was intended to allow more children to obtain coverage for mental and physical healthcare; however, to date Area Programs have not utilized this program effectively to generate significant dollars for the system. Few of the clients who receive service are enrolled in NCHC and the Area Programs have not developed effective procedures for obtaining pre-authorization for services.

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An estimated 10 to 15 % of the clients served by Area Programs are covered by private insurance. As Area Programs continue to expand service offerings and contract services to private providers, the need for more effective billing practices will become imperative. Commercial insurance represents a potential revenue source for Area Programs to pursue more aggressively and an area of potential cost savings as procedures become more refined and efficient.

Medicare

Over the last 4 years, Medicare has become a less significant funding source for Area Programs. Tighter constraints on program compliance and increased focus by HCFA on billing integrity have unsettled many finance directors statewide. Despite the issues involved, Area Programs must continue to serve Medicare clients and use other public funds to pay for these clients. Medicare reimbursement has dropped 32% in the last 4 years to \$3M in FY 98-99 as Area Programs look to other revenue sources with more understandable billing methods to fund service delivery. Eight Area Programs have actually discontinued billing Medicare

The problem is based in part on the lack of technical knowledge to establish Medicare compliant services and the capability to effectively bill and collect Medicare reimbursement. Specifically, Medicare compliance is based on much different standards than Medicaid compliance. Medicaid emphasizes service documentation standards while Medicare focuses on the technical components of program design. This tends to be more difficult to comprehend and more time consuming to manage.

Not only does the discontinuation of Medicare billing restrict Medicare reimbursement, the practice also eliminates the possibility of recouping Medicaid funds for those clients covered by each program type. In order to collect Medicaid funds for dually eligibles, Medicare must be billed first. Both Medicare and Medicaid reimbursement are constrained significantly impacting the overall revenue picture. In one Area Program, the effect of discontinuing Medicare billing resulted in a \$200K decrease in revenues at a time when the organization was experiencing a financial crisis. This impact did not include dollars lost by not billing Medicaid for those clients covered by both programs, translating to a much larger impact on the Area Program as a whole.

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To further complicate the system and reduce reimbursement figures, DMA uses y-codes while Medicare and commercial insurance use CPT coding for reimbursement. Often the crosswalks are difficult to understand. As the population continues to age and as more people are enrolled in Medicare, the collection of Medicare reimbursement will become increasingly imperative.

Self-Pay Funding

Self-pay collections do not significantly impact the overall funding in the system as Area Programs are challenged to identify appropriate enforcement procedures and implement effective self-pay billing processes.

In FY 98-99, self-pay collections totaled less than 2% of total revenue for Area Programs. Similar to Medicare and commercial insurance, actual collections over the last three years has decreased from a high of \$16.6M to \$12.4M in FY 98-99, a 25% decrease. The limited amount of self-pay collections can primarily be attributed to the Area Programs' inability to collect significant dollars from the large indigent client population and the lack of a statewide procedure for determining a client's ability-to-pay. Area Programs lack direction and structure for enforcing strict collection procedures as utilized by private sector providers. Additionally, Area Program charters require the provision of service to all citizens within the defined catchment area regardless of the ability-to-pay. By utilizing a literal interpretation of the charter, an Area Program continues to provide services even if the client has accumulated a large balance due for previous services. The Area Programs often do not enforce payment for self-pay clients (i.e. the use of collection agencies) due to the desire to avoid political opposition and the obligation that counties have to the constituents.

The current self-pay collection figures are somewhat misleading. Some of the monies posted to self-pay are actually funds collected by the Area Programs for court-required treatment services such as DUI classes and parenting skills resulting from child abuse cases. The cost of these services is mandatory prior to services rendered, increasing the self-pay collection figures for Area Programs, but distorting the assessment of the performance of collection procedures. At the current time, Area Programs report all client collections under the single category *Client Fees* on the fiscal monitoring report hindering DMH's ability to assess the effectiveness of local collection efforts on a statewide basis.

The level of administrative effort required to collect money from self-pay clients is high. Some Area Programs have begun requiring payment prior to the delivery of service effectively eliminating the need to conduct self-pay billing. Area Programs have resorted to using payment plans and reduced client dollar responsibility to subsidize the high cost of services. Area Programs are faced with the challenge of balancing the public obligation to serve clients with the individual's obligation to pay for a portion or all of the treatment costs.

Financial Operations

The complexity required to manage the Area Programs is significant as the responsibility and administrative details create a complicated working environment. All Area Programs are required to provide the same administrative support and adhere to the same State and Federal regulations regardless of their size or ability. The lack of proportional funding limits smaller Area Programs from achieving significant economies of scale, thus resulting in greater proportional costs. As Area Programs contract more services to external providers, the responsibility to contract, report and monitor service delivery increases. The lack of coordination between Area Programs further limits the potential in the system as duplicative procedures drive costs upward and reduce administrative capacities.

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Multiple Unit Cost Reimbursement Systems (UCRs)

Multiple UCRs increase complexity and administrative costs for the entire delivery system. Currently, Area Programs are responsible for reporting services into four separate UCR State systems: Willie M., Thomas S., Medicaid and Pioneer. No integration exists between the four systems making it difficult to generate accurate system-wide utilization statistics and complicating the revenue adjustment procedure for Willie M. and Thomas S. reporting. In addition, complex systems with inflated administrative costs are produced by inconsistent service definitions and varying service reporting requirements.

Thomas S., Willie M. and Medicaid require client-specific reporting while the Pioneer system requires service-specific reporting. The result is a level of data available in the Willie M. and Thomas S. system significantly greater than the Pioneer system. While running client-specific treatment reports on Willie M. clients is easily doable, a similar client specific report in the State's Pioneer reporting system is not possible. The limited capabilities of the Pioneer system negatively impacts the State's ability to track and report client service and outcome data for the 300,000 plus clients not designated by a court-ordered treatment program. The diversity in reporting systems results in significant direct (e.g., systems, personnel, training) and indirect (e.g., human resources, space, supplies) costs. Additionally, the rigid UCR tracking guidelines combined with the strict requirement for population-specific funded positions require the specialization of staff, thus eliminating the Area Programs' ability to cross-train employees and create economies of scale.

To further complicate the issue, court-ordered programs have spawned the creation of new service definitions to specify the new continuums of care. Willie M., for example, has 38 separate services constituting the service continuum that crosswalks to 23 specific service categories for Pioneer service reporting. For those services that resemble Medicaid reimbursable y-codes, the definitions closely match the ones employed by DMA with a few notable exceptions. Willie M. uses terms such as *Group Home* and *Group Living* to characterize levels of residential treatment while Medicaid uses other terms. From an administrative perspective, the variance in service titles and definitions complicates the billing process and creates an unnecessary burden on the support structure at the Area Program level. A recent review of services offered by Mecklenburg County AMH illustrates the complexity of this issue as over 90 different services are provided through the Area Program with many service definitions closely resembling others in separate disability populations. As Area Programs look to reduce costs by creating integrated systems, the administrative burden of managing multiple service definitions limits the development of efficient procedures for care delivery.

DMH has recognized the problems with the current UCR systems. In January of 2000, the Division was allocated funds to develop an integrated reporting system that, to be successful, must eliminate unnecessary duplication within the Area Programs and provide more accurate statistical data to DMH and advocacy groups alike. The new system must eliminate the need for Area Programs to report services both on an individual client basis (Willie M. and Thomas S.) as well as on a combined service basis (Pioneer), while at the same time eliminating the need to "Revenue Adjust" the State allocations for Medicaid monies received.

Contract Provider and Management

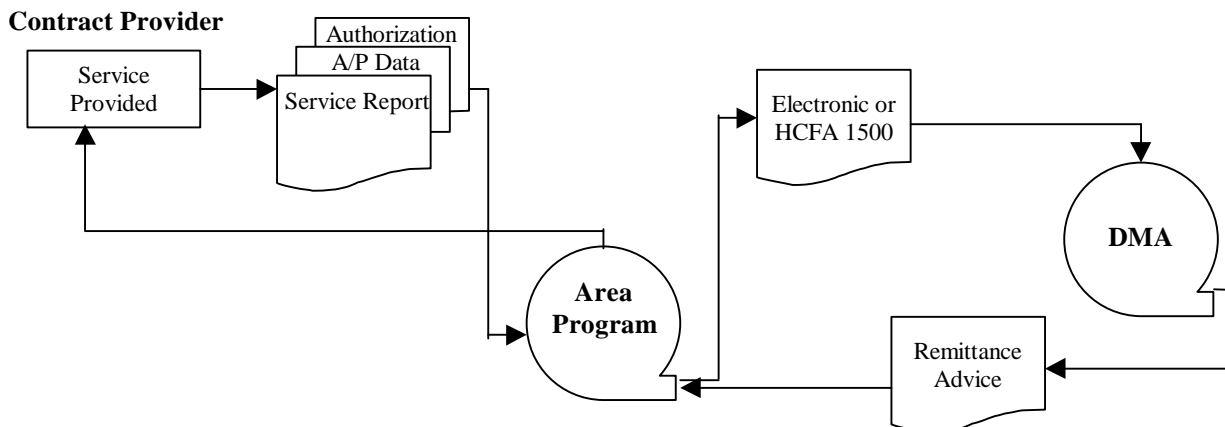
Private providers are faced with a multitude of issues when contracting with Area Programs. These issues add administrative costs to the system by creating a complex system of paperwork that has little impact on the quality of care provided. As costs continue to rise and without a significant adjustment to the rate structure, the likelihood of new providers entering into contracts with Area Programs diminishes, effectively reducing the capacity and choice of care at the community level. Private providers oftentimes contract with multiple Area Programs to provide like-services resulting in a situation where the providers are privileged and credentialed by multiple Area Programs. All Area Programs that hold a contract must privilege each clinician of a contracted entity to provide each individual service. In some instances, as many as 25 different Area Programs contract with the same provider causing duplicative privileging processes to occur and resulting in enormous costs for both Area Programs and the provider. While many Area Programs have resorted to approving the

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facility's privileging policy and having the individual facilities conduct the actual privileging process, the procedures are not standardized allowing some clinicians to be privileged by one Area Program but not by another Area Program to provide the same service.

The billing process that flows from private provider, to Area Program, to DMA, back to Area Program, and then back to provider is also duplicative and results in increased costs and poor provider cash flow. Two distinct processes are used by Area Programs to reimburse contract providers. Many providers submit monthly requests for reimbursement including volume of service reports to multiple Area Programs that in turn are submitted to Medicaid through EDS and/or the State through the Pioneer reporting system. Once this process is completed, funds are distributed to the Area Programs who then submit a check to the contract provider as payment for services rendered. The lengthy time delay caused by the extensive monthly billing process presents a major cash flow problem for providers in the system. Many Area Programs, though, prefer this method as reimbursement to the contract provider does not occur until payment to the Area Programs has been made. A few of the larger Area Programs are able to reimburse contract providers immediately upon receipt of the request for reimbursement prior to any billing taking place; however, this method requires access to funds allowing the Area Programs to "float" the contract providers until claims are reimbursed by DMA. As budgets tighten and as costs continue to rise, the trend to move away from reimbursing contract providers prior to receipt of payment from DMA will continue.

V. Current Medicaid Billing Process



The current process of billing through the Area Programs also adds an artificial buffer between the contract providers and DMA. Individual Area Programs are responsible for billing compliance for the clients associated with that Area Program only, and not for the overall contract provider organization itself. The accountability for insuring appropriate documentation practices is disseminated across the various Area Programs that contract with each private provider resulting in the lack a clear line of responsibility when issues arise. To exacerbate the issue, private providers receive different and sometimes conflicting instructions from Area Programs regarding appropriate documentation standards, adding confusion and uncertainty to the already complicated process.

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The use of non-standardized, non-coordinated contracts further drives administrative costs upward. The providers' aggregate responsibilities are not clearly defined because they are subjected to different contract language in each Area Program agreement. For example, some Area Programs require a 100% review of the notes prior to the submission of claims while others review documentation on a periodic basis through the use of internal compliance teams. Moreover, each Area Program uses a unique manual service reporting form for data entry into the information system. In some cases, a contract provider is forced to use as many as 25 different forms to report services to 25 different Area Programs resulting in higher than necessary administrative costs.

The lack of a uniform contract also results in a wide range of rates for similar treatments. Some contract providers who are paid as much as 16% less than the Medicaid rate for a particular service perceive the low reimbursement as insufficient to cover the cost of providing the service. These providers try to “recoup” losses by increasing rates to other Area Programs. This cost shifting results in a situation where rates can vary as much as 300% between Area Programs for the same service by the same provider. The lack of a coordinated rate negotiation effort also eliminates Area Programs ability to achieve economies of scale by negotiating a lower rate for increased volume.

Area Programs are not able to recoup monies for services provided to many commercial insurance clients due to the Area Programs' out-of-network status with most private insurance carriers. Many of the contract providers, though, are recognized as preferred providers for a number of commercial insurance networks allowing them to bill and directly receive reimbursement for services. When services are provided for Area Program clients the billing process is filtered through the Area Programs which are oftentimes not recognized by commercial insurance carriers. As a result, Area Programs pay for services provided to commercially insured individuals and receive little or no reimbursement from the client's carrier.

As administrative overhead continues to spiral upward, an impending and immediate problem is developing among private providers in the community. The closing of a number of inpatient units and residential treatment facilities including two large providers in the Charlotte area and a number of North Carolina facilities signifies the financial strain that private providers face. This issue appears to be worsening, not improving. Additionally, as the number of providers decline in the market, the choice for clients decreases. This decline will also force rates upward resulting in Area Programs looking towards using the State hospitals if Area Programs cannot afford the local services. DMH has recognized the issue and has convened a multi-agency task force to address residential treatment for children. This group is reviewing how to best use funding from DSS, Medicaid and that State to solve this pressing issue.

Area Programs conduct a number of operational initiatives and expend a large amount of resources managing contracts with private providers. The range of resources available to perform this function varies greatly as some Area Programs have developed separate units while others have integrated this effort into current operations. Contract management initiatives include negotiating rates, verifying appropriate quality of care, ensuring the proper handling of client rights issues, documentation training and other issues as they apply to the contract language. This is a costly endeavor for the Area Programs further limiting the dollars available for the delivery of care in the community. Oftentimes the resources available for performing this function within the Area Program have limited experience in negotiating rates, managing contracts and monitoring provider performance. The administrative costs added to the system increase as multiple oversight procedures are performed on the same providers. The immense size of the provider networks that exist further increases the challenge to Area Programs to successfully manage contracts in the current complex environment.

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MIS Capabilities

The MIS capabilities vary greatly among Area Programs. Typically, the determining factor in MIS capabilities is Area Program's financial resources resulting in a multi-tiered system of "haves and have nots." Financially stronger Area Programs have the means to purchase state of the art information systems and experienced support personnel; smaller and poorer Area Programs oftentimes must make do with older, less useful systems. All Area Programs, though, regardless of information system resources, struggle with the ever increasing complexity of data and reporting requirements. Inefficient use of information technology has resulted in increased costs (due to multiple and duplicative reporting requirements), increased resource requirements (the need for additional and experienced MIS staff) and poor cash flow management (outstanding accounts receivables).

Some Area Programs have highly technical information systems allowing for the use of electronic medical records, electronic interfaces with Medicaid, Willie M., Thomas S and Pioneer and automated payment posting processes. Other Area Programs do not have the financial means to acquire these information technology systems forcing them to operate in a less efficient manner. The impact of minimal systems capabilities is dramatic on the smaller Area Programs. For the larger Area Programs, the multiple UCRs and the Consumer Data Warehouse reporting requirements complicate the operations process; for the smaller Area Programs the myriad of reporting requirements are nearly impossible to manage with limited MIS capabilities.

Multiple MIS systems complicate the reporting process forcing DMH and Area Programs to develop creative and oftentimes inefficient ways of generating management data. Multiple systems limit the opportunity for the state and Area Programs to gain economies-of-scale through the use of more automated ways of service reporting and other technological enhancements. Resources are consumed supporting thirty-nine systems, operating various software packages and procedures. In addition, Area Programs are often tied into the county's system for reporting purposes, further complicating the issue on a local level by adding additional administrative procedures and costs. Also, most county systems are not designed to meet the complex and demanding requirements of mental health services.

Size vs. Responsibility

The lack of proportionality in responsibilities has wreaked havoc on smaller, more poorly funded Area Programs. All Area Programs, regardless of size or ability, must provide many of the same services and are subjected to the same administrative and reporting requirements. Managing the larger and "better-funded" Area Programs while complying with all Federal, State and local laws is a difficult task; successfully managing smaller Area Programs within the same legal parameters is difficult at best, and impossible at worst. For example, all Willie M. clients are mandated to receive the same level of services regardless of where treatment is needed. Larger Area programs have established in-place networks and providers who are able to service the Willie M. population. Smaller Area Programs, on the other hand, may not have established networks and providers and are mandated by law to develop them regardless of cost. This places a significant financial strain on the budgets of the smaller Area Programs. Furthermore, Willie M. revenues are not cost adjusted with individual Area Programs further limiting the capacity to provide high cost services to the Willie M. population.

The lack of proportionality is especially acute with respect to information technology. All Area Programs must report services, utilization, costs, etc. Larger Area Programs can use technology to ease the multiple reporting requirements while poorer Area Programs must rely on less efficient and more resource intensive systems. Administrators in more richly funded Area Programs are also able to access better management information allowing them to identify cost savings or revenue enhancement opportunities. Given the electronic nature of the billing and collection environment, more powerful systems also improve cash flow and, potentially, increase revenue. Area Programs with less powerful systems must still navigate the same management and billing/collection issues but must do so with antiquated systems.

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Larger Area Programs are also able to achieve greater economies of scale by driving-down the per unit costs of such functions as provider credentialing/privileging, case management, quality improvement and network development. Smaller Area Programs must still perform these functions but are unable to achieve the economies of scale available to the larger Programs.

Area Program Financial Stability and Oversight

Recent financial adversity affecting some Area Programs illustrate the difficulty in maintaining a financially viable Area Program with the requisite service and administrative infrastructure. With Medicare and commercial insurance reimbursement decreasing and unrestricted state allocated funds remaining stagnant, Area Programs are forced to support their current level of services with less revenue and fewer staff. As a result, many Area Programs are in a precarious financial position. Area Programs are in this position for many reasons – some of which are outside of their control (e.g., decreased county/state funding, non-funded mandates, etc.), while other causes are a direct result of the Area Programs lack of financial expertise and minimal oversight by either county or state agencies.

To survive financially, Area Programs must master a complex financial system with multiple funding streams, voluminous reporting requirements, a plethora of legal mandates and numerous cost centers. Some Area Programs do not have the financial resources to succeed in such an environment, as evidenced by the increased reliance on fund balances to pay for services. Use of fund balances has fluctuated considerably ranging from a low of \$2.4M in FY 95-96 to a high in FY 96-97 of \$13.7M. In FY 98-99, total fund balance dollars used increased to \$9.2M, a 2 ½ fold increase over the previous fiscal year illustrating a disturbing trend as Area Programs are utilizing fund balances more frequently to cover operating costs. An 8% fund balance is required by the State despite the fact that Area Programs are reimbursed on a cost basis meaning that fund balances are supported by local dollars. Local dollars that could be used to expand services within the community, however, are restricted from use for other means and are placed at-risk as the Area Program and/or the county remains the payor-of-last-resort. Essentially, fund balances are increasingly used to balance budgets instead of funding capital construction costs. The lack of funds available from other sources force the Area Programs to reserve the fund balance to cover operating expenses, thereby restricting the development of new service initiatives.

Additionally, Area Programs have no financial “expert” at the state level to assist with issues or questions. Area Programs that cannot afford outsourced experts are generally required to resolve financial issues on their own. DMH Regional Accountants have provided little assistance in terms of financial guidance and expertise. Minimal state assistance is provided to Area Programs on such complex issues as maximizing Medicare revenue, establishing and maintaining compliant Partial Hospitalization programs, provider contract negotiations and third party billing and collecting. With appropriate training and oversight, improvement in such areas could result in decreased system costs and/or increased revenues.

Despite the fund balance reserve requirements and the practice of using the reserve to cover operating cost, Area Programs continue to struggle financially as evidenced by the recent merger of Cleveland County with the Gaston-Lincoln Area Program and the dissolution of the Tri-County Area Program. In addition, programs such as Pitt County and CenterPoint as well as many others fight to remain solvent as increasing contract rates, decreasing State funds and pressure to serve more clients continues to mount. Potential issues involving possible paybacks for documentation issues related to Carolina Alternatives and Title IVA-EA funds combined with increasing Medicaid compliance issues are causes for concern as Area Programs must continue to find additional funding streams or reduce services to make up shortfalls.

2.5. Finances and Financial Operations

The current budget cycle prevents Area Programs from accurately estimating revenue and expenditures due to the changing landscape of the system throughout the year. The practice of DMA adjusting reimbursement rates after the Area Programs have finalized their budgets leaves financial directors in a state of uncertainty; especially those who depend heavily on Medicaid revenue. Additionally, finalizing the method and amount of allocation for the Thomas S. and Willie M. programs well after the start of the fiscal year results in a similar effect on Area Program budgets. If rates and allocations are lower than expected, Area Programs must move dollars from other programs to support the local continuum of care leaving less money to support the non-court-ordered programs.

On the surface, the State reporting requirements combined with the financial oversight of DMH's Regional Accountants would seem to provide the necessary overview for DMH to identify financial issues and address them prior to financial crisis. The financial difficulties recently experienced by some Area Programs indicate that current oversight procedures are not effective. The Quarterly Fiscal Monitoring Reports used extensively by DMHSADD to monitor the financial stability of the Area Programs are inadequate to illustrate a true financial picture. Specifically, Area Programs report almost \$40M in a category called *Other Local* representing the second largest revenue source behind Medicaid. The fund is essentially a miscellaneous "catch-all" allowing programs to report revenue generated from block grants, SSI funds for Willie M. clients, charitable contributions, etc. that do not fall into one of the other defined categories. Due to the lack of specificity, *Other Local* funds are difficult to manage and cannot be used to predict future issues even though they represent a significant funding source.

As stated in the Governance/Structure section of this report, the county oversight varies greatly among internal staff and local government's which have varying levels of financial sophistication. The complex financial structure of Area Programs intimidates Boards and County Commissioners alike resulting in limited oversight from the key people most closely affiliated with the operation. In most cases, County Commissioners and County Management are not familiar with the Area Program budgets. Currently, in most multi-county Area Programs, the county is only familiar with their county contribution amount. Additionally, Area Program budgets are not reviewed in detail by DMH, further reducing the impact of general oversight provided at the State level. The strength and integrity of financial management and oversight depends heavily upon the Area Program Director and Area Finance Director with County involvement primarily occurring during times of crisis.

Medicaid Fiscal Policy Administration

The current relationship between DMA, DMH and the Area Programs is loosely coordinated and not well defined. While DMA maintains an important position as the purchaser of services, DMH monitors the Area Programs for billing compliance and enforces paybacks when necessary. DMH interprets regulations set forth by DMA for clinical documentation guidelines often relaying misleading messages to the Area Programs.

The current relationship between DMA, DMH and the Area Programs is loosely coordinated and not well defined. While DMA maintains an important position as one of the primary funding sources for the Area Programs, DMH monitors the Area Programs for billing compliance and enforces paybacks when necessary. Over the last several years, Medicaid has become a major funding source for Area Programs. The additional funds, however, have not come without some negative repercussions as Area Programs struggle to maintain and monitor sufficient documentation practices for both internal clinicians and external providers. The poor results from some of DMH's recent audits of Area Programs and individual providers has eroded the confidence in the financial aspects of the system causing further discord between DMA, DMH and the Area Programs.

2.5. Finances and Financial Operations

In addition, the limited coordination between DMA and DMH's MIS systems requires increased administrative support by the Area Programs further driving up costs and reducing funds available for service expansion. The MH/SA delivery system lacks integrated service reporting, outcome evaluation and fiscal oversight creating a complex structure and limiting the ability to analyze system issues as a whole.

Carolina Alternatives, North Carolina's first attempt to capitate payments to the Area Programs for the delivery of services, was expected to provide much needed quality mental health services to children. The program was an attempt to capitate payments to the Area Programs for the delivery of services representing a potential solution to the limited expansion dollars available to the community-based programs. For various reasons DMA, DMH and the Area Programs were not able to appropriately administer the new payment initiative resulting in the disbandment of the program after only a few years. North Carolina is now faced with significant potential paybacks and a loss of trust by HCFA to manage similar programs in the future. Additionally, a tremendous growth in Medicaid dollars in the community has occurred over the last several years. The Area Programs were instructed to use Medicaid revenue to expand the system resulting in more services provided to a larger number of clients. This initiative has been successful in increasing dollars in the community. Some Area Programs, however, were ill prepared to develop and implement the required billing compliance infrastructure. As DMH audited Area Programs, a significant payback of dollars were identified for improperly documented services further impacting the financial credibility of the system and eroding the trust among the various parties involved. This situation has dramatically undermined the overall confidence in the financial management of the system. Additionally, the Medicaid Match Reserve (MMR) problem has created issues among all of the parties resulting in more distrust and a decrease in financial confidence in the system.

The practice of DMA adjusting rates during the fiscal year after Area Programs have set operating budgets fuels uncertainty in the system. Each fall, rates can be significantly altered based on the previous year's cost-finding figures, which requires finance directors to reallocate funds away from programs not supported by Medicaid funds to those programs with the greatest dependence on Medicaid. Some Area Programs are left with an insufficient amount of operating capital.

Statewide Financial Operations Analysis Findings and Recommendations

Based upon PCG's recommendation in the Governance and Structure section of this report, Area Programs from the standpoint of the re-designed system are referred to as County MH/DD/SA Programs (County Programs) in this part of the report and the state agencies are DMHSAS and DDD.

RECOMMENDATIONS ON FINANCES AND FINANCIAL OPERATIONS

Financing Sources

Recommendation 1

- ***A major structural financial recommendation is the reimbursement through State funds to County Programs for a Basic Service Package available across all areas of North Carolina. This Basic Benefit Package includes both mental health and substance abuse services required to be provided by all County Programs.*** (A full explanation of the services is in Section 2.4, and is costed out in Section 2.6 of this report.) The key premise of this funding process is the use of State funds to cover this financial cost that clearly defines the services that the State is responsible to fund.

The intent of our financial modeling is a preliminary determination of the financial feasibility of the Basic Benefit Package and the foundation for a financial model that can be used by the State during the implementation phase of the system redesign. We developed a financial model as a methodology for determining the potential cost of implementing a Basic Benefit Package. A general lack of consistent financial data available at the State level limits the accuracy of the estimated dollar impact on the system. For example, the number of clients served in each service category is difficult to determine based on the State's Pioneer reporting system, which tracks utilization by unit, not by clients served. Little historical data exists to understand the percentage of clients entering into specific service categories. In addition, we used current Medicaid rates to determine the cost of providing an individual unit of service. These rates are set based on the contracted rates paid by the Area Programs to contract providers to provide service, not the actual cost of providing the service by the external provider. Further financial modeling will be required during implementation by the State in order to develop a final cost model for the Basic Benefit Package. Additionally, this financing methodology will require development of the rate determination, a purchase of service methodology and a phased-in implementation timetable. (A complete explanation of the modeling is contained in the Financial Modeling – Community and Hospitals section of this report)

One of the most glaring weaknesses of the current local continuum of care is the lack of services offered to the substance abuse population. To respond to this issue, our proposed Basic Benefit Package includes services to address both acute and ongoing needs of the substance abuse population. The service continuum includes a clinical assessment, inpatient detoxification, residential treatment, day treatment, psychiatric consultation, and group and individual outpatient treatment programs. The Basic Benefit will ensure a consistent level of treatment across the State and provide much-needed care to the currently under-served substance abuse population.

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Recommendation 2

- ***In conjunction with the recommendation of a Basic Service Package, PCG strongly recommends the development of identifying Target Populations, which includes dual diagnosed mental health/substance abuse clients, children and adolescents, and seriously mentally ill adults in the state hospitals.*** These Target Populations will include clients that are currently being served by the system in only a limited capacity, thus additional funds will be required to fund the full continuum of care for each group. In order to fund these Target Population benefit packages, a “matching” process between State funds and local funds is recommended. This funding mechanism provides the State with the option of identifying specific populations that need services, along with the option for counties to participate in funding depending upon their perceived local needs. The funding of target populations allows County Commissioners and County Management to know the specific services being purchased.

A critical component of this “matching” process involves taking into account the economic strength of counties, since North Carolina includes a wide variation among the counties. The goal is to create a funding process that fiscally allows all Counties to participate in providing services to their selected Target Populations without creating inequity among the wealthy and economically distressed counties. In order to avoid this problem, a key element of the local match amount could be based upon the economic category of the county by having lower wealth counties required to participate at a lower financial share than the more wealthy counties in order to draw upon State funds. This would account for the variation in economic strength among counties across the state. The basis of the local match amount could be the county’s economic category ranking. For example, the State could require a 20% county match, allowing for a 10% match for economically distressed counties. This would be in addition to current funding levels.

Recommendation 3

- The redefinition of the eligibility criteria and the service continuum available to the Willie M. population will result in more money available to serve a broader population of adolescent Willie M. clients. Additionally, there are numerous other groups not receiving much needed services and funding. **The State must re-evaluate the role of Willie M funds in light of the expiration of the consent decree, the impending transformation of the entire delivery system and the under-served populations. To address these issues, the State should carefully consider the following:**
 - ◆ **Broaden target population eligibility definition**
 - ◆ **Review mandated services**
 - ◆ **Re-define service continuum**
 - ◆ **Increase Area Program administrative expenditure flexibility**
 - ◆ **Provide financial assessment to current Willie M. families to identify other funding sources and ability-to-pay**

We do not expect that additional Willie M. funds will be available. The intent is to serve more clients with the same funding through the above-mentioned approach. For example, another group of clients that could be served through liberalizing the eligibility definition is sexually aggressive youth. The process could be completed without changing services to the existing Willie M. clients through: utilizing available funds when children leave the program, age out of the program, and also by decreasing the County Program permitted annual budget increase by less than 15% for the existing Willie M population (the existing permitted budgetary increase/decrease is 15%). For example, 279 Willie M. slots became available from 1997 to 1998 as children left the program. This represents approximately \$8.4M in available funds. This process would protect the existing Willie M. clients, while expanding the program to other clients in need.

2.5. Finances and Financial Operations

Recommendation 4

- ***To achieve the goals of downsizing the state hospital by 667 beds, the State must make an investment into the community mental health system. In order to preserve the continuity of care of its consumers, the State must assist in building adequate capacity within the community provider system to provide alternatives to the State Hospital system.*** These alternatives can come in the form of the development of acute inpatient treatment services provided by community hospitals, psychiatric day programs at the Area Program level, residential programs for supported independent living arrangements, and/or a combination of these services, or other community based programs. This investment is required to assist the community in building capacity. It is expected that this investment will serve as “bridge funding” until savings can be realized from a smaller State hospital system. Realistically, during implementation, the State is forced to fund both systems, the community and the State hospitals, to ensure the safety and continuity of care of its consumers. The State must consider various mechanisms and funding sources that includes incentivizing County participation to build these community-based programs. The State should seriously consider, among other options, the following sources for bridge funding:
 - ◆ Using funds remaining from open positions in the State hospitals that currently revert to the General Fund
 - ◆ Incentivizing Counties to contribute additional funds

A bridge fund of \$10 million per year, available for two years would give the County Programs time to begin the transfer of \$38 million to \$51 million from the hospitals to the community (Section 2.6). Once savings from the downsizing are achieved, the State must transfer expenditures from the State hospital to the community to continue to fund these programs. The allocation methodology to equitably redistribute the projected cost savings to the community must acknowledge low historical use in the first distribution to County Programs. The State cannot punish those Area Programs that have prudently utilized the State facilities.

Recommendation 5

- ***A methodology needs to be developed that requires Area Programs to “pay” for the full use of state hospitals on an on-going basis.*** The methodology must embody the following principles in order to be successful:
 - ◆ Financial incentives for low hospital use
 - ◆ Financial penalties for high hospital use

The utilization targets should be coordinated with the movement of 667 beds to the community. Additionally, the State will need to establish initial hospital use standards for each County Program and appropriate hospital rate charges. These standards must be based upon targets that the State believes are appropriate based upon PCG’s analysis (see Hospital Utilization and Projected Demand section and Financial Modeling – Community and Hospital section in this report) and their own analysis. For example, according to our financial modeling of downsizing the state institutions, annual thresholds over a five-year period would need to be established for each County Program to achieve. This time period will allow for the appropriate development of community-based programs for these individuals.

This process will require altering the current budgeting mechanism of State funds being appropriated directly to the State hospitals. Instead, these State funds must be allocated directly to County Program to be used at their discretion to either utilize and pay for their use of state hospitals or used for locally delivered services. Additionally, it is recommended that any savings are allowed to be re-invested by the County Program into community programs.

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Recommendation 6

- ***With less than 1% of community revenue attributed to commercial insurance, significant amounts of denials, and increasing managed care coverage in the private healthcare market, it is recommended that the State of North Carolina draft a mental health insurance parity law. The insurance parity law should build upon the Mental Health Parity Act of 1996 and North Carolina's previous effort.*** In 1992 parity legislation was passed only for the North Carolina State Employee Health Plan. A parity law that extends into the private sector should be implemented that is based upon the following principles:
 - ◆ Coverage of mental health and substance abuse
 - ◆ Equivalency in annual and lifetime caps
 - ◆ Equivalency in deductibles and out-of-pocket expenses
 - ◆ Threshold of minimum employer size or maximum allowable cost increase for smaller employers

It has been determined through a 1998 report on parity to Congress by the National Advisory Mental Health Council that the introduction of parity has a minimal impact on total health care costs (1% during a one-year period) in a managed care environment. This study reported that “both utilization and cost of services have decreased, while treated prevalence has increased” in the North Carolina State Employee Health Plan since parity legislation. Likewise, the impact on costs in Maryland, New Hampshire, Texas and other states has been minimal. Additionally, according to a survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), the vast majority of employers did not reduce other benefits because the cost increase was minimal. Conversely, not having a parity law does have a negative impact because it redirects the use of valuable funds that are needed to cover services for indigents on individuals who do have commercial insurance without mental health coverage.

It is recommended that any mental health parity law be coupled with requiring County Programs and contracted private providers becoming “preferred providers” (member of insurance provider panels) for commercial insurance carriers. If not, the amount of commercial insurance reimbursement will not actually increase in the public system because commercial insurance carriers will simply deny the claims, for the reason that the County Program is not a preferred provider. Another option is to rewrite enabling legislation to clearly state that County Programs are permitted to direct clients to a private provider that is recognized as the client’s commercial insurance in-network provider. The County Program in this situation would not provide services or case management. The County Program would be responsible for services after the client’s commercial insurance coverage expires.

Recommendation 7

- ***In order to increase and maximize the amount of Medicare reimbursement in the mental health system, DMH should develop technical resources to assist County Programs. Currently, these skills are limited at both the community and state level. These resources need to assist County Programs with the technical aspects of establishing compliant programs and billing processes/requirements.*** With less than 1% of community-based revenue generated through billing Medicare in the current system, Medicare represents a significant potential revenue source. Additionally, with denials increasing and some Area Programs not even billing for services provided to Medicare recipients, critical resources are directed away from “truly” indigent clients. Of the 325,000 clients served last fiscal year, 14,400, or 4%, of those were sixty-five or older. This signals a missed opportunity for additional revenue in the system.

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Some Area Programs have effectively discontinued the practice of billing Medicare for services rendered to Medicare recipients. The current national environment of Medicare fraud and abuse concerns has intimidated finance and clinical directors who fear negative repercussions resulting from the operation of non-compliant programs. Not only does this impact Medicare reimbursement, the impact on Medicaid reimbursement is also significant as Area Programs are restricted from billing Medicaid for the Medicare/Medicaid dually eligible clients without an initial claim submission to Medicare.

DMH should establish a task force to develop compliant Partial Hospitalization programs across the State. These programs would include appropriate staffing levels and clinical components to adhere to current Medicare guidelines. The DMH task force would then be responsible for working with the County Programs to establish and maintain these programs and submit appropriate billing to Medicare for reimbursement. Additionally, these resources could assist County Programs implement processes to identify coverage of other reimbursement sources including Medicaid, North Carolina Health Choice and Commercial Insurance. The DMH task force would also monitor and compare County Program reimbursement source levels in order to identify County Programs that are not maximizing Medicare as a funding source, and thus need additional technical assistance.

Recommendation 8

- ***PCG strongly recommends continuation of DMH’s Residential Treatment initiative for Children in DSS custody and the plan to maximize available financial resources for these services.*** The current environment of decreasing residential supply must be addressed. This will become even more relevant with our recommendation to decrease the use of the State hospitals. Additionally, PCG recommends an immediate and thorough analysis of the current declining inpatient beds in the community due to the recent and impending closures. Both of these initiatives will require a comprehensive analysis of the cost to deliver the services versus rates, including both private provider and Area Program costs. If these problems are not addressed, the financial and service problems will continue to grow.

Financial Operations

Recommendation 9

- ***The current confusion among all parties concerning the specific role of Area Programs in the system needs to be clarified. Other than in certain parts of the system, Area Programs currently play varying administrative and service roles. It is necessary to establish in the new county-based system, County Programs as the “lead agency” on behalf of Medicaid and the State.*** A sample of key responsibilities include:

- ◆ 365 days/24 hour professional clinical assessment
- ◆ Authorizing admissions to State institutions
- ◆ Crisis stabilization
- ◆ Service plan development and care management
- ◆ Linking clients to required services, ensuring provider choice
- ◆ Establishing a comprehensive private provider network
- ◆ Provider credentialing and privileging
- ◆ Quality Assurance
- ◆ Utilization Management
- ◆ Client Rights
- ◆ Billing compliance

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A county would be required to document their ability to have a County Program with the capacity to provide or contract for all of the responsibilities, while staying under a maximum allowable overhead percentage. We anticipate that due to the significant scope of responsibilities and a maximum percentage of funds allowable for administrative overhead, the number of County Programs will decrease because counties will need to work together to meet the requirements.

In addition to the services listed on the previous page, responsibilities for other numerous principal Medicaid administrative tasks must be defined. The following tables outline these tasks:

Contract Administration

State plan with HCFA	Interagency agreements and MOUs with other public agencies	Cost allocation plan
Provider agreements	Agreements with MCOs and PHPs	MMIS contract
Other contracts		

Eligibility Functions

Policy development per State plan	Instructions	Training
Eligibility outreach	Eligibility intake	Completion of applications
Data verification	Eligibility determinations/ redeterminations	Approvals
Denials and terminations	Hearings	MMIS data input to eligibility master file

Provider Reimbursement Functions

Policy development per State plan	Instructions	Training
Collection of cost data, charge data and utilization statistics	Public notices and hearings	Rate setting
MMIS data input to provider rate file	Provider audits	Cost settlements, if applicable

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Services Coverage Functions

Policy development per State plan	Instructions	Training
MMIS data input to procedure code file	MMIS edits	Provider audits

Provider Functions

Standards development per State plan	Instructions	Training
Provider recruitment	Survey and licensure/certification	Provider intake and enrollment
Provider relations	Standards enforcement	Terminations and hearings
MMIS data input to provider master file		

Beneficiary Services

Outreach and information on eligibility, services and providers	Providing Medicaid cards	Facilitating access to services
Complaints and grievances	Making arrangements to provide medical transportation	Providing medical transportation
Other beneficiary services		

Third Party Liability

Identifying recipients who may have other coverage	Data matches and verification of coverage	Medicare buy-in
Other insurance premium buy-in	TPL matrix development	MMIS data input to TPL file
Pre-payment edits (cost avoidance)	Post-payment reviews	Recoveries from third parties

MMIS

Planning, design and development of the system	Claims processing	Financial and statistical reporting
Surveillance and utilization reporting	Oversight of the fiscal agent	Contact management

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Management of Services Utilization

Medical necessity criteria	Development of utilization review procedures	Utilization control mechanisms (e.g., prior authorizations)
Practice Guidelines	Training	Identification of aberrant providers and recipients
Medical Review	Medical audits	Other program integrity initiatives
Coordination with fraud control unit	Recoveries from providers	Sanctions against providers (e.g., lock-out)

Some of these administrative tasks lie clearly in the centralized domain of DMA while other tasks could be the responsibility of DMHSAS, DDD or the County Programs. There are some tasks that could be the joint responsibility of the parties. *During the implementation phase of the new system, DMHSAS, DDD and DMA will be responsible to finalize the specific scope of responsibility of County Programs prior to contract negotiation. A detailed contract or memorandum of understanding between DMHSAS, DDD, DMA and each County Program would be required to document the relationship, as well as the roles of DMA and DMH.*

Recommendation 10

- ***A target should be established for maximum County Program administration costs.*** Due to the expected variation in County Program size, the target should be a percentage of total expenses rather than a specific dollar figure. Administration costs are overhead expenses not associated with direct patient care such as rent, MIS, Human Resources, Senior Management, etc. High administration expenses reduce the money available for direct patient care and service expansion.

PCG's governance recommendation to transition from an Area Program-based system to a larger County Program system will result in the reduction of local delivery programs (i.e., the number of County Program's in the new system will be less than the number of existing Area Programs). Due to their larger size and catchment area, County Programs will be able to realize significantly greater economies of scale than current Area Programs. A direct result of the increase in economies of scale will be a reduction in administration costs as a percentage of total expenditures. Over time, service expansion and quality improvement initiatives will be realized because more money will be spent on direct patient care rather than administration expenses. By imposing a cap on administration costs the State will ensure that the maximum amount of money is spent on direct patient care rather than on support services or ancillary expenses.

Three steps must be taken to implement a maximum administration cost threshold. First, current administration costs must be identified. Second, an administration cost cap must be established based on current and historical expenses. Third, a mechanism must be established to reimburse County Program's for administration expenses.

An appropriate administration cost threshold cannot be determined without accurate data. Currently, true administration costs are unknown due to inconsistency in reporting requirements. Administration costs are reported in the Fiscal Monitoring Report in a category called "Other Expenditures." There is, however, no clear definition of administration expense to which Area Programs can use to determine exactly what expenses should be included in this catch-all

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category. Additionally, certain direct patient care expenses are also included in the “Other Expenditures” category. Our review of data from the Cost Finding reports submitted by Area Programs provided conflicting results. Without knowing the current level of administration expenses in the system it is impossible to control and, in the long-term, reduce them.

PCG strongly recommends developing a standard cost allocation methodology and system-wide reporting definitions as a means to accurately identify administration costs. Standard processes and definitions will provide the data necessary to establish an administration cost threshold. Using accurate and consistent data may also allow the State to identify County Program’s which are financially struggling early enough so that appropriate interventions can be taken.

After an appropriate cost threshold is established, a mechanism for reimbursing County Programs for administration expenses must be determined. The financing mechanism can take numerous forms including:

- ◆ Increasing service rates by the administration cost threshold. This method is the simplest because reimbursement increases or decreases are proportional to utilization swings;
- ◆ A monthly or quarterly lump sum based on the County Program’s budgeted costs and utilization. This mechanism requires a semi-annual or annual reconciliation based on actual utilization.

Another alternative is to make counties responsible for administration expenses. Because County Programs fall under the governance and financial purview of counties, making counties accountable for administration expenses provides the benefit of maximizing County “ownership” of the County Program. If counties are responsible for administration cost overruns they will likely establish strong oversight of the County Program’s operating budget and expenses. The State could incentivize County Programs and Counties to control administration costs by allowing them to use unspent administration money on program expansion.

Due to the potentially significant financial impact on County Program operations, PCG recommends phasing-in an administration cap over a 3-5 year period. The transition period could include reimbursing a percentage over the cap and then reducing the allowable overrun each year or beginning with a high threshold and reducing it each successive year.

Recommendation 11

- ***DMH must develop and implement a singular Unit Cost Reimbursement (UCR) system.*** The current Pioneer system is outdated and ineffective while the Willie M and Thomas S systems create additional administrative requirements. The system needs to include consistent service definitions across all funding sources and client-specific reporting. The new UCR system must be capable of tracking new Target Population funds and clients without requiring a new system or reporting method. Additionally, the UCR must be inter-related with Medicaid to automatically perform Medicaid/State payment adjustments without additional information requirements from County Programs. It is critical that thorough training and review of data occurs to ensure that all client services are tracked through the single UCR system. The single UCR system is necessary to help improve deficiencies in DMH’s current tracking and reporting capabilities.

Recently, DMH has entered into a contract with EDS to develop an Integrated Payment and Reporting System (IPRS). According to DMH, the goal of this system “will be to have one integrated payment system for all MH/DD/SA services and Medicaid claims, replacing the current Willie M., Thomas S., and Pioneer systems. IPRS will be used to process, track, pay and report all claims submitted by Area Programs and

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providers” (NC Community News Update, January/February, 2000). As stated previously, an integrated payment and reporting system is an integral component in our proposed system of care. With an expected statewide rollout of the new system to occur in FY 01-02, PCG strongly recommends the continuation of this project. The project’s existing procedures and goals should remain in place, along with the specifications including the capacity to accommodate reporting and payment for services provided to new Target Populations as they are developed. This is a very important initiative that will improve quality of utilization data for tracking/reporting and rate setting, along with decreasing County Program administrative costs.

Recommendation 12

- ***PCG recommends increasing the financial participation of Counties through a minimum contribution level as the system migrates to a County-based operation.*** Counties must be incentivized to increase both direct (cash) and indirect (in-kind services and facilities) participation. As Counties increasingly take on greater responsibility of oversight and knowledge about “what their money buys” in the community system, increased participation will inevitably occur. This is evident in the fact that on average single-county Area Programs currently receive four times as much direct support from their county than compared to multi-county Area Programs. A wide economic variation exists amongst counties, and thus a wide variation in the ability to contribute towards the system. For this reason, flexibility must be provided in “how” a county can contribute. The goal is to increase County participation in the system, thus minimum levels should be established that are attainable by Counties over a period of time. The minimum level of County contribution requirement for a County to establish a County Program should be based upon the following guiding principles:

- ◆ Standardized accounting methodology
- ◆ Include both direct (cash) and indirect (administrative services and facilities) contributions
- ◆ Include other “alternative funding” contributions (i.e. grants)
- ◆ Establish a maximum permissible level of indirect contribution that counts toward the minimum County contribution level
- ◆ Calculate County contribution amount either individually or collectively among multiple counties organizing to form an County Program
- ◆ Base County contribution requirements on a per capita basis
- ◆ Phase-in higher thresholds over 3-5 years

Prior to establishing the specific minimum level, the State will need to undertake a financial analysis to calculate the “actual” amount of current county contributions. This is necessary because only direct (cash) County contributions are reported to the State. The indirect County contributions are not reported to DMH. Currently, a significant amount of indirect County contributions are provided to the system.

The State also needs to re-evaluate the financial maintenance of effort requirement placed upon Counties. This requirement had the good intention of not permitting a county to decrease its financial participation to an Area Program; however, this has created contention among the parties. The maintenance of effort requirement does not incentivize counties to make a one-time contribution to the system, or increase annual participation. In either case, the County would be required to maintain this higher level. Obviously, counties do not like this lack of flexibility. We recommend that the financial maintenance of effort requirement be eliminated to provide counties the desired flexibility. Also, this would now require County Programs to “earn” their annual and one-time contributions as the funding would not necessarily be a guaranteed entitlement.

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Recommendation 13

- ***In order to improve private providers' financial stability and cash flow, the State should enroll private providers directly with Medicaid, removing Area Programs as financial intermediaries.*** This would decrease County Program administrative costs through eliminating duplicated efforts. Private providers would use their own Medicaid provider numbers to submit claims. Thus, timeliness of reimbursement would be based upon the private providers own timely submission of claims. Private providers would not be dependent upon County Program processes. The process would establish private providers as directly responsible for ensuring proper documentation standards and processes for the clients they serve, more clearly establishing the lines of accountability between private providers and County Programs. (See recommendation on compliance oversight process in this section). Additionally, private providers should be required to bill commercial insurance directly, potentially increasing reimbursement from this source as many private providers have already been established as preferred providers, thus able to receive reimbursement from private insurance companies. Similarly, private providers should also bill Medicare directly and be responsible for compliance with Area Programs and DMH responsible for providing technical assistance and oversight.

In order to maintain tight control over the billing process, a system whereby contract providers include an authorization number with each claim submitted to Medicaid and/or the State, similar to the Primary Care Physician (PCP) provider number given to specialists in Carolina ACCESS for referrals. In addition, copies of the Remittance Advises should be sent to the County Programs to monitor the quantity of the delivery of care. By requiring this number to be submitted with each claim, County Programs would have the ability to terminate the billing process if necessary as quality of care, documentation, and other issues arise.

Recommendation 14

- ***There is a need to streamline the contract management process in order to decrease administrative costs, improve results, and decrease frustration levels.*** Over the years Area Programs have increasingly opted to contract for more services instead of providing services internally. This has led to the unintended consequences of an unnecessary increase in administrative costs and frustration due to the non-standardized and uncoordinated approach to contract management. A large number of private providers contract with multiple Area Programs creating an overlap in contract administration as each of these Area Programs will privilege, credential, and monitor billing compliance, of the same private provider. Thus, one private provider will operate under multiple administrative processes with four, five, or sometimes even more Area Programs. The end result is more administrative costs and effort being consumed than necessary. The following principles need to be applied to redesigning the privileging, credentialing, and billing compliance processes used across the state:
 - ◆ Specific policies and procedures developed by the State that would be carried out by all County Programs
 - ◆ Documentation requirements and forms standardized by the State and used by all County Programs
 - ◆ County Programs conduct privileging, credentialing and monitor billing compliance for all private providers in its catchment area. Results would suffice for other County Programs contracting with these private providers
 - ◆ Standard private provider contract format, with allowable local adaptation, used by all County Programs
 - ◆ List information and results on an internet site

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Overall, the premise is the State setting standardized policies, procedures, and documentation while locally the County Programs are executing the processes in a coordinated fashion without unnecessary duplication of effort. The end result is lower administrative costs for both the County Programs and private providers.

Recommendation 15

- ***The State should standardize the private provider accreditation process and require County Programs to either internally accredit private providers located within their own catchment areas or use the results of the COA process more effectively without adding a duplicative administrative effort.*** The existing accreditation process for contract providers is inconsistent and requires duplicative processes among the various Area Programs. Multiple Area Programs employ unique accreditation standards to the individual external providers often duplicating the effort of other Area Programs without adding much benefit. While the current COA process attempts to standardize accreditation, the COA results are not utilized consistently by Area Programs to monitor contract provider performance. Many Area Programs employ an internal Accreditation procedure while, at the same time, require the contract providers to undergo the COA process. This lack of coordination adds excessive administrative costs to the system.

County Programs would remain responsible for maintaining records on licensure, clinical outcomes and significant incidences and combine this data with the documentation monitoring results to be used in the accreditation process. In addition, the County Programs would report significant incidents to DMH. All of this information including the results of the accreditation process and the significant incident reports would be made available to other County Programs wishing to contract with the specific external providers.

Recommendation 16

- ***Standard intake protocols should be implemented across all County Programs.*** Financial information gathered during the intake process is extremely important in maximizing County Program revenue. During the intake process insurance information is gathered and indigent patients are identified. Area Programs have difficulty and oftentimes face the impossible obstacle of realizing the maximum potential revenue if information collected during the intake process is incorrect or not complete. To ensure the best possible intake protocols, the State should partner with County Programs to identify and implement best practices including those processes related to insurance gathering, client need identification, financial resources and patient/family history. Accurate and complete intake protocols insures not only that first and third party revenue is maximized but also that the State does not subsidize individuals with commercial insurance.

In addition to developing a uniform intake process, PCG recommends that the State works with County Programs to develop a standard methodology for determining self-pay amounts and collection procedures because no standards currently exists. This will help to ensure that based upon income, the same payment amount is due by patients across the state creating equity. A standardized self-pay determination methodology is consistent with the implementation of a Basic Benefit Package funded by the State. Also, self-pay collections should be monitored by DMH in order to place an expectation on County Programs that appropriate payment for services by clients is expected. Additionally, self-pay money owed for services must be vigorously pursued and collected by Area Programs. PCG has found that oftentimes it is more efficient to collect self-pay money prior to rather than after services are rendered.

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Standardized intake protocols and self-pay collections allow the State to accurately estimate the amount of first and third-party revenue that will be received by Area Programs. These estimates can be integrated into the Basic Benefit Package reimbursement calculation to ensure the State does not over-reimburse Area Programs for services that are covered by commercial insurance. As referenced in the financial modeling, the proposed Basic Benefit Package cost methodology assumes that appropriate revenue is received from clients, commercial, and government sponsored insurance programs. Reducing reimbursement for the Basic Benefit Package by the anticipated collection amount will incentivize County Programs to monitor intake protocols and maximize non-State revenue.

Recommendation 17

- ***We recommend that DMH establish a unit to oversee the County Programs' financial performance and provide guidance.*** In the Governance and Structure section of this report, PCG has recommended that this responsibility lie within the newly established Office of County Programs (OCP). This unit would have specific responsibility and accountability for financial oversight of the County Programs from a state perspective. This unit does not need to be decentralized, like the current DMH Regional Accountants. Instead, a centralized unit that provides constant and consistent monitoring, technical advice, and a point of contact for County Program Finance Directors would be more appropriate. In order to establish this unit, DMH should consider utilizing the current DMH Regional Accountant positions. This would require restructuring the roles and responsibilities of these positions. Examples of the roles and responsibilities of the financial portion of the OCP include:

- ◆ Review and approve County Programs budgets
- ◆ Provide technical financial/accounting assistance
- ◆ Monitor County Programs against financial contract requirements
- ◆ Review interim financial performance (quarterly) against budget
- ◆ Analyze reimbursement results by source (i.e. Medicaid, Medicare, etc.)
- ◆ Issue an annual financial report for each County Program

In addition to the focusing on the financial stability of County Programs, the unit must monitor each County Program's ability to generate reimbursement from insurance sources. Through analyzing and comparing the data from all the County Programs on a regular basis, it would be possible to assist all the County Programs in securing the maximum appropriate amount of insurance reimbursement from all sources. This is important because any reimbursement that is not being received from insurance sources, but should be received from insurance sources, is diverting funds from indigent care. Likewise, the analysis and comparison of each County Program's cost performance is critical to ensure appropriate levels.

The State oversight of County Programs must be coupled by local oversight. Under our recommended restructuring to a county-based system, the county is now responsible to fiscally monitor the County Program. Specifically, the County Program's budget must also be reviewed and approved by the County Finance Director. In the case of multiple counties composing an County Program, a designated "lead county" finance director could perform the responsibility on behalf of all the other participating counties. Or, the respective Counties could designate this responsibility to the County Program board. Nevertheless, it is required that the County Program budget be presented to all sets of the County Commissioners composing the County Program. The Counties have the responsibility for these County Programs, and must be fully aware of the budget.

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With the combination of a dedicated DMH unit monitoring financial and contract performance and local oversight by County Commissioners and/or County Management, there will be appropriate oversight of the financial component of this sizeable community delivery system. When financial issues arise, there will be significant lead-time and knowledge in order to be able to take appropriate action for effective resolution.

INTRODUCTION

This section of our report estimates the cost savings that can be achieved through reductions of State Psychiatric Hospital beds and estimates the cost of the Basic Benefit Package outlined in our services section. An overview of the factors placing pressures on the system is provided to highlight the reasons for change. The analysis begins with the establishment of a baseline model of the existing services and costs within the current State Hospital system. Two scenarios are presented for revising this system whereby the State will achieve significant cost savings over the current delivery model. After presentation of these savings, a model is developed to project the cost associated with a basic benefit package. This benefit package establishes a core set of services to be available to all mental health and substance abuse clients throughout all of North Carolina. This section of the report estimates the cost associated with these core services. This benefit package will assist the State in developing more appropriate community based services to support a smaller State Hospital system. Capital funding is required to build and renovate the State Hospitals and bridge funding is required to build capacity within the community system. These changes to the service system will ensure that North Carolina provides the highest quality of care to its consumers at the lowest net state cost. These factors should ensure the long-term viability of the system and will assist in regaining the confidence of consumers and advocates alike.

STATUS OF THE PHYSICAL PLANTS OF THE STATE HOSPITALS

The Department of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) conducted numerous studies on the failing state of the physical infrastructure of North Carolina's State Hospitals. During the first phase of our project, PCG reviewed the most recent study by MGT of America and offered alternative recommendations. PCG largely concurred with the most recent study on the status of these facilities. Where the analyses differ is in the solution. The MGT of America study recommended the building of four new state hospitals and the reduction of nearly 50% of all beds. Our analysis includes downsizing the State Hospitals by about a third of the beds, but a more aggressive approach to the facilities: closing one and rebuilding two and a mixed building/renovation approach to the third. PCG's focus is on the long term viability of a modern, efficient and affordable hospital system, and the transfers of resources, with clients to the community system.

The physical condition of the State Hospitals is one of the main drivers of change to the delivery system in North Carolina. The inefficiencies inherent in the Hospitals require significant recurring investment of operating resources that might otherwise be used for direct patient care. By reducing the services provided in these facilities, the State's capital investment into the Hospitals will be reduced as fewer beds are required. These savings would be available to purchase increased community-based service capacity.

It is important to note that the removal of beds from the State Hospitals will have an impact on the remaining cost per bed. The State cannot realistically reduce the administrative costs of operating the Hospitals at the same rate as direct care expenditures are reduced. Therefore, administrative costs are distributed over a decreasing number of beds resulting in higher proportionate costs for administrative services. This increase in average administrative costs would not be perceived as inefficiencies of the new system and must be considered in comparing the effects of downsizing.

COMMUNITY BASED TREATMENT ALTERNATIVES

Current trends in the care and treatment of mental health and substance abuse consumers focus on treatment alternatives in community based settings. Several models have proven extremely effective in treating consumers outside of institutional care, and other models are still evolving. The downsizing of state mental health institutions during the 1970's and 1980's sometimes came at the expense of consumers. Community based programs were not always equipped to serve a population with a long history of institutionalization, who were incapable of managing themselves in the community based system of care. The creation of community programs to help support these individuals in the community during the past decade has attempted to alleviate these problems.

As the mental health delivery model continues to evolve throughout the country, the system is seeing both internal and external pressures to change. Families, consumers, advocates and taxpayers are placing increasing pressure on the public system to develop more appropriate, less costly approaches to the care and treatment of mental health consumers. In 1999, the US Supreme Court ruled, in *Olmstead vs. L.C.*, 119 S. Ct. 2176, that the Americans with Disabilities Act of 1990 (the ADA) obligates States to provide services in the most integrated settings appropriate to the needs of individuals with disabilities. The court ruled that States are required to provide community-based services for persons with disabilities who would otherwise receive institutional services if the State's treatment professionals determine that community placement would be appropriate, the individuals accept community placement, and the placement can be reasonably accommodated, taking into account the resources available to the State. This ruling has the potential to dramatically change the methods of delivering care by many States. North Carolina's system of care is heavily reliant on a State Hospital model that costs significantly more than the national average and their peer group averages. As North Carolina is forced to confront the challenges posed by the *Olmstead* case, the State must develop a stronger community based system of care. The recommendations proposed here support such development through the removal of 667 beds, a 29% reduction, from the State Hospitals in favor of developing community based alternatives. Long-term impact of *Olmstead* might push for movement of more beds to community.

FEDERAL CHANGES TO THE DISPROPORTIONATE SHARE HOSPITAL PROGRAM

During FY 1999, North Carolina's State Psychiatric Hospitals claimed approximately \$96.6 million in federal Medicaid reimbursement under the disproportionate share hospital (DSH) provision. OBRA 93 imposed hospital specific limits on DSH which impact the State's ability to claim for all costs of uncompensated care. The Federal government reimburses hospitals for the cost of uncompensated care for uninsured persons (excluding Medicare and private insurance payment shortfalls for insured persons) through the DSH program. This Federal program is administered through the Medicaid agency and is subject to the same Federal participation rate as general Medicaid – 62.47% in North Carolina in FY 01. The high incidence of uninsured individuals results from a Federal provision prohibiting Medicaid reimbursement for individuals between twenty-one and sixty-four years of age who reside in public or private psychiatric facilities. This provision classifies facilities larger than sixteen inpatient beds that are primarily engaged in providing mental health services as an Institution for Mental Diseases (IMD). Medicaid eligible patients receiving services from an IMD are not eligible for Federal reimbursement under traditional Medicaid. This is the primary population served in North Carolina's State Psychiatric Hospitals and whose care is reimbursed under the Medicaid DSH program.

In August of 1997, the US Congress passed the Balanced Budget Act of 1997 (BBA 97), which sought to slow the rate of growth in Federal health care spending and to improve the current means by which the Federal government purchases health care services. BBA 97 established revised State ceilings on aggregate claims

under the Federal DSH program. These ceilings were established based on FY 1995 DSH levels. Additionally, HCFA instituted specific, proportional, caps on the amount of DSH that an individual State may claim for the IMD population. These proportional caps were phased in over a six year period, from FY 98 to FY 03. As of FY 03, individual States must limit their IMD DSH claim to thirty-three percent of their total DSH limit for that year.

The Federal changes to the DSH provision pose financial challenges for several states, including North Carolina. In FY 99, North Carolina had an aggregate DSH cap of \$272 million in federal Medicaid reimbursement. Although the State Psychiatric Hospitals could have generated \$148 million in federal Medicaid reimbursement under the DSH provision but for OBRA 93 limitations, only \$96.6 million in federal Medicaid reimbursement was available. During FY 99, the proportion of IMD DSH was not to exceed the relationship of IMD DSH to total DSH during FY 95 (54.99%), the base year for the aggregate DSH cap, but was actually 35.51% due to the limitations imposed under OBRA 93.

Finding 1

During FY 99 North Carolina was not adversely impacted by the BBA 97 reductions in IMD DSH. By FY 2002, North Carolina will be forced to reduce the proportion of IMD DSH to 40% of its total DSH cap for that year, or \$94.4 million net FFP. If North Carolina is unable to reduce its State IMD costs, it will be forced to finance uncompensated care above these caps with 100% State funds. One mechanism to reduce reliance on IMD DSH is to reduce emphasis on treating patients in State Psychiatric Hospitals, and instead serve these patients in community hospitals, nursing homes, or a variety of alternative community based programs, where services are eligible under traditional Medicaid.

The following analysis projects the impact of BBA 97 on the DSH funding of North Carolina. This analysis assumes no change in capacity at the State Hospitals, comparable utilization and payor mix, and comparable cost structures for these facilities. This analysis only projects the impact of BBA 97 on IMD DSH funding if all else remained constant. The IMD DSH implications of two alternative scenarios are discussed later in this section. The projected impact of Federal participation in DSH funding for the baseline model is depicted below. The IMD DSH caps are derived from Federal statute, and IMD DSH FFP is a function of FY 1999 DSH expenditures claimed.

Finding 2

The change in IMD DSH Cap (FFP) presented below is the incremental change in allowable Federal funding to North Carolina. All Federal funds related to the DSH program have historically been deposited in North Carolina’s General Fund and as such any change to this funding has a direct impact on the State’s aggregate budget, not directly on DMHDDSAS.

Federal Fiscal Year	Total DSH Cap (FFP)	IMD DSH Cap (FFP)	IMD DSH FFP (FY99)	Change in IMD DSH (FFP)
1999	272,000	149,573	148,112	1,461
2000	264,000	145,174	148,112	(2,938)
2001	250,000	125,000	148,112	(23,112)
2002	236,000	94,400	148,112	(53,712)
2003	245,440	80,995	148,112	(67,117)

Note: Figures are in Thousands (\$ 000’s)

The analysis on the previous page depicts the dramatic effect of the BBA 97 reductions to the IMD DSH on North Carolina. In FY 99, the State is unaffected by these reductions as the DSH claim is less than the IMD DSH cap. Beginning in FY 00, the Federal government will decrease the Federal funding related to IMD DSH. This funding shortfall grows from \$3 million to \$67 million over a four year period. From FY 2003 forward, North Carolina will be required to replace \$67 million from their annual budget due to these reductions in Federal financial participation. The chart and analysis above solely assesses the impact of BBA 97 on the DSH funding independent of the OBRA 93 requirements. This assumes that all IMD DSH eligible expenditures will be eligible for reimbursement, which may not be the case as it is impacted by aggregate State DSH expenditures.

Finding 3

Imposing the OBRA 93 restrictions and assuming FY 99 DSH levels for the State Psychiatric Hospitals significantly reduces the impact of BBA 97. North Carolina is first impacted by the changes imposed by BBA 97 in FY 02 where the cap establishes a limit of \$94.4 million on IMD DSH expenditures. For FY 03 and subsequent years, PCG projects North Carolina will be forced to replace close to \$15.7 million of Federal funds with State General Fund dollars due to the IMD DSH limitations of BBA 97. These projections are dependent upon inflation and actual uncompensated care costs at the State Hospitals, however, the impact is expected to be at least \$15.7 million.

METHODOLOGY FOR PROJECTING SAVINGS FROM STATE HOSPITAL REDUCTIONS

Projecting the expected cost savings from a smaller State Hospital system requires careful consideration. There are many factors that must be considered in determining a reasonable expectation of savings. As beds are removed, the State naturally expects to see reductions in the operating cost at the Hospitals. To derive the savings, one must make individual considerations on the various types of costs in order to determine the level of savings from the reduction in capacity. For example, unless full patient wards are closed, the State will not experience the desired level of cost savings from the closure of these beds. The removal of individual beds may marginally decrease overtime expenditures of direct care staff, may reduce the cost of drugs, medical supplies, dietary expenditures, and other expenditures. However, this action will not result in the reduction of routine nursing staff, the largest component cost of the hospital. The analysis that follows has taken careful consideration of each element of the current expenditures at the State Hospitals. A model for determining the fixed and variable costs at the Hospitals was developed, all assumptions were reviewed to ensure actual savings would be realized as a result of each assumption.

In order to accurately project expected savings from a smaller State Hospital system, current operating costs of the State Hospitals were reviewed. This analysis considered the current number of inpatient beds at each facility; the various services and units at each facility; and the related cost of operating these services.

The current bed configuration at each hospital was taken from the MGT of America survey. The results of this study were reviewed with Division staff for accuracy. The only notable change since the original study was the addition of 70 inpatient forensic beds on the Dorothea Dix Hospital campus and the reduction of 19 nursing facility beds on the Cherry Hospital campus.

Our analysis reviewed three years of admission practices of the Area Programs to the State Hospitals. The utilization patterns were analyzed to determine which providers appropriately use the State Hospital. The mix of services at each facility is based on historical utilization rates and best practices of Area Programs to derive the mix of hospital services provided by each individual hospital. Utilization information was chosen instead of unit/ward census data because utilization data was a more reliable indicator of hospital usage than census data.

For example, one might expect that individuals residing in an admission ward would have relatively short lengths of stay, while individuals residing in a long term or nursing ward would have relatively long lengths of stay. When we reviewed the utilization data, this was not necessarily the case. This resulted in our use of historical utilization data as the basis for our projections.

Expenditure data on each unit/ward is taken from the HCFA – 2552 cost report, an annually audited report of utilization and expenditures for each facility. This data is used to determine the discrete cost of individual units/wards, and identify direct routine patient care expenditures, ancillary expenditures, and overhead expenditures. These three factors are critical in evaluating the cost of any service, particularly when projecting the impact of potential reductions to the system of care.

Routine patient care expenditures included nursing staff directly assigned to each individual unit/ward. Expenditures related to physicians were allocated according to the patient populations in the ward while rehabilitation services were allocated as part of overhead expenditures consistent with the HCFA – 2552 cost report. Ancillary expenditures were allocated according to average use rates since no data was provided to more accurately assign the cost of ancillary services to individual units/wards. This limitation is not expected to distort the projected cost savings related to bed reductions as ancillary expenses represent only ten percent of total patient care expenditures. Even with one hundred percent variation in use rates, average use rates will not materially impact the results of our analysis.

Overhead cost areas were reviewed and individually considered to determine whether cost savings would be achieved if beds were removed. With the exception of fringe benefits, no overhead expenditures were projected to decrease at the same rate as direct care expenditures. Overhead areas such as Capital Depreciation and Plant Operations were projected to remain constant despite a decrease in operating capacity. This is due to the fact that the hospital campus is expected to continue to operate and thus no cost saving can be achieved. Overhead areas such as Dietary, Laundry, Pharmacy, and Medical Supplies were expected to move at relatively the same rate as direct care expenditures, but not entirely. Our analysis considered the fixed costs associated with these programs in projecting any savings. Other areas like, rehabilitation, medical records, and psychology were expected to move only slightly due to changes in the operating capacity of the hospitals.

We have taken a conservative approach to reduction of ward expenditures. In the rare case where we reduced a unit size to a bed count less than a full ward, we attempted to compensate for the inherent inefficiencies created by the relative size of these units. This analysis shied away from removing the entire cost of a unit/ward. *Our analysis recognizes the persistent costs associated with operating hospitals. To recognize 100% of the hospital expenditures as savings potentially overstates these savings. Our analysis accounts for the overhead costs that remain after that unit is closed and costs shift to other areas of the hospital.*

IMPLEMENTATION

Our analysis assumes the downsizing of the State Psychiatric Hospitals is implemented over a period of five years. The State must set realistic goals for removing beds from these hospitals and ensure these goals correlate with the overall goals of reducing 667 beds from the system by State Fiscal Year 2005. The actual number of beds to be removed from each Hospital must be reviewed in detail with DMHDDSAS to ensure their feasibility. This level of reduction over this time frame requires that an average of one hundred and thirty-three beds are removed from the system each year. The goal of reducing 667 beds over five years is not unrealistic. Many states have been able to achieve comparable reductions in similar timeframes without negatively impacting the care delivered to consumers.

The implementation strategy of downsizing the State Hospital system varies depending upon the intended outcomes of the future system. The implementation strategy will look very different if the State chooses a Four Hospital Model rather than a Three Hospital Model. In either case, *the State must work toward closure of full inpatient units/wards in order to achieve true savings from these reductions.*

In order to achieve the goals of downsizing, the State must make an investment into the community mental health system. In order to preserve the continuity of care of its consumers, the State must assist in building adequate capacity within the community based system to provide alternatives to State hospitalization. These alternatives can come in the form of acute inpatient treatment services provided by community hospitals, development of psychiatric day programs at the Area Program level, development of residential programs for supported independent living arrangements, and/or a combination of these services, or other community based programs (see Section 2.4 for more details). This investment is required to assist the community in building capacity. It is expected that this investment will serve as “bridge funding” until savings can be realized from a smaller State hospital system. Once savings from the downsizing are achieved, the State can transfer expenditures from the State Hospital to the community to continue to fund these programs. During implementation, the State is forced to fund both systems, the community and the Hospitals, to ensure the safety and continuity of care of its consumers.

PROJECTING THE BED CONFIGURATION AND ESTIMATED COST SAVINGS OF A NEW STATE HOSPITAL SYSTEM

Current Operating Expenditures at the State Hospitals

PCG reviewed the current fiscal operations of the existing four State Psychiatric Hospitals to determine whether the State could recognize savings through the downsizing of inpatient beds and transfer these funds to support community based services. The first phase of this analysis was to review the operating budgets, revenue receipts and the corresponding net state cost of operating these hospitals.

The Fiscal Year 1999 operating budgets for the Four State Hospitals are as follows:

AREA	<i>Broughton Hospital</i>	<i>Cherry Hospital</i>	<i>Dorothea Dix Hospital</i>	<i>Umstead Hospital</i>	TOTAL
PATIENT CARE	\$60,140	\$56,314	\$61,866	\$62,622	\$240,942
NON PATIENT	\$2,683	\$13,102	\$7,397	\$8,237	\$31,420
TOTAL EXPENSES	\$62,823	\$69,416	\$69,263	\$70,859	\$272,362

Note: Figures are in Thousands (\$ 000's)

The annual operating cost of the current 2,288 bed system is \$105,307 per bed per year.

In reviewing the operating expenses for these four hospitals, it is important to understand that all four hospitals are located on large campuses which provide services to a variety of other state programs. The expenditures listed as non patient represent expenditures incurred by the Hospitals for services provided to these non patient programs. These programs incur direct operating expenditures outside of those recognized here. The primary costs recognized here relate to depreciation, administration, plant operations and in some instances, direct salaries and miscellaneous expenditures of the Hospital. This analysis is concerned with only the patient care expenditures of these facilities, however, we recognize the State's investment in these other programs and the costs incurred for analysis purposes.

Current non-state revenue receipts for Fiscal Year 1999 for the Four State Hospitals are as follows:

Payor	Broughton Hospital	Cherry Hospital	Dorothea Dix Hospital	Umstead Hospital	TOTAL
Medicare	\$ 4,353	\$ 1,881	\$ 7,271	\$ 4,544	\$ 18,049
Medicaid (Net FFP)	8,503	10,224	3,281	5,786	27,795
Third Party	2,709	2,175	4,438	2,691	12,013
PATIENT CARE	\$ 15,566	\$ 14,281	\$ 14,990	\$ 13,020	\$ 57,857
NON PATIENT	\$ 3,921	\$ 4,408	\$ 3,119	\$ 2,360	\$ 13,808
DSH (Net FFP)	36,880	32,036	37,143	42,054	148,112
TOTAL REVENUE	\$ 56,367	\$ 50,725	\$ 55,252	\$ 57,434	\$ 219,777

Note: Figures are in Thousands (\$ 000's)

It should be noted that although \$148 million (net FFP) of expenditures are eligible for reimbursement under the Federal DSH program, provisions under OBRA 93 limited the States' ability in FY 99 to claim these expenditures to \$96.6 million.

Comparing revenue and expenses of the patient care areas of the four State Hospital result in the following net state cost analysis:

	Broughton Hospital	Cherry Hospital	Dorothea Dix Hospital	Umstead Hospital	TOTAL
PATIENT REVENUE	\$ 15,566	\$ 14,281	\$ 14,990	\$ 13,020	\$ 57,857
PATIENT EXPENSES	\$ 60,140	\$ 56,314	\$ 61,866	\$ 62,622	\$ 240,942
NET STATE COST	\$ (44,574)	\$ (42,033)	\$ (46,876)	\$ (49,602)	\$ (183,085)

Note: Figures are in Thousands (\$ 000's)

Finding 4

According to these figures, the net state cost to operate the patient care areas of these four State Hospitals is over \$183 million annually. These figures intentionally exclude reimbursement from the Federal DSH program as these funds are deposited directly into the State's General Fund and are not directly tied to the State Hospital budgets. This baseline net state cost analysis is the basis for comparison for the two scenarios that are posed in the following pages. This baseline will be adjusted for changes in Federal policy and then compared to the projected operational changes of each scenario for each Hospital.

Operating Expenditures under a 1,621 Bed State Psychiatric Hospital System

Sections 2.2 of our report projects that North Carolina can reasonably be expected to remove 667 beds from the State Psychiatric Hospitals and operate with 1,621 inpatient beds. This projection is based on a review of the admitting practices and discharge rates of a group of Area Programs who have existing local service capacity and a low State Hospital utilization rate.

This analysis does not only project the number of beds to be removed from State Hospitals, but also the types of beds. The analysis limited the types of services impacted by the reductions to youths, short term and long term adults, short term and long term geriatrics, and substance abuse. All other programs were excluded from our analysis. The model includes a reduction of 107 beds for youths, 141 beds for short term adults, 93 beds for long term adults, and 326 beds for long term geriatric patients. The projections are based on the admission practices of Area Programs and as such, link admission practices back to Area Programs in order to determine the most appropriate hospitals for specific bed reductions. The following paragraphs explain the projected reductions to the inpatient beds at each Hospital including a chart of the projected bed configuration at each facility.

It is important to note that this analysis considered changes to only the general psychiatric populations. No changes were recommended in the following units: Medical/surgical, Pre-Trial Evaluation (Forensic), Research, Deaf, and Tuberculosis. These units were excluded from the analysis as they are viewed as state-wide programs and serve specialized populations. This is not to say that all services and associated expenditures would not be considered in review of hospital operations, however, these areas were not considered in this analysis.

Based on the findings of Section 2.2, two scenarios are presented for achieving the projected bed reductions of State Psychiatric Hospitals. These scenarios project estimated savings that can be achieved from reductions to capacity at the State Hospitals. As stated earlier, our methodology approaches the downsizing in a comprehensive manner resulting in a flexible model to arrive at reasonable estimates of the level of savings that may be achieved. These two scenarios result in the reduction of an equal number of beds and an identical service mix of beds in the system. The consistency of these two elements is important for comparison as the key independent variable in the two models is the operating efficiencies attained under the various scenarios. *Savings associated with the removal of different numbers or types of beds from the State Hospitals could significantly change the level of savings estimated in our report.*

The following chart provides a summary of the current beds, patient care costs, patient revenues, and net state costs associated with the three scenarios presented in detail in this section.

	Patient Beds	Patient Care Expenditures	Patient Revenue	Net State Cost of Patient Care	NSC Variance from Baseline
Current/Baseline Model	2,288	\$ 240,942	\$ 57,857	\$ 183,085	\$ -
Four Hospital Model	1,621	\$ 190,722	\$ 45,853	\$ 144,870	\$ (38,216)
Three Hospital Model	1,621	\$ 173,394	\$ 41,717	\$ 131,677	\$ (51,408)

The first scenario, the Four Hospital Model, maintains a four hospital system with the nearly half of the reductions achieved at Cherry Hospital while the Three Hospital Model proposes to close the Dorothea Dix Hospital in favor of more modest reductions at the remaining Hospitals.

Under the Three Hospital Model, services provided by Dorothea Dix under the Four Hospital Model are provided by Cherry and Umstead Hospitals. Changes proposed for Broughton Hospital under the Three Hospital Model are identical to the Four Hospital Model, as Broughton Hospital is not expected to assume any of the capacity previously provided by Dorothea Dix Hospital due to its location. The two alternative scenarios are presented below.

Scenario #1 – Four Hospital Model

As noted earlier, this scenario results in a reduction of 667 inpatient beds from the State Hospitals. These beds are removed from individual Hospitals according to the admission practices of the Area Programs. The net results of changes to the operating beds at each Hospital identified in this scenario are as follows:

<u>Hospital</u>	Current Beds	Changes in Beds	Future Beds
Broughton Hospital	632	(114)	518
Cherry Hospital	642	(309)	333
Dorothea Dix Hospital	501	(71)	430
John Umstead Hospital	513	(173)	340
TOTAL	2,288	(667)	1,621

In applying this scenario to each Hospital, we have made a number of assumptions about ward closure, staffing impact, etc. These assumptions are identified to show how the model is implemented consistently. We know, of course, that the actual configuration of services, ward structure and staffing at each hospital will be somewhat different and will reflect the situation at the time the changes are made.

Broughton Hospital

Broughton Hospital continues to provide a full array of mental health services to the western region of the State. In order for the State to meet the 1,621 bed demand level, Broughton Hospital is required to reduce inpatient admission by eighteen percent. The patient populations that are of primary concern are the short term adults and long-term geriatric populations. Broughton must reduce a total of 114 beds. The areas of the Hospital to be reduced in order to reach the State’s target are 12 youth beds; 32 short-term beds; and 70 geriatric long-term / nursing beds. The following chart depicts the current bed complement, the changes proposed under this scenario, and a revised view of the future bed complement.

<u>Unit / Ward</u>	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	32	(12)	20
Adult admissions	161	(32)	129
Rehabilitation	101	0	101
Adult long-term	118	0	118
Geriatric admissions	44	0	44
Geriatric long-term / nursing	154	(70)	84
Medical / surgical	22	0	22
TOTAL	632	(114)	518

The reduction in beds identified on the previous page result in the closing of four inpatient units/wards. The four wards identified include one youth ward, one adult admission ward, and two geriatric long-term / nursing wards. This fact is important in estimating the savings associated with the reduction in beds.

Based on the reduction of beds and the new service configuration at Broughton Hospital, the projected changes in expenditures resulting from these reductions are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$1,179)
Adult admissions	(1,849)
Rehabilitation	0
Adult long-term	0
Geriatric admissions	0
Geriatric long-term / nursing	(3,642)
Medical / surgical	0
TOTAL	(\$ 6,670)

Service configuration presented under the Four Hospital Model, revised patient care expenditures by unit/ward at Broughton Hospital are as follows including the projected unit cost per bed.

<u>Unit / Ward</u>	Revised Proj. Expenses (000's)	Projected Cost per Bed
Short-term and long-term youth	\$ 3,010	\$150,489
Adult admissions	12,646	98,030
Rehabilitation	9,344	92,515
Adult long-term	9,615	81,480
Geriatric admissions	3,443	78,247
Geriatric long-term / nursing	12,261	145,968
Medical / surgical	4,078	185,376
TOTAL	\$ 54,397	\$ 105,013

Administrative and overhead expenditures associated with the reduction in beds are reallocated throughout the Hospital. In some cases, the reallocations result in inflated costs of a particular unit. This is due to the fact that the now empty wards are allocated overhead which remains with the original wards. This is the case for the geriatric long-term / nursing ward at Broughton. This unit is currently estimated to operate at \$81,408 per bed, a \$64,560 variance from the projections under this scenario. This is largely due to the seventy bed reduction in this area. The youth and adult admissions units have similar effects, however less dramatic. Although projected costs per bed may be skewed slightly for individual units, total projected cost per bed is an accurate reflection of the total patient care costs.

Cherry Hospital

Cherry Hospital continues to provide an array of mental health services to the eastern region of the State, however some significant changes to the levels of service are recommended. In order for the State to meet the 1,621 bed demand level, Cherry Hospital is required to reduce inpatient admission by forty-six percent, the largest of the Four Hospital Model. The patient population of primary concern is the long-term geriatric / nursing populations. Current admission practices suggest Cherry Hospital must reduce a total of 306 beds. The population that must be reduced in order to reach the State’s target is a reduction of 35 youth beds; 31 short-term beds; and 240 long-term beds – including 86 adult and 154 geriatric/nursing beds.

The removal of 35 beds in the youth unit results in only 3 beds remaining for youth services. As a clinical delivery model, a three bed model is inefficient and too costly for the required service. As a result, this scenario removes the remaining 3 beds from the youth unit at Cherry Hospital in favor of providing these services at John Umstead Hospital. (They could, of course, be moved to the community as well.) The removal of these three additional beds results in an overall reduction of 309 beds at Cherry Hospital. DMHDDSAS may instead choose to close more beds in other youth units at other Hospitals instead and fill the excess capacity at Cherry with patients from the previous youth unit. Our analysis recognizes that there are numerous options to the State in deciding how to configure services across the State, we have chosen to cost out this option in our analysis. Similarly, our analysis removes the entire Nursing Facility at Cherry. Capacity remains to serve long-term adults and geriatrics, however access to nursing services is cut by more than 87%.

After these 309 beds are removed from Cherry, the remaining beds would be configured as follows:

<u>Unit / Ward</u>	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	38	(38)	0
Adult admissions	136	(31)	105
Rehabilitation	62	0	62
Adult long-term	187	(86)	101
High management	16	0	16
Geriatric admissions	20	0	20
Geriatric long-term / nursing	178	(154)	24
Tuberculosis	5	0	5
TOTAL	642	(309)	333

The reduction in beds identified above will result in the closing of numerous inpatient units/wards. The reductions identified include all youth wards, one adult admission ward, three adult long-term wards, and five geriatric long-term / nursing wards.

Based on the reduction of beds and the new service configuration at Cherry Hospital, the projected expenditure savings from these reductions are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$ 4,458)
Adult admissions	(1,876)
Rehabilitation	0
Adult long-term	(4,190)
High management	0
Geriatric admissions	0
Geriatric long-term / nursing	(8,397)
Tuberculosis	0
TOTAL	(\$ 18,921)

Under the revised service configuration presented under the Four Hospital Model, total patient care expenditures by unit/ward are as follows including the projected unit cost per bed.

<u>Unit / Ward</u>	Revised Proj. Cost (000's)	Projected Cost per Bed
Short-term and long-term youth	\$ 0	\$ 0
Adult admissions	10,460	99,617
Rehabilitation	5,071	81,790
Adult long-term	9,330	92,376
High management	2,914	182,165
Geriatric admissions	1,819	90,930
Geriatric long-term / nursing	1,912	79,684
Tuberculosis	439	87,797
TOTAL	\$31,945	\$95,932

The revised projected costs of the youth unit indicates that all expenditures have been removed from this area. All persistent costs have been reallocated to the remaining units within the Hospital. Our analysis did not project that all expenditures related to this unit would be saved if the unit was closed.

Dorothea Dix Hospital

Under this scenario, Dorothea Dix Hospital continues to provide an array of mental health services to the southern region of the State, however some minor changes to the levels of service will occur. In order for the State to meet the 1,621 bed demand level, Dorothea Dix Hospital is required to reduce inpatient admission by twenty-one percent. No patient population is of obvious concern at this point. Dorothea Dix Hospital must reduce a total of 71 beds. The population that must be reduced to reach the State’s target is a reduction of 32 youth beds; 15 short-term beds; and 17 geriatric long-term beds; and 7 substance abuse beds (taken from adult long-term). It would be noted that Dorothea Dix has recently increased the operating capacity with the addition of 70 pre-trial evaluation (forensic) beds.

Reductions in beds at Dorothea Dix Hospital raise some interesting points about the service configuration at the Hospital. It appears from the chart that follows, Dorothea Dix has a number of smaller more specialized units in comparison to the other State Hospitals. The Hospital has the largest capacity to serve the adult long term, adult admission, and pre-trial evaluation populations. No other units comprise a significant portion of the Hospital. It is important to note, that the specialized units at Dorothea Dix were not considered in our analysis as these units provide statewide capacity and serve unique target populations. Our analysis considered only the 339 beds in those units serving general psychiatric patients. The potential savings associated with these 162 beds in specialized units were not considered in these projections. After removal of the proposed 71 general psychiatric beds, these specialty beds represent thirty-eight percent of the total beds at Dorothea Dix Hospital.

After 71 beds are removed from Dorothea Dix Hospital, the remaining beds would be configured as follows:

<u>Unit / Ward</u>	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	51	(32)	19
Adult admissions	70	(15)	55
Adult long-term	128	(7)	121
High management	4	0	4
Geriatric admissions	37	0	37
Geriatric long-term / nursing	49	(17)	32
Medical / surgical	31	0	31
Pre-trial evaluation (forensic)	102	0	102
Research	12	0	12
Deaf	17	0	17
TOTAL	501	(71)	430

The reduction in beds identified above will result in the closing of only one inpatient unit/ward. One youth ward is closed with incremental reductions to beds in other units and wards. This fact is important in estimating the savings associated with the reduction in beds.

Based on the reduction of beds and the new service configuration at Dorothea Dix Hospital, the projected expenditure savings from these reductions are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$ 3,771)
Adult admissions	(1,517)
Adult long-term	(501)
High management	0
Geriatric admissions	0
Geriatric long-term / nursing	(1,167)
Medical / surgical	0
Pre-trial evaluation (forensic)	0
Research	0
Deaf	0
TOTAL	(\$ 6,956)

Under the revised service configuration presented under the Four Hospital Model, total patient care expenditures by unit/ward are as follows including the projected unit cost per bed.

<u>Unit / Ward</u>	Revised Proj. Expenses (000's)	Projected Cost per Bed
Short-term and long-term youth	\$4,989	\$262,605
Adult admissions	9,048	164,506
Adult long-term	15,036	124,263
High management	486	121,381
Geriatric admissions	4,465	120,676
Geriatric long-term / nursing	4,638	144,944
Medical / surgical	8,531	275,208
Pre-trial evaluation (forensic)	10,347	101,439
Research	2,333	194,417
Deaf	2,463	144,895
TOTAL	\$62,336	\$144,968

Comparing the projected cost per bed at Dorothea Dix Hospital and the other three State Hospitals raises some obvious questions as to the cause for significant variance. Dorothea Dix is between 17% to 51% more costly than other State Hospitals. This fact has been identified in past studies and has been attributed to the inherent inefficiencies of the physical structure at the Hospital. This raises more serious questions about the future of the hospital, which are addressed in the three hospital model.

John Umstead Hospital

John Umstead Hospital continues to serve as the primary provider of mental health services to the northern region of the State, however significant changes to the levels of service are recommended. In order for the State to meet the 1,621 bed demand level, John Umstead Hospital is required to reduce inpatient admission by thirty-four percent. The Hospital must reduce a total of 173 beds. The population to be reduced in order to reach the State’s target is a reduction of 25 youth beds; 63 short-term adult beds; and 85 geriatric long-term / nursing beds.

The reductions in beds at John Umstead remove sixty-nine percent of the capacity to serve long-term patients. Review of the admission practices of John Umstead revealed a need to reduce 53 beds for substance abuse admissions. This scenario presumes that these beds would be removed from the adult admissions unit. These admissions were not exclusively made to the adult admissions, however by removing beds from this area of the Hospital the analysis takes a conservative stance as the projected savings would be higher if beds were removed from other areas of the Hospital. The Hospital maintains a large capacity to serve rehabilitation patients, with adult admissions remaining a large component of their service configuration.

After 173 beds are removed from John Umstead Hospital, the remaining beds are configured as follows:

<u>Unit / Ward</u>	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	64	(25)	39
Adult admissions	150	(63)	87
Rehabilitation	136	0	136
High management	40	0	40
Geriatric long-term / nursing	123	(85)	38
TOTAL	513	(173)	340

The reduction in beds identified above will result in the closing of six inpatient units/wards. The reductions identified include one youth ward, two adult admission ward, and three geriatric long-term / nursing wards.

Based on the reduction of beds and the new service configuration at John Umstead Hospital, the projected expenditure savings from these reductions are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$ 2,847)
Adult admissions	(4,492)
Rehabilitation	0
High management	0
Geriatric long-term / nursing	(8,040)
TOTAL	(\$ 15,379)

Under the revised service configuration presented under the Four Hospital Model, total patient care expenditures by unit/ward are as follows including the projected unit cost per bed.

<u>Unit / Ward</u>	Revised Proj. Cost (000's)	Projected Cost per Bed
Short-term and long-term youth	\$ 7,035	\$180,388
Adult admissions	11,574	133,032
Rehabilitation	9,993	73,476
High management	7,654	191,342
Geriatric long-term / nursing	5,789	152,343
TOTAL	\$42,044	\$123,660

The total savings on expenditures under scenario one, the Four Hospital Model are as follows:

<u>Unit / Ward</u>	Revised Proj. Cost (000's)	Projected Savings (000's)	Proj. Ave Cost per Bed
Broughton Hospital	54,397	(\$ 6,671)	\$105,013
Cherry Hospital	31,945	(18,922)	95,932
Dorothea Dix Hospital	62,336	(6,955)	144,968
John Umstead Hospital	42,044	(15,379)	123,660
TOTAL	190,722	(\$ 47,927)	\$117,658

Finding 5

Reducing the number of beds, while maintaining the four hospitals, increases the per bed annual cost by 11%. The increase in average bed costs are due to the persistent costs that remain while direct care services decrease along with the number of beds. Because the State must operate significant portions of the Hospital campuses, they are unable to achieve full savings from the closing of inpatient units resulting in higher per bed costs.

REVENUE IMPLICATIONS

The reduction of operating beds at the State Hospital’s not only has a direct impact on expenditures, but also on their ability to generate non-state revenues for the services provided. Traditionally, the ability of State Hospitals to generate non-state revenue in these facilities is limited. The primary funding source has been Disproportionate Share Hospital (DSH) payments, with Medicaid, Medicare, and to a smaller extent, third-party receipts making up the balance. The following chart projects the non-state revenue receipts received at each facility by each of these four major payor classifications:

Payor	Broughton Hospital	Cherry Hospital	Dorothea Dix Hospital	Umstead Hospital	TOTAL
Medicare	\$ 3,877	\$ 1,181	\$ 6,542	\$ 3,327	\$ 14,927
Medicaid (Net FFP)	7,574	6,421	2,952	4,236	21,184
Third Party	<u>2,413</u>	<u>1,366</u>	<u>3,992</u>	<u>1,970</u>	<u>9,742</u>
PATIENT CARE	13,865	8,968	13,486	9,533	45,853
NON PATIENT	3,921	4,408	3,119	2,360	13,808
DSH (Net FFP)	32,852	20,119	33,414	30,791	117,176
TOTAL REVENUE	<u>50,638</u>	<u>33,495</u>	<u>50,019</u>	<u>42,684</u>	<u>176,836</u>

Note: Figures are in Thousands (\$ 000’s)

It should be noted that although \$117 million (net FFP) of expenditures are eligible for reimbursement under the Federal DSH program, provisions under OBRA 93 limited the States ability in FY 99 to claim these expenditures to \$96.6 million.

Based on the projected patient revenues and expenditures, the net state cost of the Four Hospital Model, excluding Federal funding of the DSH program are as follows:

	Broughton Hospital	Cherry Hospital	Dorothea Dix Hospital	Umstead Hospital	TOTAL
PATIENT REVENUE	\$ 13,865	\$ 8,968	\$ 13,486	\$ 9,533	\$ 45,852
PATIENT EXPENSES	54,397	31,945	62,336	42,044	190,722
NET STATE COST	(\$ 40,532)	(\$ 22,977)	(\$ 48,850)	(\$ 32,511)	(\$ 144,870)

Note: Figures are in Thousands (\$ 000’s)

The revised net state cost under the patient care areas of Four Hospital Model result in savings of \$38.2 million over the baseline projection. Under the original scenario the net state patient care cost was projected at \$183 million. These figures exclude the Federal funding of the DSH program.

The impact of the Federal changes to the DSH program under the Four Hospital Model is as follows:

Federal Fiscal Year	Total DSH Cap (FFP)	IMD DSH Cap (FFP)	IMD DSH FFP (FY99 & Proj)	Change in IMD DSH (FFP)
1999	272,000	149,573	148,112	1,461
2000	264,000	145,174	148,112	(2,938)
2001	250,000	125,000	148,112	(23,112)
2002	236,000	94,400	148,112	(53,712)
2003	245,440	80,995	117,176	(36,181)

Note: Figures are in Thousands (\$ 000's)

The Four Hospital Model projects a decreased reliance on the DSH program as services are moved to the community. This decreased reliance on DSH as a State funding source results in a smaller impact from Federal changes to the DSH program under BBA 97. The chart and analysis above solely assesses the impact of BBA 97 on the DSH funding independent of the OBRA 93 restrictions. This assumes that all IMD DSH eligible expenditures will be eligible for reimbursement, which may not be the case as it is impacted by aggregate State DSH expenditures. Imposing the OBRA 93 restrictions and assuming the FY 99 DSH levels for the State Psychiatric Hospitals significantly reduces the impact of BBA 97. Although the impact is significantly reduced, North Carolina will be forced to replace \$15.7 million of Federal funds with State General Fund dollars due to the limitations of BBA 97 beginning in FY 03.

Scenario #2 – Three Hospital Model

As in Scenario #1, the Three Hospital Model is based on a reduction of 667 inpatient beds from the State Hospitals. The same number and type of beds are removed from the system as in the Four Hospital Model, however, the elimination of Dorothea Dix Hospital from the system results in the reallocation of beds between Cherry Hospital and John Umstead. These two hospitals were reallocated beds according to their perceived specialties and capacity. Broughton Hospital has not been reallocated any of the Dorothea Dix beds for geographical reasons. Because Dorothea Dix is between 30 and 40 miles from Cherry and Umstead, it is reasonable to assume that the elimination of Dorothea Dix does not pose significant barriers to access to the State Hospital system for the Southern Region formerly served by Dorothea Dix.

The net result of changes to the operating beds at each Hospital identified in this scenario is as follows:

<u>Hospital</u>	Current Beds	Changes in Beds	Future Beds
Broughton Hospital	632	(114)	518
Cherry Hospital	642	(177)	465
Dorothea Dix Hospital	501	(501)	0
John Umstead Hospital	513	125	638
TOTAL	2,288	(667)	1,621

As in the previous model, the Three Hospital Model requires a number of assumptions to be made about the services, wards and staffing at each hospital. We have clarified these assumptions in the text. We understand that decisions made in implementation will look different from our projections.

Broughton Hospital

The changes proposed in the Three Hospital Model for Broughton Hospital are identical to those proposed in the Four Hospital Model.

<u>Unit / Ward</u>	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	32	(12)	20
Adult admissions	161	(32)	129
Rehabilitation	101	0	101
Adult long-term	118	0	118
Geriatric admissions	44	0	44
Geriatric long-term / nursing	154	(70)	84
Medical / surgical	22	0	22
TOTAL	632	(114)	518

Based on the reconfiguration of beds at the State Psychiatric Hospitals, the projected expenditure decreases at Broughton Hospital are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$ 1,179)
Adult admissions	(1,849)
Rehabilitation	0
Adult long-term	0
Geriatric admissions	0
Geriatric long-term / nursing	(3,642)
Medical / surgical	0
TOTAL	(\$ 6,670)

Under the revised service configuration presented under the Three Hospital Model, total patient care expenditures by unit/ward are as follows including the projected unit cost per bed.

<u>Unit / Ward</u>	Revised Proj. Cost (000's)	Projected Cost per Bed
Short-term and long-term youth	\$ 3,010	\$150,489
Adult admissions	12,646	98,030
Rehabilitation	9,344	92,515
Adult long-term	9,615	81,480
Geriatric admissions	3,443	78,247
Geriatric long-term / nursing	12,261	145,968
Medical / surgical	4,078	185,376
TOTAL	\$54,397	\$105,013

Cherry Hospital

Under the Three Hospital Model, Cherry Hospital maintains primary responsibility for the eastern region of the State. Cherry Hospital, along with John Umstead Hospital, will also serve the southern region previously served by Dorothea Dix. Despite the expansion of regional responsibilities, Cherry Hospital is required to reduce 177 beds from its current system. Under this scenario, Cherry will not provide services to the youth population. Youth services for the northern, southern and eastern regions will be provided by John Umstead Hospital (58 bed program). Additionally, 87 beds are removed from the adult long-term units and 112 beds from the geriatric long-term / nursing units. In order to serve the population previously served by Dorothea Dix, Cherry Hospital is no longer required to remove beds from their adult admissions unit, they will increase the high management and geriatric admissions units, and will limit the reduction in geriatric long-term / nursing beds. Additionally, two specialty units, the Research and Deaf units, will relocate to the Cherry Hospital campus from Dorothea Dix.

The revised bed configuration at Cherry Hospital results in the following:

Unit / Ward	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	38	38	0
Adult admissions	136	0	136
Rehabilitation	62	0	62
Adult long-term	187	87	100
High management	16	(4)	20
Geriatric admissions	20	(37)	57
Geriatric long-term / nursing	178	122	56
Research	0	(12)	12
Deaf	0	(17)	17
Tuberculosis	5	0	5
TOTAL	642	177	465

The reduction in beds identified above results in several changes to inpatient units/wards. It is presumed that all youth units/wards, three adult long-term units/wards, and four geriatric long-term / nursing units/wards will be closed. Two new wards/units will be added to the service configuration, one geriatric admissions, and one ward/unit split between the research and deaf units. The addition of four high management beds has little impact on ward configuration.

Based on reconfiguration of beds at the State Psychiatric Hospitals, the projected expenditure savings at Cherry Hospital are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$ 4,458)
Adult admissions	0
Rehabilitation	0
Adult long-term	(4,238)
High management	472
Geriatric admissions	2,186
Geriatric long-term / nursing	(6,199)
Research	1,735
Deaf	1,616
Tuberculosis	0
TOTAL	(\$ 8,886)

Under the revised service configuration presented under the Three Hospital Model, total patient care expenditures by unit/ward are as follows including the projected unit cost per bed.

<u>Unit / Ward</u>	Revised Proj. Cost (000's)	Projected Cost per Bed
Short-term and long-term youth	\$ 0	\$ 0
Adult admissions	12,154	89,367
Rehabilitation	4,865	78,473
Adult long-term	8,897	88,966
High management	3,331	166,550
Geriatric admissions	4,213	73,912
Geriatric long-term / nursing	4,316	77,063
Research	1,959	163,265
Deaf	1,825	107,350
Tuberculosis	421	84,236
TOTAL	\$41,981	\$90,281

Note: revised projections include reallocation of overhead – thus addition of the research and deaf units have revised costs that are higher than strictly the amount of the additions.

Dorothea Dix Hospital

Under the Three Hospital Model, all beds and units at Dorothea Dix Hospital will be eliminated. The services previously provided by the Hospital will be provided by Cherry Hospital and John Umstead Hospital. Cherry Hospital will assume a total of 132 beds of the 430 beds provided by Dorothea Dix (note: 430 beds are the remaining beds after adjustments outlined in the Four Hospital Model). Cherry Hospital will assume 31 beds of adult admissions, 4 beds of high management, 37 beds of geriatric admissions, 32 beds of geriatric long-term / nursing, the research unit, and deaf unit. John Umstead Hospital will assume 298 beds previously provided by Dorothea Dix Hospital. John Umstead will assume 19 beds of youth services, 24 beds of adult admissions, 122 beds adult long-term, and will assume the medical/surgical and pre-trial evaluation (forensic) units.

The revised bed configuration at Dorothea Dix Hospital results in the following:

<u>Unit / Ward</u>	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	51	(51)	0
Adult admissions	70	(70)	0
Adult long-term	128	(128)	0
High management	4	(4)	0
Geriatric admissions	37	(37)	0
Geriatric long-term / nursing	49	(49)	0
Medical / surgical	31	(31)	0
Pre-trial evaluation (forensic)	102	(102)	0
Research	12	(12)	0
Deaf	17	(17)	0
TOTAL	501	(501)	0

Based on removal of all beds at Dorothea Dix Hospital, the projected expenditure savings are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$ 8,322)
Adult admissions	(10,036)
Adult long-term	(14,760)
High management	(461)
Geriatric admissions	(4,242)
Geriatric long-term / nursing	(5,515)
Medical / surgical	(8,531)
Pre-trial evaluation (forensic)	(10,347)
Research	(2,216)
Deaf	(2,340)
TOTAL	(\$ 66,771)

Under the revised service configuration presented under the Three Hospital Model, total expenditures remaining at Dorothea Dix Hospital for the operation and maintenance of hospital grounds are estimated at \$2,521,000. This conservative estimate of persistent costs provide DMHDDSAS and Dorothea Dix the necessary resources to continue to maintain the site until alternative plans are developed for the campus.

Finding 6

The State should establish a special Dorothea Dix Mental Health Transfer Account that would account for all of the savings and revenue operations accrued from hospital downsizing. All operational savings should be budgeted to this new fund before being allocated to County Programs. If revenue opportunities are created as a result of the closure of Dix, for example through lease agreements of the land or property, a portion of that money should be placed in the Transfer account will be crucial for the state agencies to regain the public's trust in its financial management of mental health resources. The Dorothea Dix Transfer Account will add an opportunity for public review and scrutiny of the process.

John Umstead Hospital

John Umstead Hospital maintains primary responsibility for the northern region of DMHDDSAS, under the Three Hospital Model. As indicated earlier, John Umstead Hospital along with Cherry Hospital will serve the southern region that was previously served by Dorothea Dix Hospital. John Umstead Hospital is required to add additional beds above their current level to accommodate the reduction in services at Dorothea Dix Hospital. In order to accommodate the changes required under the Three Hospital Model, John Umstead Hospital is required to add an additional 125 beds to their current configuration. The addition of these beds does raise John Umstead’s capacity above existing levels, however, sufficient space exists on the campus to accommodate these new beds. During the most recent MGT of America study, a total of seven wards (approximately 150 beds) were identified as potential patient care areas which are more than sufficient to accommodate the increase.

Despite an overall increase in beds, the Hospital is required to remove some beds in favor of others, due to poor admission practices of the Area Programs. John Umstead Hospital must remove 6 beds from the youth unit/ward, 38 beds from adult admissions units/wards, and 85 beds from the geriatric long-term/nursing units.

In order to serve populations previously served by Dorothea Dix Hospital, John Umstead Hospital would remove only 6 beds from the youth unit/ward instead of the original 25 beds in the Four Hospital Model. Additionally, the Hospital would remove 39 beds from the adult admissions unit instead of the original 63 beds proposed in the first scenario. The geriatric long-term / nursing units are still required to reduce 85 beds. John Umstead Hospital will provide three new types of services above those currently offered. A total of 122 beds will be added to the Hospital for adult long-term units/wards, 31 beds for a medical/surgical unit, and 102 beds for forensic units/wards.

Based on reconfiguration of beds at the State Psychiatric Hospitals, the projected expenditure savings at Umstead Hospital are as follows:

Unit / Ward	Current Beds	Changes in Beds	Future Beds
Short-term and long-term youth	64	(6)	58
Adult admissions	150	(38)	112
Rehabilitation	136	0	136
Adult long-term	0	121	121
High management	40	0	40
Geriatric long-term / nursing	123	(85)	38
Medical / surgical	0	31	31
Forensic	0	102	102
TOTAL	513	125	638

The increase in beds identified above result in several changes to inpatient units/wards. It is presumed that one adult admissions unit/ward will be closed along with three geriatric long-term / nursing units/wards. The reduction of 6 youth beds will have little impact on ward configuration. The addition of adult long-term beds can be accommodated by the vacant space created by reductions in the adult admissions and geriatric long-term/nursing units/wards. The addition of the medical/surgical unit/ward and the forensic units/wards will require renovation of currently unoccupied space.

Based on reconfiguration of beds at the State Psychiatric Hospitals, the projected expenditure *increases* at John Umstead Hospital are as follows:

<u>Unit / Ward</u>	Changes in Expenses (000's)
Short-term and long-term youth	(\$ 683)
Adult admissions	(2,781)
Rehabilitation	0
Adult long-term	9,697
High management	0
Geriatric long-term / nursing	(8,040)
Medical / surgical	6,987
Forensic	8,940
TOTAL	\$14,120

Under the revised service configuration presented under the Three Hospital Model, total patient care expenditures by unit/ward are as follows including the projected unit cost per bed.

<u>Unit / Ward</u>	Revised Proj. Cost (000's)	Projected Cost per Bed
Short-term and long-term youth	\$ 9,118	\$157,198
Adult admissions	13,096	117,980
Rehabilitation	9,786	71,955
Adult long-term	9,983	81,827
High management	7,495	187,381
Geriatric long-term / nursing	5,669	149,188
Medical / surgical	7,193	232,040
Forensic	9,204	90,235
TOTAL	\$71,544	\$112,137

The total cost savings under scenario two, the Three Hospital Model, is as follows:

Unit / Ward	Revised Proj. Cost (000's)	Changes in Expenses (000's)	Proj. Ave Cost per Bed
Broughton Hospital	\$54,397	\$(6,671)	\$105,013
Cherry Hospital	41,981	(8,886)	90,281
Dorothea Dix Hospital	2,521	(66,771)	N/A
John Umstead Hospital	74,495	14,120	112,137
TOTAL	\$173,394	\$(65,687)	\$103,591

Note: In projecting the average cost per bed, the \$2.5 million of expenditures remaining at Dorothea Dix is removed as there are no longer beds at the Hospital. These costs should be classified as non-patient care costs and not be considered in projecting the average cost per bed.

Finding 7

The Three Finding Hospital model average bed cost is \$103,591 per bed; 12% less than the Four Bed Model of \$117,658 per bed and 2% less than the current cost of \$105,307 per bed. The decrease in average cost per bed is due to the reduction of general overhead expenditures from Dorothea Dix that would be removed if the Hospital were closed.

REVENUE IMPLICATIONS

The revenue implications associated with the Three Hospital Model are considered in the following chart for each facility by each of the four major payor classifications:

Payor	Broughton Hospital	Cherry Hospital	Dorethea Dix Hospital	Umstead Hospital	TOTAL
Medicare	\$ 3,877	\$ 1,553	\$ -	\$ 5,606	\$ 11,036
Medicaid	7,574	8,438	-	7,139	23,152
Third Party	2,413	1,795	-	3,320	7,529
PATIENT CARE	13,865	11,786	-	16,065	41,717
NON PATIENT	3,921	4,408	3,119	2,360	13,808
DSH	32,852	26,439	-	51,889	111,180
TOTAL REVENUE	\$ 50,638	\$ 42,634	\$ 3,119	\$ 70,314	\$ 166,704

Note: Figures are in Thousands (\$ 000's)

It should be noted that although \$111 million (net FFP) of expenditures are eligible for reimbursement under the Federal DSH program, provisions under OBRA 93 limited the States ability in FY 99 to claim these expenditures to \$96.6 million.

Based the projected revenues and expenditures, the net state cost of the Three Hospital Model, excluding the impact of the Federal changes to the DSH program are as follows:

	Broughton Hospital	Cherry Hospital	Dorothea Dix Hospital	Umstead Hospital	TOTAL
PATIENT REVENUE	\$ 13,865	\$ 11,786	\$ -	\$ 16,065	41,717
PATIENT EXPENSES	54,397	41,981	2,521	74,495	173,394
NET STATE COST	(\$ 40,532)	(\$ 30,195)	(\$ 2,521)	(\$ 58,430)	(\$ 131,677)

Note: Figures are in Thousands (\$ 000's)

Finding 8

The revised net state cost under the patient care areas of the Three Hospital Model results in savings of \$51.4 million. Under the original scenario the net state patient care cost was projected at \$183 million. Savings related to the Three Hospital Model are 13.2 million higher than those projected in the Four Hospital Model.

The impact of the Federal changes to the DSH program under the Three Hospital Model is as follows:

Federal Fiscal Year	Total DSH Cap (FFP)	IMD DSH Cap (FFP)	IMD DSH FFP (FY99 & Proj)	Change in IMD DSH (FFP)
1999	272,000	149,573	148,112	1,461
2000	264,000	145,174	148,112	(2,938)
2001	250,000	125,000	148,112	(23,112)
2002	236,000	94,400	148,112	(53,712)
2003	245,440	80,995	111,180	(30,185)

Note: Figures are in Thousands (\$ 000's)

The Three Hospital Model projects a decreased reliance on the DSH program as services are moved to the community. This decrease results in a smaller impact on the State as a result of Federal changes to the DSH program. The projections outlined in the Three Hospital model show a decreased reliance on DSH by \$6 million annually over those identified in the Four Hospital Model. The chart and analysis above solely assesses the impact of BBA 97 on the DSH funding independent of the OBRA 93 requirements. This assumes that all IMD DSH eligible expenditures will be eligible for reimbursement, which may not be the case as it is impacted by aggregate State DSH expenditures.

SPECIALTY UNITS WITHIN THE STATE HOSPITALS

The State Psychiatric Hospitals in North Carolina currently provide a variety of other non-psychiatric services for state-wide target populations. These populations were not considered in our earlier analyses as it focused on the general psychiatric services and the admissions practices of the Area Programs into these programs. As North Carolina reviews the current configuration of its State Hospitals, this presents a unique opportunity to reevaluate these specialty units to determine if the State should continue to provide these services at the State Hospitals or find alternatives to delivering this care.

The non-traditional psychiatric programs identified above include the medical / surgical units at Broughton (22 beds) and Dorothea Dix (31 beds) Hospitals, the Tuberculosis Unit (5 beds) at Cherry Hospital, and the Research Unit (12 beds) and Deaf Unit (17 beds) at Dorothea Dix Hospital. These programs currently occupy a total of eighty-seven beds in the State Hospitals. In order to evaluate these programs to determine their

appropriateness at the State Psychiatric Hospitals, we must first review the make-up of these units to see who is being served. In order to understand who is served in these units, our analysis focused on the recent MGT of America study of the State Hospitals.

Specific Programs at Individual Hospitals

The tuberculosis unit at Cherry Hospital is a five bed, state-wide unit serving patients diagnosed with tuberculosis, who have refused treatment or are non-compliant with their medications. Patients admitted to this unit are not required to have a psychiatric diagnosis, but instead are referred by county health departments. This program offers the State an alternative placement of a difficult population to serve as their condition requires “isolation” from general wards, however, these patients require only minimal nursing support. The units nursing services are provided by the staff of the Nursing Unit, resulting in only minimal incremental operating expenditures. However, this program does occupy five inpatient beds which could be used to provide psychiatric services.

The medical / surgical unit at Dorothea Dix Hospital provides inpatient and outpatient medical services to DMHDDSAS and DOC patients on a statewide basis. Clinical services include clinics, surgery, dental, therapies, and radiology services. The Hospital offers a critical care unit on hospital grounds which provide a full range of medical care for these patients. This unit is affiliated with both the UNC and Duke teaching programs. The 31 bed units are separated to allow for the efficient management of both the DOC and DMHDDSAS populations. Although this segregation is necessary, it reduces the effectiveness of the program as it acts as two separate and distinct units in terms of admissions, and the segregation hinders the ability of staff to share responsibilities. The two distinct populations within the medical / surgical unit at Dix complicates the recommendations for this unit. State Psychiatric Hospitals generally are ill-equipped to efficiently provide the full array of medical services required by this population. Although they offer relief, these hospitals are designed and focused on the care and treatment of psychiatric patients. Other community providers can more effectively care for the medical conditions of these patients.

Broughton Hospital houses a twenty-two bed medical surgical unit which provides the highest intensity of medical services at the Hospital. This unit provides surgical and general medical care on an inpatient and outpatient basis. It was noted that the unit operates similarly to a community hospital medical / surgical unit.

Dorothea Dix Hospital houses a seventeen bed deaf unit to serve the statewide population. The unit is operated by mental health staff trained to communicate in sign language. Unlike some of the other state-wide programs, this specialty unit does require mental health/psychiatric staffing in order to effectively treat this population.

A twelve bed clinical research unit is also located on the grounds of Dorothea Dix Hospital. This unit is a collaborative program with the local State University’s Department of Psychiatry. The conditions of patients in State Psychiatric Hospitals have provided the University fertile research grounds as many of the conditions found at the Hospitals are rarely found outside these institutions. The unit offers patients access to clinical trials and has provided clinical staff access to the research environment enhancing the ability of the Hospital to retain and attract employees.

Secondary Observations

Based on the information above and our experience in other mental health and chronic care systems across the country, our recommendation is to remove many of these programs from the Psychiatric Hospitals, for both clinical and financial reasons. Clinically, patients in medical units and in some instances the nursing units at the Hospitals are faced with chronic medical conditions. North Carolina has chosen to serve these patients in the State Hospitals as excess capacity exists in these facilities, not because it is clinically appropriate to serve patients in this environment. Financially, these patients are being served in an Institute for Mental Disease where access to traditional Medicaid coverage is limited to the populations either under 21 or over 64 years of age. Patients with chronic medical conditions typically are eligible for reimbursement from Medicaid and as such the State is not maximizing reimbursement of this target population, particularly in light of recent change to the IMD DSH regulations. In some cases these units are not even certified for reimbursement from the Medicaid program.

Patients served in the State Hospitals for psychiatric conditions do, on occasion, have demand for specific medical care, however the current capacity far exceeds these demands. The nursing units primarily serve the chronic medical populations of North Carolina. The State must develop a strategic plan to serve this target population in the most effective manner. These patients generally have exhausted current community alternatives, and as a result end up at the State Hospitals. North Carolina must build capacity within their existing system to serve this population. This may require additional investment by the State to develop programs specifically designed to treat this vulnerable population.

Effect on Individual Programs

Cherry Hospital should close the five bed tuberculosis unit. The State must either find a residential program that is willing to develop a small community based program for this target population, or the State should contract with a community hospital for the provision of these services.

The medical / surgical units at Dorothea Dix and Broughton should be closed in favor alternative medical programs in community hospitals and nursing homes. The Department of Corrections must contract with a new provider for the medical care currently provided by Dix. This change in delivery must be carefully considered as the care and treatment of a correctional population poses new challenges for the State. The 22 bed medical / surgical unit at Broughton Hospital should also be considered for closure. The State should contract with a community based medical provider for the short term care and treatment of medical conditions of its psychiatric populations and investigate alternative means of treating the chronic care populations currently served at the Hospital. The treatment of chronic health conditions should not be the responsibility of the State Psychiatric Hospital.

The State should maintain capacity within its system to treat deaf patients in their State Hospitals, either within Dorothea Dix, or transfer this unit to one of the other State Hospitals. This program is a psychiatric program designed to assist patients transition into the community. An alternative to providing this care at the Hospital, would be for the State to partner with a local provider to develop alternative means to treat this population. Our primary recommendation is to maintain the program as a DMHDDSAS program, although there are various options as to how this care can be provided. The State must develop a strategic plan on how to deliver the most effective care at the lowest net state cost.

DMHDDSAS should move the research unit to one of the other State Hospitals (Umstead Hospital has been chosen in our Three Hospital Model as an option) if the State chooses to implement the Three Hospital Model. DMHDDSAS should continue the university affiliation to maintain the research environment, and to offer patients access to the clinical trials of the State University.

Other Observations

Additional review of this recent study by MGT of America indicates that other programs within the four State Psychiatric Hospitals might more appropriately be classified as non-psychiatric treatment. For example, the ten-bed Nursing Unit at Cherry Hospital (one of the areas *not* targeted for downsizing in the analysis above) is described as primarily a medical/surgical ward providing post-surgical and other less intensive medical care. The proposed reduction of the Nursing Facility (154 beds) in the two scenarios described earlier in our report remove the intermediate care and skilled nursing populations that are currently served at Cherry. The removal of this capacity removes most (all but the 10 bed nursing unit) of the chronic medical capacity that currently exists at the Hospital.

The 62 bed Nursing Unit at Broughton Hospital primarily treats medical conditions with one of the three wards serving as an infirmary, while the other two treat more chronic medical conditions. These wards were characterized as being similar to many of the chronic medical units at community hospitals in other parts of the State. The two proposed scenarios above projected the downsizing one of the three wards in this unit.

The 34 bed Nursing Facility at Umstead Hospital that is proposed for closure in the Four Hospital Model would remove all Umstead's capacity to treat patients with pure medical conditions – either acute or chronic care. Under the proposed Three Hospital Model, Umstead would house the 31 bed medical surgical unit that currently resides at Dorothea Dix Hospital, replenishing some capacity to treat medical conditions of patients at Umstead Hospital.

These other options on the services provided at the Hospitals detailed above offer the State another opportunity to analyze the current system of care in the State Hospitals to make it better. These options are not ordinarily available in the magnitude that they are today. Traditionally, State systems are slow to change, as is evidenced by the fact that North Carolina hasn't significantly changed their current system in many years. The State should take this opportunity to take a hard look at their current system and invest in a system that will ensure the quality of life of all its consumers.

STATE HOSPITAL SAVING FOR COMMUNITY BASED PROGRAMS

The two proposed scenarios for reconfiguring the State Psychiatric Hospital system will require significant efforts from the entire State system on many fronts. The proposed changes to the system will not only require organizational and operating change, but will require the State to make an additional investment into the system to finance these changes. It is important to reiterate that, due to changes in the Federal funding of the DSH program, the State will be required to find alternative funding sources in order to replace the Federal shortfall of DSH on the existing State budget. Although the proposed changes to the current mental health system require additional funding, these efforts will help to minimize the impact of the Federal funding shortfall imposed by OBRA 93 and the Balanced Budget Act of 1997 on the North Carolina State Budget.

The additional funding required to enhance community based services should be viewed as one-time or “bridge” funding of the system, although this funding will be over the five year transition. This funding should be viewed as “rounds” of funding over at least two years. This approach to bridge funding will provide the State with the flexibility to decide which patients should be removed first and provides the community with a mechanism to request additional funding of programs to support the downsizing.

The Federal funding shortfall created by OBRA 93 and BBA '97 are annual shortfalls that the State is forced to replace each year. The bridge funding is necessary in order for the State to maintain the existing system while the community builds capacity to serve patients currently residing at (or admitted to) the State Hospitals. As patients are discharged from the hospitals and units are closed to new admissions, the Hospitals will achieve saving. These savings will eventually be transitioned into the community where the patients will be served. Once the Hospitals are appropriately downsized and the community system of care is established, the State will no longer require this supplemental “bridge” funding. The State must carefully plan this implementation process to ensure that funding is truly “bridge” funding, not new funding of operations at the State’s Psychiatric Hospitals.

This implementation process must set realistic goals for projected savings from the State Hospitals and for available funding of new community programs for each of the five implementation years. This plan must not focus solely on financing arrangements but must, most importantly, be grounded in principles to ensure patients are provided the appropriate levels of clinical care.

Finding 9

The savings under the two scenarios presented earlier project the net reduction in State expenditures as a result of a change in service delivery. These savings are expected to be used to fund new programs at community based providers.

Most patients discharged from these Hospitals will have resources available to them to pay for this community based care. Some patients have third party resources such as Medicare, commercial insurance, and HMO coverage, while others are Medicaid beneficiaries and still others have no resources to pay for their treatment. The State must use the savings achieved from the downsizing of the Hospitals to fund the State’s share of Medicaid expenditures and for the care delivered to those individuals who have no ability to pay.

Federal regulations surrounding Institutes of Mental Disease prohibit Federal funding for Medicaid beneficiaries between the ages of 21 and 65 residing in facilities like North Carolina’s State Psychiatric Hospitals. If these same individuals received services in another, non-IMD, facility, Medicaid reimbursement and Federal funding would be available. Shifting the care of this population to the community will allow the State to leverage the State dollars to receive Federal reimbursement for these services. North Carolina does currently leverage State expenditures at the Psychiatric Hospitals through the DSH provision, however, the changes to DSH limit the State’s ability to do so in the future.

The savings achieved from the downsizing of State Hospital system in the two scenarios presented earlier can be used to leverage significantly higher third party payments, resulting in significantly more dollars available to community providers. For example, the projected \$38.2 million of operating savings achieved under the Four Hospital Model should support additional community programs of approximately \$71.2 million (\$68.8 million of fee for service and \$2.4 million of county contributions). These estimates assume that ten percent of the expenditures would be funded through non-State sources, such as Medicare, commercial insurance and other payors. This assumption projects that these non-State sources would fund \$6.9 million of care in the community. Additionally, we assumed that fifty-five percent of patients would qualify for Medicaid coverage. This assumption projects Medicaid expenditures of approximately \$37.9 million to fund the community system,

of which \$23.7 million will be funded by the Federal government leaving \$14.2 million to be funded by North Carolina. The State will invest the remaining \$24.0 million of operating savings from the Hospital downsizing in these community services to pay for the care of the indigent population. The remaining \$2.4 million is the local County contributions required to draw-down the State’s contribution for indigent care. This assumes that local Counties will invest an additional ten percent of the State’s funding of these programs above their existing county contributions. This State matching process would be administered through a negotiation process whereby the State prioritizes service needs and the availability of funding.

If the State chose to implement the Three Hospital model, projected savings are estimated at \$51.3 million, or \$13.2 million higher than the Four Hospital model. This level of savings would support additional community programs of approximately \$95.4 million (\$92.2 million of fee for services and \$3.2 million of county contributions). This is \$24.2 million higher than the service system created through savings under the Four Hospital Model. These estimates assume that ten percent of the expenditures would be funded through non-State sources, such as Medicare, commercial insurance, and other payors. This leads to \$9.2 million of funding from these non-State sources for community services. Additionally, fifty-five percent of patients would qualify for Medicaid coverage. This lead to \$50.6 million of funding by Medicaid, of which \$31.6 million is funded by the Federal government and \$19.0 million by the State. The State will invest the remaining \$32.4 million of operating savings from the State Hospital downsizing to fund the care for the indigent population. Counties will be required to invest \$3.2 million in order to draw-down the State’s contribution for indigent care.

The following chart depicts the incremental differences of the two scenarios.

	Four Hospital Model (\$38.2M of Savings)	Three Hospital Model (\$51.4M of Savings)	Variance
Non-State Revenue	\$ 6.9	\$ 9.2	\$ 2.3
Medicaid	37.9	50.6	12.7
State only (DMH)	24.0	32.4	8.4
County Contribution	<u>2.4</u>	<u>3.2</u>	<u>0.8</u>
Total Comm. System	\$ 71.2	\$ 95.4	\$ 24.2

Note: Figures are in Millions

This chart again highlights the advantages of the three hospital model over the four hospital model. The incremental operating saving (\$13.2 million) achieved under the three hospital model equate to an additional \$24.2 million in new community services with no incremental state dollars.

These are a few of many options available to the State to finance the care of patients in the community. As the State begins the process of implementing change to this system, these factors must be clearly articulated and thoroughly analyzed to ensure the validity of these estimates. These scenarios have been developed with the best information available, however the implementation of this plan requires another level of detail than provided in this plan. Implementation requires detailed review of all assumptions, reviewing target populations of the Hospitals and in some cases an individualized plan must be developed in order to successfully discharge patients into the community. This level of detail has not been conducted in this planning stage as our plan took a global look at the statewide system of care. This detail planning must be done as implementation draws near.

STATE HOSPITAL SERVICE SYSTEM - CONCLUSION

There are three major drivers leading to the need to change the way North Carolina provides mental health services statewide. These three drivers are:

- the decaying infrastructures of the North Carolina's Psychiatric Hospitals;
- the industry trend toward community based service delivery, highlighted by the Olmstead case; and
- Federal limitations on the funding of Mental Health services under traditional Medicaid and DSH.

These factors have led to development of this study and will ultimately result in system-wide changes to the way mental health services are delivered in North Carolina. This study surveys the current system of care, identifies strengths and weaknesses in this system, and lays a plan for implementing change to a more appropriate means of serving mental health consumers in North Carolina. This section of the report identified the financial implications of the proposed changes highlighting the savings to be achieved through the downsizing of the State Hospitals.

This section of the report identifies the savings associated with two individual scenarios for reducing the capacity of the Hospitals. These are strictly proposed scenarios and should be viewed as such. The projections were based on the admitting practices of Area Programs, not by reviewing the individuals that currently reside in the Hospitals. This factor is important during implementation. This analysis indicates that some DMHDDSAS regions potentially have deficient local resources to treat target populations. For example, the data suggests that the eastern region does not have sufficient resources to treat patients admitted to the nursing units thus these patients are admitted to Cherry. As the State implements this plan, the eastern region must create new programs in the community to treat these individuals locally as the Hospital will no longer have capacity to serve these patients in the State Hospital.

The two scenarios proposed in this report compare in the same number and type of bed reductions at the State Hospitals. This fact allows for relative comparison of the two scenarios to determine the impact of savings. The Four Hospital model projects operating savings of \$38.2 million from the State Hospital system. These savings would be available to fund additional community based programs as an alternative to State Hospital care.

The Three Hospital model projects net state savings of \$51.4 million as a result of the downsizing of the State Hospital system. This is significantly, \$13.2 million or 34%, higher than projected in the Four Hospital model. This additional saving provides the State alternatives to delivering care in the community and/or provides DMHDDSAS with funding of new programs/initiatives to treating their consumers.

No matter which path the State ultimately decides to choose for their Mental Health system of care, North Carolina will be faced with a shortfall in their State budget as a result of Federal changes to the DSH program. This shortfall is expected to be as much as \$15.6 million *annually* in Federal funding of their State Budget.

The following chart depicts the current net state cost of operating the four state hospital under the “do nothing” scenario. The current operating costs of the Hospitals do not include the impact of the Federal changes to IMD DSH on the State Budget as the impact remains unchanged in the three models due to limitations imposed in OBRA 93. This baseline scenario is then compared to the two scenarios to assess the financial impact on the State Budget.

Scenarios	Projected Net State Cost (Patient Care)	Change in Net State Cost from Null Hypothesis	Change in Net State Cost from Four Hospital Model
"Do Nothing" Scenario	\$ 183,085	\$ -	N/A
Four Hospital Model	\$ 144,870	\$ 38,215	\$ -
Three Hospital Model	\$ 131,677	\$ 51,408	\$ (13,193)

Note: Figures are in Thousands (\$ 000's)

Operational savings realized from the State Hospitals will be transferred to the community for the establishment of community based alternatives for delivering this care. These operating savings will result in significantly more dollars in community services. It is expected that savings from the Four Hospital model will earn \$71.2 million in the community and \$95.4 million from the Three Hospital model. These projections assume that ten percent of the services will be provided by other non-State sources, fifty-five by Medicaid, and the remaining thirty-five percent will represent free care services paid for by DMHDDSAS. An additional \$2.4 and \$3.2 million, respectively, will be funded by local Counties as they are required to expend ten percent of the DMHDDSAS funding in order to draw down these State funds.

These figures indicate that North Carolina could achieve significant incremental savings (\$13.2 million) from operations under the Three Hospital model as this model is able to eliminate significantly more overhead expenditures that the Four Hospital model cannot. Additionally, operating savings under the Three Hospital model will “earn” \$24.4 million additional community services over the Four Hospital model. The savings identified above do not include the savings associated with not building or remodeling the Dorothea Dix campus which requires significant (projected to be at least \$20 million) capital funding that would not be required under the Three Hospital model (see Section 2.3 for details).

In summary, the Three Hospital model provides an additional \$24.4 million in annual community service funding over the Four Hospital model and requires at least \$20 million more in capital investment of the Dorethea Dix Hospital campus.

OVERVIEW OF CURRENT COMMUNITY BASED SERVICE SYSTEM

The consistency and capacity of mental health and substance abuse services varies widely among North Carolina's 39 Area Programs and across geographic regions, with the exception of the Willie M. program. Third party and County funding sources available to Area Programs directly impact the amount and types of services provided by these programs. Most Area Programs provide a core set of services including: medication clinics, outpatient counseling, some version of psychosocial rehabilitation (day treatment, clubhouse, drop-in center) and some supported housing. Although most programs provide these services, differences exist within these services in their levels of accessibility, provisions for urgent care, availability of inpatient resources and mobile services, and in their use of the state hospitals. These differences make Area Programs look more different than alike.

Adult mental health services are more comprehensive and abundant statewide than services for children, adolescents and individuals in need of substance abuse services. Through joint ventures and internal initiatives some Area Programs have developed full continuums of care including assessments, outpatient treatment, day treatment and residential care for children and adolescents. Other Area Programs lack this full complement of services, particularly in intermediate care required to "step-down" patients from inpatient and residential services. The limited State funding dedicated to providing these programs hinders the Area Programs' ability to develop these service continuums, which, in turn, forces clients to remain in more costly types of care, as evidenced by the over-use of the State Psychiatric Hospitals.

The range of services offered to the substance abuse population is narrower than the range for mental health as many Area Programs struggle to maintain an adequate offering of services. Many Area Programs depend heavily on local emergency rooms to provide care to intoxicated individuals and lack intensive rehabilitation services to address on-going detoxification needs. A few Area Programs have developed more extensive substance abuse continuums; however, these programs are very expensive to operate and currently maintain a high utilization rate leaving little room to expand capacity.

INTRODUCTION TO THE BASIC BENEFIT PACKAGE

The lack of adequate funding to support a similar array of targeted services is one of the primary causes for the inconsistency of services across the State. The wide variation of service offerings throughout North Carolina provides consumers significantly different levels of care based on their location. In order to address this issue, PCG proposes development of a basic benefit package implemented statewide making these core services available to all North Carolinians regardless of location. The basic benefit package is funded by DMHDDSAS for those consumers who have no third party resources to pay for their care while other clients care will be subsidized by Medicaid, Medicare, commercial insurance and self-pay reimbursement. Local County government is responsible for funding any additional services based on the needs of the individual counties involved. The goal of the basic benefits package is a consistent array of services regardless of location and a reliable State operated funding mechanism.

The model for arriving at the cost of this basic benefit package is looked at in two-phases. The first phase consists of a detailed analysis of the clinical services available within the various continuums of care. This phase focused specifically on those services with the greatest need. These services were reviewed to ensure the existence of standards of clinical practices similar to other states within the various methods of delivering care. Based on the information obtained through these reviews, a model was developed for a basic benefit package for North Carolina. PCG envisions that the services of the basic benefit package would be provided by each participating County Program and funded by the State and other revenue sources. Services included in the basic benefit package attempt to define the core services necessary to effectively treat each citizen of North Carolina regardless of location or ability to pay.

As described in the Services Section of our report, the basic benefit package includes but is not limited to:

Assessment Services

- Up to three sessions (50 minutes each) for individual and/or family assessment by a masters prepared clinician privileged in specific age and disability category of the consumer being evaluated
- Case management services
- One session (up to 50 minutes) of initial psychiatric evaluation
- Psychological testing, if indicated, to clarify eligibility for intensive services

Acute Care Services – Mental Health

- Urgent assessment by a masters prepared clinician privileged in specific age and disability category of the consumer being evaluated; available twenty-four hours per day, 365 days per year
- Up to 15 days of inpatient treatment, or
- Conversion of unused inpatient benefit to hospital alternatives on a two for one basis (i.e., two days of alternative care for every one day of hospital). Covered services include: residential; day; intensive outpatient or in-home treatment
- Initial psychiatric consultation and medication follow-up visits
- Six individual or family outpatient sessions, or
- Conversion of unused individual outpatient benefit to group treatment on a two for one basis

Acute Care Services – Substance Abuse

- Urgent assessment by a masters prepared clinician privileged in substance abuse; available twenty-four hours per day, 365 days per year
- Up to 5 days of medically monitored inpatient detoxification (ASAM level III.7)
- Up to 10 days of clinically managed residential treatment (ASAM level III.5)
- Conversion of unused inpatient and residential days on a two for one basis (i.e., two days of non-inpatient care for every day of inpatient or residential care) to intensive community services including intensive outpatient, partial hospital, day treatment, group and/or individual outpatient treatment
- Initial psychiatric consultation and medication follow-up visits
- Six individual or family outpatient visits, or
- Conversion of unused individual sessions to group treatment on a two for one basis (i.e., two group visits for every unused individual visit)

The availability of a basic benefit package ensures a consistent level of care between the County Programs. A reliable well-defined funding mechanism allows the State to distribute the funds allocated by the General Assembly on an equitable basis. A consistent and predictable State funding mechanism also allows County Programs to accurately budget their operational revenue. In addition, County Programs are provided the opportunity to expand services based on the individual needs of the region using local dollars to fund the extended delivery of care.

The second phase of our analysis develops a model used to estimate the cost of the basic benefit package. In this phase, PCG's goal is not to provide a *specific* dollar cost of the benefit package, but instead provide a reasonable estimate of what such a benefit package should cost. This provides a starting point for discussion purposes and illustrates a simple methodology to estimate costs. For development of this model, PCG was provided with a significant amount of financial and utilization data by the State. The data was often inconsistent

and sometimes conflicting between various sources making it difficult to estimate the true cost of the benefit package with a high degree of certainty. Some data necessary to estimate costs, such as utilization rates of individual services, were unavailable. Where the data provided conflicted or was unavailable, we were forced to make assumptions based on our experience in other states and our knowledge of North Carolina’s MH/ SA system.

METHODOLOGY FOR PROJECTING THE COST OF THE BASIC BENEFIT PACKAGE

PCG analyzed current utilization statistics among individuals with mental health and substance abuse diagnoses to determine the number of people who will access the delivery system based on historical utilization rates. This estimate was then used to project utilization within the basic benefit package. Current Medicaid rates were used to calculate the total cost associated with the projected utilization of each benefit package component: inpatient treatment, residential services, intensive outpatient treatment, therapeutic foster care and outpatient treatment services. This report does not necessarily endorse the use of Medicaid rates to determine the cost of the basic benefit package, however, they provide the most comprehensive utilization and reimbursement data of any North Carolina payor. Finally, the benefit package cost was compared to current community revenue to determine the level of service that exists within the current delivery system.

Utilization data for the model is based on information received from the State and our experience in other mental health delivery systems. Utilization estimates are based on expected utilization rather than the maximum benefit in basic package. For example, we estimated two assessments per client rather than the maximum proposed benefit of three assessments as only a small number of clients are expected to utilize three assessments. Expected utilization rates provide a more realistic estimate of the projected cost than using maximum utilization rates.

The following is a detailed summary of the methodology used to calculate the net State costs of the proposed basic benefit package:

Component #1 – Complete Assessment Benefit

The first component of the basic benefit package is the initial assessment. The assessment is performed by a master’s level social worker to determine the medical necessity of services required to appropriately care for the client. Each new or acute client entering the system will be provided an assessment by the local County Program. Using FY 98-99 data, we estimated the annual number of new mental health and substance abuse clients to be 99,913. Each of these clients will require an assessment to determine their eligibility for the benefit package. We estimated that most clients require two sessions at a cost of \$84.72 per session (the current Medicaid rate for Individual Outpatient Treatment Services).

Assessment	MH	SA	Total
Total Assessments	71,480	28,433	99,913
Maximum # Of 60 Minute Sessions/Episode	2	2	2
Maximum # Of 60 Minute Sessions	142,960	56,866	199,826
Cost Per Unit (Current Medicaid Rate)	\$84.72	\$84.72	\$84.72
Cost Of Assessment Benefit	\$12,111,571	\$4,817,688	\$16,929,259

In addition, on-going case management services are required to ensure the appropriate coordination of care. We assumed that eighty percent of clients will receive one sixty minute case management session. The current Medicaid cost of a sixty minute case management session is \$72.

Case Management	MH	SA	Total
Total Case Management Units	71,480	28,433	99,913
Estimated Utilization Rate	80%	80%	80%
Estimated Number of Case Mgmt Units	57,184	22,746	79,930
Cost Per Unit (Current Medicaid Rate)	\$72.00	\$72.00	\$72.00
Cost Of Case Management Benefit	\$4,117,248	\$1,637,712	\$5,754,960

Finally, we assumed forty percent of the new clients require psychiatric consultation to determine the appropriate level of care. Again, the current Medicaid rate was used to estimate the cost of this service.

Psychiatric Consults	MH	SA	Total
Total MH Assessments	71,480	28,433	99,913
Estimated Utilization Rate	40%	40%	40%
Estimated Number Of Psychiatric Consults	28,592	11,373	39,965
Cost Per Unit (Current Medicaid Rate)	\$84.72	\$84.72	\$84.72
Cost Of Psychiatric Consult Benefit	\$2,422,314	\$963,521	\$3,385,835

By adding the estimated costs of the assessment, the associated case management and the required psychological consultations, the total cost of the assessment component of the basic benefits package is approximately \$26 million.

Component # 1 Total	MH	SA	Total
Cost Of Assessment Benefit	\$12,111,571	\$4,817,688	\$16,929,259
Cost Of Case Management Benefit	\$4,117,248	\$1,637,712	\$5,754,960
Cost Of Psych Consult Benefit	\$2,422,314	\$963,521	\$3,385,835
Total Cost Of Complete Assessment Benefit	\$18,651,133	\$7,418,920	\$26,070,054

Once the assessment is complete, each client is eligible to receive any of the following services inpatient, substance abuse or other mental health services through the basic benefit package. Based on current utilization data and our knowledge of the delivery system, PCG estimated the total number of potential clients to access the system under the proposed structure. The following is a brief description of the services and respective costs within each of the components of the benefit package.

Component #2 – Inpatient Acute Treatment Benefit

The cost of the Inpatient Acute Treatment Benefit is estimated based on current utilization rates of the four State Psychiatric Hospitals and an extrapolation of community hospital admissions. Based on FY98-99 utilization data, PCG estimates that a total of 3,641 acute admissions for inpatient care are required. The allocation between mental health and substance abuse is based on the current relationship of these services. The average length of stay is assumed at 12 days and the cost per day is estimated at \$400 based on current Medicaid reimbursement data adjusted to reflect the increased intensity of this service.

Inpatient Acute Admissions	MH	SA	Total
Inpatient Acute Admissions	2,913	728	3,641
Maximum Benefit Days (SA Includes 5 Detox)	12	12	12
Maximum # of Inpatient Days	34,956	8,736	43,692
Cost Per Day	\$400	\$400	\$400
Cost Of Inpatient Acute Benefit	\$13,982,400	\$3,494,400	\$17,476,800

The projected admission and utilization rates estimate that an additional 150 acute inpatient beds (assuming an occupancy rate of 80%) are required in the system to adequately served the psychiatric needs of North Carolinians and to support the downsizing of the State Psychiatric Hospitals. Some of these beds act as replacement beds for the 141 beds removed from the State Hospitals. It is important to note that our model does not assume a one for one replacement of State Hospital beds for community beds. The model assumes thirty to forty percent of current acute admissions to the State Hospital can be diverted to other programs identified in the basic benefit package such as those identified in component #3. Our projections estimate that a third of these beds are new beds to the system, not replacement beds for services currently provided by the State Hospitals.

Component #3 – Residential, Outpatient, Day Treatment, and Detox Services

In addition to assessment and inpatient acute benefits, the basic package also includes step-down and intermediate services. These benefits include residential services, intensive outpatient treatment, day treatment and therapeutic foster care. Note, the number of clients accessing these step-down and intermediate services is estimated based on our knowledge and experience.

Our model projects that five percent of patients assessed will require an inpatient stay in a residential program at an average length of stay of eight days. The reimbursement rate is based on the current Medicaid rate. Utilization projections for this program estimate that an additional 130 residential beds are required in the current system of care, assuming an eighty percent occupancy rate.

Residential Services	MH	SA	Total
Maximum # Of Assessments (Minus Inpatient)	68,567	27,705	96,272
Est. % Of Assessments Resulting in Residential	5%	5%	5%
Est. # Of Assessments Resulting In Residential	3,428	1,385	4,813
Average # Of Residential Days Per Client	8	8	8
Est. # Of Residential Benefits Days	27,424	11,080	38,504
Weighted Cost Per Benefit Day	\$106	\$106	\$106
Cost Of Residential Benefit	\$2,906,944	\$1,174,480	\$4,081,424

It is expected that ten percent of patients assessed will require intensive outpatient treatment. Patients who enter this program are expected to receive a total of twenty-five units of service. The cost per unit of service is based on the current Medicaid rate.

Intensive Outpatient Treatment (IOP)	MH	SA	Total
Maximum # Of Assessments (Minus Inpatient)	68,567	27,705	96,272
Est. % Of Assessments Resulting In IOP	10%	10%	10%
Est. # Of Assessments Resulting In IOP	6,857	2,771	9,627
Average # Of IOP Units In Benefit	25	25	25
Est. # Of IOP Units In Benefit	171,425	69,275	240,700
Cost Per Benefit Unit	\$84.72	\$84.72	\$84.72
Cost Of IOP Benefit	\$14,523,126	\$5,868,978	\$20,392,104

An additional ten percent of patients assessed will require day treatment. Patients who enter this program are expected to receive a total of twenty-five units of service. The cost per unit of service is based on the current Medicaid rate.

Day Treatment	MH	SA	Total
Maximum # Of Assessments (Minus Inpatient)	68,567	27,705	96,272
Est. % Of Assessments Resulting In Day Tx	10%	10%	10%
Est. # Of Assessments Resulting In Day Tx	6,857	2,771	9,627
Est. # Of Units Of Day Tx	25	25	25
Est. # Of Day Tx Days (6 Hrs/Day)	171,425	69,275	240,700
Cost Per Benefit Day	\$84.72	\$84.72	\$84.72
Cost Of Day Tx Benefit	\$14,523,126	\$5,868,978	\$20,392,104

An additional ten percent of mental health patients assessed will require therapeutic foster care. Mental health patients who enter this program are expected to receive a total of twenty-five units of service. The cost per unit of service is estimated based on the expected cost and the relative cost of similar programs. In the proposed basic benefit package, therapeutic foster care services are not available to the substance abuse population.

Therapeutic Foster Care	MH	SA	Total
Maximum # Of Assessments (Minus Inpatient)	68,567	NA	68,567
Est. % Of Assessments Resulting In Foster Care	10%	NA	10%
Est. # Of Assessments Resulting In Foster Care	6,857	NA	6,857
Est. # Of Foster Care Days Per Client	25	NA	25
Est. # Of Foster Care Benefit Days	171,425	NA	171,425
Cost Per Benefit Day	\$50	NA	\$50
Cost of Therapeutic Foster Care Benefit	\$8,571,250	NA	\$8,571,250

Component #3 Total	MH	SA	Total
Estimated Total Cost Of Component #3	\$40,524,446	\$12,912,436	\$53,436,507

Component #4 – Outpatient Treatment Services

For patients requiring less intense mental health and substance abuse services, the basic benefits package includes lower intensity services. These services are designed to assist clients transition from more intensive services, and as a preventative mechanism to assist clients in their current settings. These services include Individual and Group Outpatient Treatment and medication follow-up.

The model estimates that thirty-five percent of the patients that are assessed and don't require acute inpatient treatment will require other alternative residential inpatient treatment. The remaining sixty-five percent of all assessments require outpatient treatment services. Of those clients receiving outpatient treatment fifty percent will receive individual treatment and fifty will receive group treatment. Both client groups were assumed to receive 6 treatment sessions. We used the current Medicaid rate to estimate the benefit cost.

The following is the estimated cost of this services along with the accompanying calculation.

Individual Outpatient Treatment	MH	SA	Total
Maximum # Of Assessments (Minus Inpatient)	68,567	27,705	96,272
Est. % Of Assessments Resulting In Outpt Tx	65%	65%	65%
Est. # Of Assessments Resulting In Outpt Tx	44,569	18,008	62,577
Est. % Outpt Tx Resulting In Individual	50%	50%	50%
Est. # Of Individual Outpt Tx	22,285	9,004	31,289
Est. # Of units Of Ind Outpt Tx	6	6	6
Total Units	133,710	54,024	187,734
Cost Per Benefit Unit	\$84.72	\$84.72	\$84.72
Cost Of IndividualTx Benefit	\$11,327,911	\$4,576,913	\$15,904,824

Group Outpatient Treatment	MH	SA	Total
Maximum # Of Assessments (Minus Inpatient)	68,567	27,705	96,272
Est. % Of Assessments Resulting In Outpt Tx	65%	65%	65%
Est. # Of Assessments Resulting In Outpt Tx	44,569	18,008	62,577
Est. % Outpt Tx Resulting In Group	50%	50%	50%
Est. # Of Group Outpt Tx	22,285	9,004	31,289
Est. # Of Units Of Group Outpt Tx	6	6	6
Total Units	133,710	54,024	187,734
Cost Per Benefit Unit	\$12	\$12	\$12
Cost Of Group Tx Benefit	\$1,604,520	\$648,288	\$2,252,808

Our analysis assumes 50% of the non-inpatient acute population will receive four follow-up visits for medication management. The current Medicaid rate of a fifteen minute visit is used to calculate the benefit cost. The cost estimate does not include medication expenses.

Medication Follow-up	MH	SA	Total
Maximum # Of Assessments (Minus Inpatient)	68,567	27,705	96,272
Est. % Of Assess. w/ Medication Follow-Up	50%	50%	50%
Est. # Of Assess. w/ Medication Follow-Up	34,284	13,853	48,137
Est. # Of Units Per Assessment	4	4	4
Est. # Of Medication Follow-Up Units	137,136	55,412	192,548
Cost Per Unit	\$21.18	\$21.18	\$21.18
Cost Of Medication Follow-Up Benefit	\$2,904,540	\$1,173,626	\$4,078,167

	MH	SA	Total
Estimated Total Cost of Component #4	\$15,836,972	\$6,398,827	\$22,235,799

The following is a cost summary of the four basic benefit package components:

Total Cost	MH	SA	Total
Component #1 – Assessment	\$18,651,133	\$7,418,920	\$26,070,054
Component #2 – Inpatient/Detox	\$13,982,400	\$3,494,400	\$17,476,800
Component #3 – Step-Down	\$40,524,446	\$12,912,436	\$53,436,882
Component #4 – Outpatient Services	\$15,836,972	\$6,398,827	\$22,235,799
Total	\$88,994,951	\$30,224,584	\$119,219,535

NET STATE COSTS OF THE BASIC BENEFIT PACKAGE

The total benefit package cost estimate of \$119M does not represent total *additional* State costs over current funding levels. The proposed basic benefit package includes many services which are already delivered by Area Programs and are funded by State, Federal, County, commercial and self-pay revenue. To estimate the net State costs to provide the basic benefit package, the current service complement must be compared to the services within the benefit model. For example, we estimate the cost of the benefit package to be \$119M this should be compared to current community mental health and substance abuse revenue of \$387M (revenue includes State, Medicaid, commercial, Medicare and self-pay sources). This comparison indicates that the basic benefit package should represent between twenty-five and thirty percent of the service complement for Area Programs, assuming some expansion of services.

	MH	SA	Total	Current Community Revenue
<u>Total Benefit Package Cost</u>	\$88,994,951	\$30,224,584	\$119,219,535	\$387,200,000

Our analysis recognizes that a large portion of the current community revenue is reimbursement for services outside of the basic benefit package. Because patient specific data was unavailable, we are unable to estimate how much of the \$387M is for services within the basic benefit plan and how much is for services outside the plan. Additionally, some components of the basic benefit plan may not yet exist or does not exist at the required capacity. Based on the total community revenue currently in the system and our knowledge of the array of services provided, we believe a significant portion of the services required under the basic benefit package already exist in the system, thus the majority of the costs of these services are also included. Therefore, the basic benefit package does not represent entirely new costs to the State or other payors, but rather a blend of new and existing costs to the current system. Although the benefit package is expected to increase the cost of the community based system of care, we believe the State will ultimately save money through the implementation of the basic benefit package, due to Federal constraints on payments to the State Psychiatric Hospitals under Medicaid and DSH.

To maximize third party revenue, and to offset State/County costs, we strongly recommend that the State provide technical and financial resources to help County Programs implement effective billing and collection policies. Area Programs historically have had difficulty collecting revenue from non-State sources due to the complex regulatory environment and the current lack of focus on reimbursement in these programs. Many Area Programs do not have the administrative infrastructures or technical capabilities to effectively manage these revenue functions in their current state.

Additionally, Area Programs are chartered to provide care regardless of the clients ability to pay. This mandate limits their ability to dictate the types of clients they serve. With respect to self-pay clients, PCG recommends the implementation of a standardized, statewide sliding fee scale to determine a client’s ability-to-pay. The implementation of a statewide sliding fee scale provides uniform measures for all Area Programs on levels of patient responsibilities. This will shift some of the States responsibilities to the Area Programs potentially leading to reductions in the net state cost. (see Section 2.5for a more detailed analysis)

After accurate and consistent data is collected, State reimbursement for the basic benefit package could be automatically adjusted to reflect more accurate volume and cost estimates, or a quarterly/annual revenue adjustment could be made (similar to the current Willie M. adjustment). The State could also choose to reduce State funding to Area Programs who do not maximize non state revenues shifting this financial responsibility to the sponsoring County.

TARGET POPULATIONS

The basic benefit package proposed by PCG is designed for new, acute care clients entering the system. After clients deplete their maximum benefits in the basic package or are no longer in need of acute care, they may become eligible for target population benefits. Target populations are defined as clinically similar clients in need of services for whom a specific allotment of funds is made available for reimbursement purposes. PCG proposes that the State, in partnership with Counties, identify specific categories of clients who are in need of additional services outside of the basic benefit package. Services for target populations would be partially paid for by the State and supplemented by Counties. Utilization and costs of target population benefits would be controlled primarily at the State level by varying the funding of these programs. This targeted approach provides DMHDDSAS the flexibility to use these funds to develop new programs in the community or expand existing programs. For example, if the State identifies a high need for aggressive youth services, they could provide supplemental funding as the program builds capacity, or they can provide supplemental funding where third party reimbursement rates are inadequate, or can provide a host of other alternatives to assist these targeted populations. These proposals must be negotiated by Counties with the State. During negotiations, the State will determine the level of funding of each proposal to ensure that the needs of the entire system are considered. In addition to target populations identified in partnership between the State and Counties, the Counties could also identify target populations on their own accord. Services for these non-State identified target populations would be funded 100% at the County level.

THE BASIC BENEFIT PACKAGE – CONCLUSIONS

The State should begin implementation of a basic benefit package to ensure the consistency of mental health and substance abuse services across North Carolina. The first step in this implementation process must include clear definition of the services to be included within this benefit and the associated level of benefit within each service. This report begins this process by proposing such a package. The services included in this benefit package should serve as the starting point for discussions between the State and Counties. After the services have been defined, the State must begin the process of projecting the costs associated with these services to determine the funding necessary to support such a system. The cost model presented in this report provides a starting point for this model. Although this model includes many assumptions, we believe it provides a reasonable estimate of the total cost of the basic benefit package. A more accurate projection of these costs would require actuarial projections and a more thorough review of historical data that was outside the scope of this report. Despite the potential for variances in our projections, PCG is advocating for the concept of a basic benefit package with consistent services across the State and a standard reimbursement mechanism funded primarily by the State. In addition to the basic benefit package costs, costs associated with serving the target populations must also be included in the analysis to determine an aggregate system-delivery cost. Furthermore, revenue from other sources including Medicaid, Medicare, commercial insurance and self-pay must be approximated to calculate a net-State cost associated with the basic benefit.

To assist in developing a model to determine the true costs of the basic benefit package PCG recommends that the State complete the following steps:

1. *Obtain accurate utilization data:* The first and most difficult step to determine true benefit package costs is to obtain accurate utilization data. This data is critical to ensure the basic benefit package meets the needs of North Carolinians and also fairly compensates County Programs for the provision of services. As stated previously, PCG is unaware of any accurate Statewide data that is available on a per client basis (i.e., the number and type of services utilized by each client). Client specific data is important because the basic package assumes a maximum benefit per client. For example, the State might reimburse two, ten day inpatient stays but would only pay for a maximum of 15 days for any individual inpatient. It is likely that the development of appropriate information systems to collect necessary utilization data could take 3-5 years. Therefore PCG recommends identifying statistically valid sample utilization data from existing patient information (specific patient identifying information could be deleted to ensure there is no breach of confidentiality). Statewide utilization could then be actuarially developed based on the sample data.
2. *Determine the basic benefit package components using utilization and cost data:* PCG has proposed a four component benefit package which includes both inpatient, alternative and outpatient care. The benefit package should be developed in partnership with the Counties and should reflect clinical, advocacy, actuarial and financial perspectives. Additionally, the benefit should reflect, not only current utilization, but should “focus” care in historically needy but unmet demand areas.
3. *Identify true service costs:* Current cost allocation methodologies, including the Fiscal Monitoring and Cost Finding Reports, are reflective of what costs “are” rather than what costs “should be.” For example, inpatient costs are reported as the rate an Area Program is able to negotiate. Therefore, an Area Program that has an inexperienced negotiator may report costs that are greater than an Area Program which employs a more senior negotiator (multiple costs are evidenced by the fact that PCG has identified community providers which have numerous rates for different Area Programs for the same service). If the State hopes to control overhead expenses and drive-down system costs, reimbursement must be based on the “true” costs rather than on reported expenses. True service costs should not be artificially inflated due to poor cost allocation methodologies or improper data collection techniques. True service costs should, however, reflect *appropriately* allocated administrative overhead expenses. In the long-term, accurate cost finding reports should be developed and used as the basis for benefit package rate setting. In the short-term, true service costs can only be identified by performing a detailed audit of Area Programs which are identified as best practices in terms of controlling costs. True service costs should not simply be the lowest cost provider; rather they should be reflective of high quality and positive outcomes as defined by both the State and County Programs.

4. *Develop benefit package costs:* Using the true cost data identified in the previous step, the benefit package rates can be set to reflect both short and long-term State and County goals. If the State identifies an unmet need, the rates for those services can be adjusted above the true costs to incentivize County Programs to provide those services. Conversely, if some services are being over utilized, the State can lower reimbursement below the true costs. However, these types of supply-side initiatives should focus primarily on target populations rather than the basic benefit package. The basic benefit package is designed for new and acute patients. By decreasing reimbursement for those clients, the State would negatively incentivize County Programs to treat only existing patients and to provide as few services as possible to new or acute clients.
5. *Identify non-State revenue:* Once the benefit package and rates are determined, non-State revenue must be estimated. Non-State revenue includes Medicaid, Medicare, commercial insurance and self-pay. This revenue should be estimated based on the data obtained in step one of the model and the benefit package developed in step two. State reimbursement for basic benefit package services should be net of all non-State reimbursement received by the County Program. In other words, County Programs should not be reimbursed twice for providing the same basic benefit package service.
6. *Develop target populations and reimbursement:* In addition to developing a basic benefit package for new and acute clients, the State and Counties must also develop target population benefits and reimbursement. Target populations should be identified at both the State and County level. For State identified target populations, funding for services should be reimbursed in some part by the State (e.g., the State may reimburse County Programs 50% of costs). For those target populations identified by Counties but not the State, the Counties would be entirely liable for the cost of services. Counties should identify target populations based on special needs of their catchment area. Again, State reimbursement for target populations can be adjusted to drive utilization at the community level.
7. *Ongoing system “maintenance:”* All system components (utilization data, basic benefit package, reimbursement and target populations) should be reviewed and updated annually to ensure services and reimbursement are consistent with the current delivery system environment. Additionally, reimbursement rates and target populations should be set prior to County budget cycles to ensure County Programs have all information necessary to develop sound, accurate budgets.

While PCG’s model is limited in its ability to accurately project the true cost of the benefit package, due to data constraints, we feel that it provides a basic framework from which a more accurate and reliable cost methodology can be developed. A sound, actuarially developed model can and should be developed by the State in partnership with Counties and advocacy groups.

FINAL RECOMMENDATIONS FOR DOWNSIZING THE STATE HOSPITALS AND THE BASIC BENEFIT PACKAGE

This section of our report projects savings under two scenarios for a smaller State Psychiatric Hospital system. These projections propose a reduction of 667 beds from the State Hospital system, one projection with four state hospitals the other with a three hospitals. These projections indicate that a total of \$50.2 million of patient care operating expenses can be removed from the State Hospitals under the Four Hospital model, with a net state savings of \$38.2 million due to reductions in non-State revenues earned at the Hospital. These projections are significantly higher under the Three Hospital model. Under the Three Hospital model, a total of \$67.5 million of patient care operating expense can be removed at a net State savings of \$51.4 million over the current system. This indicates that the Three Hospital model is able to save the State an additional \$13.2 million over the Four Hospital model. These savings are annual savings to the State's mental health and substance abuse system of care.

Despite the savings to be achieved from a smaller State Hospital system, changes imposed under the Balanced Budget Act of 1997 reduce the Federal funding of the States' Psychiatric Hospitals. The reductions in Federal funding exist in all three models, (baseline, Four Hospital, and Three Hospital) despite changes to the cost of services delivered at these institutions. The changes imposed in the Balanced Budget Act of 1997 will reduce the Federal funding of the existing State Psychiatric Hospital system by \$15.6 million annually.

The current community-based service system is inconsistent and lacks reliable funding from the State. The inconsistency of services throughout North Carolina results in consumers receiving varying levels and access to services based on their location, not on their needs. In an effort to provide uniform services Statewide to all consumers who require services, PCG proposes development of a basic benefit package. This benefit package provides a core set of services to new or acute consumers to ensure appropriate assessment of their mental health and substance abuse needs. Once these needs are assessed, individuals requiring additional services will enter a target population, and clients requiring limited services will receive these services through the basic benefit package.

The savings achieved under the downsizing of the State Hospitals must at least support the provision of their care in the community. Any additional savings remaining after these treating these consumers would be available to fund the basic benefit package. These elements are related as the absence of a fully developed statewide system of care has resulted in the inappropriate use of the State Hospitals. The implementation of a Basic Benefit Package will assist in diverting these inappropriate admissions and supports a smaller State Hospital system.

The charts on the following pages depict the savings available from the downsizing of the State Hospitals to fund the Basic Benefit Package. Some basic assumptions were included in development of these charts. Acute care services currently provided in the Four State Psychiatric Hospitals will be paid for under the Basic Benefit package. Assumptions were made on the cost of youth, adult long-term, and geriatric long-term services. These assumptions were based on Medicaid costs, adjusted for the intensity of services required by this population.

The projected replacement costs, excluding acute care services, is projected to be \$33.5 million. This represents the total cost of care, not the State's cost in providing these services. Comparing these replacement costs to the savings projected under the two scenarios indicate that significant savings remain to fund the Basic Benefit Package. The savings remaining under the Four Hospital Model are projected to be \$37.7 million and \$61.9 million under the Three Hospital Model. These projections leave \$81.6 million and \$54.4 million, respectively, of costs associated with the Basic Benefit Package unfunded. The current community based system of care provides \$387 million in mental health and substance abuse services throughout the State. It is reasonable to assume that many of the services covered under the Basic Benefit Package already exist in the system and in fact are already funded within this system.

Our model indicates that it is reasonable to presume that current annual operating funds within DMHDDSAS might be sufficient to support the downsizing of the State Hospitals and the funding of the Basic Benefit Package. It is important to note that these savings are not sufficient to support the necessary bridge funding, capital funding, or to recover the loss of the Federal funding of DSH.

In order for DMHDDSAS to fund these changes within their current operating funds, the “ unfunded” portions of the Basic Benefit Package identified under the Four Hospital Model requires that twenty-one percent of these services exist within the current system. The Three Hospital Model requires that fourteen percent of these services exist within the system. These are reasonable presumptions of levels of funding for mental health and substance abuse services that currently exist within the community-based system.

Finally, we believe the areas of primary concern and need for enhancement are youth and substance abuse services. These service systems will require significant funding and attention to ensure a comprehensive system of care is developed statewide. We believe that many of the necessary adult services exist within the current system. This is not to say that these adult services don’t require attention, but rather that youth and substance abuse services require additional attention.

The recommendations proposed in this section of our report require significant attention and planning as the State begins implementation. As the State begins the process, these recommendations must be reviewed and recast to reflect any known changes to the delivery system. Our report indicate that North Carolina’s system of care can change and achieve these results through appropriate planning and an implementation process which includes support from the State, Counties, consumers and advocates.

2.7 Implementation

PROJECTED TOTAL ANNUAL COSTS OF THE FOUR HOSPITAL MODEL & BASIC BENEFIT PACKAGE

Service Component	Capacity	Units	Cost per Unit	Total Cost	
Adult Acute Admissions	141 Beds	N/A	N/A	N/A	Cost of A under the
Short-term and Long-term Youth Services (projected at 90% occupancy)	107 Beds	35,150	\$ 400 / day	\$ 14,060,000	
Adult Long-term Admissions (projected at 90% occupancy)	93 Beds	30,551	\$ 175 / day	\$ 5,346,425	
Geriatric Long-term Admissions (projected at 95% occupancy)	326 Beds	113,041	\$ 125 / day	\$ 14,130,063	
Total Replacement Cost of Community Based Programs (excluding Acute Care)	526 Beds	178,742	N/A	\$ 33,536,488	Replacem exclude th
Total Beds Removed from the State Psychiatric Hospital System	667 Bed Reduction	N/A	N/A	\$ (71,200,000)	Total esti potential
Savings Available to fund the Basic Benefit Package	N/A	N/A	N/A	\$ (37,663,513)	
Total Cost of the Basic Benefit Package				\$ 119,219,535	
Unfunded cost of Basic Benefit Package (level of service required from existing system)	N/A	N/A	N/A	\$ 81,556,023	Total Cor current sy

2.7 Implementation

PROJECTED TOTAL ANNUAL COSTS OF THE THREE HOSPITAL MODEL & BASIC BENEFIT PACKAGE

Service Component	Capacity	Units	Cost per Unit	Total Cost	
Adult Acute Admissions	141 Beds	N/A	N/A	N/A	Cost of A under the
Short-term and Long-term Youth Services (projected at 90% occupancy)	107 Beds	35,150	\$ 400 / day	\$ 14,060,000	
Adult Long-term Admissions (projected at 90% occupancy)	93 Beds	30,551	\$ 175 / day	\$ 5,346,425	
Geriatric Long-term Admissions (projected at 95% occupancy)	326 Beds	113,041	\$ 125 / day	\$ 14,130,063	
Total Replacement Cost of Community Based Programs (excluding Acute Care)	528 Beds	178,742	N/A	\$ 33,536,488	Replacem exclude th
Total Beds Removed from the State Psychiatric Hospital System	667 Bed Reduction	N/A	N/A	\$ (95,400,000)	Total esti potential
Savings Available to fund the Basic Benefit Package	N/A	N/A	N/A	\$ (61,863,513)	
Total Cost of the Basic Benefit Package				\$ 119,219,535	
Unfunded cost of Basic Benefit Package (level of service required from existing system)	N/A	N/A	N/A	\$ 57,356,023	Total Cor current sy

INTRODUCTION

The success of a state's mental health system reforms to accomplish its intended goals depends upon: (a) a strategy that includes widespread support from legislators, state mental health officials, consumers and families, advocates and providers and (b) an implementation plan that balances the goals of system change with the realities of public management and financing requirements. Many reforms have passed the first test only to succumb to the pressures of an implementation process that could not reconcile the pressures of daily management with major system change. It is helpful to look at other states that have attempted substantial reforms and have been able to achieve many of their goals.

Recently, the U.S. General Accounting Office reviewed four states that have had certain measures of success implementing major changes in their mental health system using Federal waivers: Washington, Colorado, Massachusetts and Iowa. In addition, PCG has had experience with Pennsylvania, Michigan, Alaska, Ohio, Massachusetts, Delaware, Vermont and New Hampshire planning and implementing substantial changes in their service delivery structure, financing and contracting. From these twelve states we have derived the following lessons to provide guidance for the North Carolina implementation process.

1. It is not necessary to convert the whole state system at once. A phased in process can be used over time for large, complex systems.
2. It is helpful to have an oversight group representing consumers , families, public officials, and legislators monitor and guide the implementation process against the goals of reform. The oversight group is not the subject of the changes, but serves as a trustworthy and credible third party committed to transforming the system.
3. Managing daily business operations should be maintained organizationally apart from detailed planning for the new initiatives. They can be coordinated by policy, until the new initiatives are ready for implementation, and can be brought under the umbrella of operations.

We have kept these lessons in mind as we developed the implementation process that follows.

PCG recommends a North Carolina implementation process that occurs in three phases: (I) legislative, (II) planning and (III) system roll-out. Each phase has distinctive responsibilities and objectives and each is overseen by an entity of state government. Assuming it begins in April 2000, full implementation is expected to take approximately five years. It is important to note that during that time frame North Carolina is administering two systems, the current Area Program model and the replacement County Program model. The restructuring of developmental disabilities is accomplished during the first two phases of implementation, as well. The implementation process that follows is based on the recommendations in this report. Significant changes in this approach may, of course, require changes in this process.

PHASE I – ENABLING LEGISLATION

Implementation of the new governance structure and financing recommendations will require substantial changes in Chapter 122C and Chapter 159 of North Carolina Laws.

The change in statutes should clearly establish the ability of the State to enter into contracts with Counties for mental health, developmental disabilities and substance abuse services as well as enabling county governments to provide such services in a variety of structures. It should not create “unfunded mandates” for the Counties, but should establish county financial contributions to the new system. The new enabling legislation should allow for and encourage Counties singularly, and through multi-county associations, to administer the State’s local MH/DD/SAS system. The role of the local Board structure and Advisory Committees, should be identified in general terms, but their should be specific requirements to involve knowledgeable consumers, family members and advocates for MH/DD/SAS services in the county governance structure.

Specific attention should be paid to the changes required in the purchase of services and reimbursement rates (122C – 147.2) and responsibilities of those receiving appropriations (122C – 151).

It is assumed that this could be accomplished during the FY2000 legislative session, ending in June, 2000. If the changes in enabling legislation are not completed during the short session, the following steps still hold, but the timelines will need to be reconsidered.

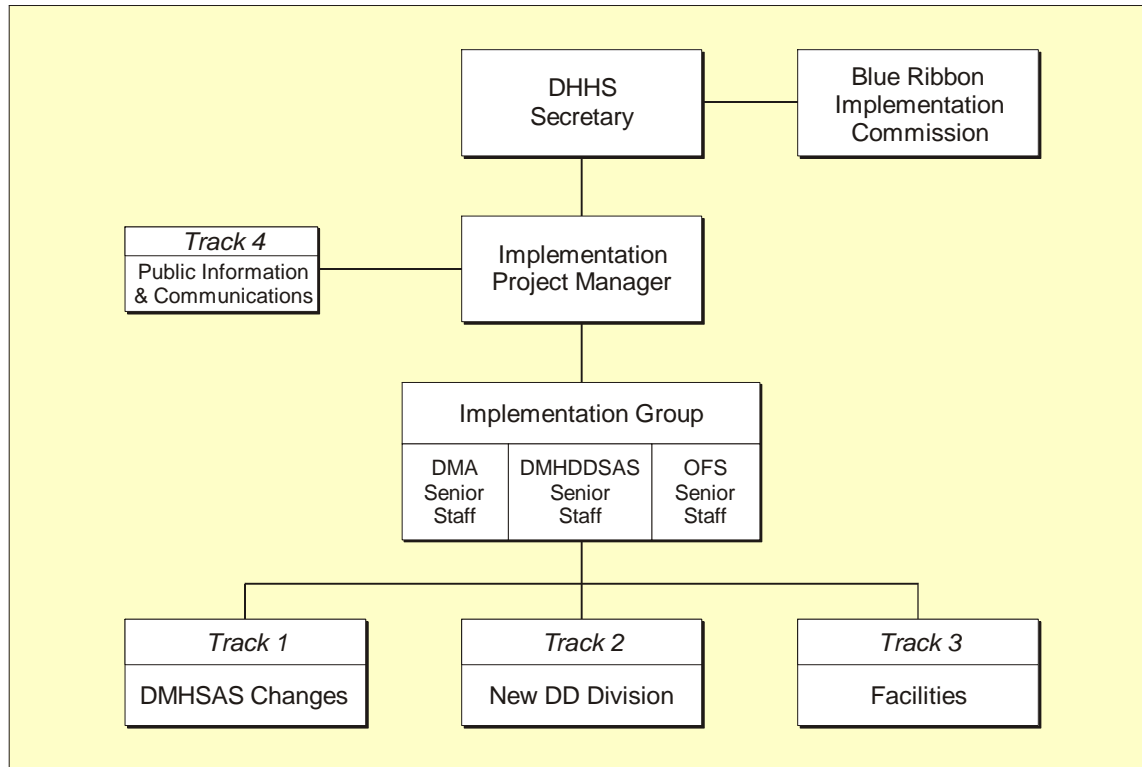
PHASE II – IMPLEMENTATION PLANNING

Implementing the changes in the State’s MH/DD/SAS enabling legislation, as well as the policy recommendations of this Report, will require an intensive and broad based planning process that we estimate will take eighteen months. We see the planning work proceeding on three separate but related tracks: (1) mental health structure, services and finances, (2) developmental disabilities organizational change and (3) state hospital masterplanning. In addition, there is a critical fourth track for public information and communications, including working directly with county management and County Commissioners.

It is essential to have a credible and trustworthy public body oversee this work. We recommend establishing a special Blue Ribbon Implementation Commission for a period of five years for this task. Two thirds of its membership should be comprised of Legislative leadership and interested state senators and representatives, with a third of the members appointed by the Governor to represent consumers, family members and advocates of those whom the public service system serves. Representatives from participating counties also should be on the Commission. The Commission should be designed to oversee and approve all major steps and decisions of the process, and should go out of business (“sunset”) at the end of implementation.

The planning staff work should have a structure that can coordinate efforts, as well as provide leadership for the work apart from daily operations. This should be handled by the Department of Health and Human Services, under the leadership of the Secretary, who oversees all the state agencies essential to implementation: DMHDDSAS, DMA and the Division of Facility Services. A high level project manager who reports to the Secretary will be needed to direct and coordinate the work. He/She will need senior level staff drawn primarily from the affected agencies, to do the detailed work.

The organizational chart below illustrates this proposed structure:



The products of the Implementation Group will be reviewed on a regular basis, perhaps monthly, by the Legislative Blue Ribbon Implementation Commission. Each track should be directed by a senior manager from DMHDDSAS, with additional staff input from DMH, DMA and Facilities. It is expected that this structure would stay intact for the eighteen months of implementation planning and would cease to exist before the roll out process begins.

TRACK #1 - DMHSAS POLICIES AND OPERATIONS

The senior staff involved in this track would focus on the tasks and products necessary to overhaul the Division policies and operations related to administering mental health and substance abuse services.

Task A - Services

This report has proposed a number of new service concepts, or changes to existing services, that will require more detailed work before they can be implemented. Also, current service policy and guidelines will need to be reviewed and revised.

Products (examples)

- basic benefit standards and definitions
- target population benefit standards and definitions
- state hospital replacement service standards and definitions
- state hospital bed allocation methodology
- state hospital target size and service mix
- state hospital downsizing plan

Task B – Finance and Financial Operations

The purpose of this task is to conduct the necessary financial analyses, develop the required financial tools, prepare the FY2002 budget in accordance with the new legislation and prepare the financial packages for the county contracts.

Products (examples)

- final cost models for all benefit packages and state hospital replacement services
- rate determination and purchase of services methodology for basic benefit package and target population services
- standard cost finding methodology and reimbursement rates for the County programs administrative cost.
- allocation of new state funds; county matching requirements
- hospital downsizing cost model and resource reallocation projections and targets
- state hospital bed charges to county by type; e.g. acute, long term, child and adolescent, substance abuse
- Medicaid revenues and other third party revenue projections
- disproportionate share revenue impacts under the 1997 Balanced Budget Act
- FY2002 budget impact; projections for FY2003 through FY2005 budgets
- County contract financial operational requirements

Task C – Human Resources

The purpose of this task is to review the impact of the legislation and organizational and service on human resource policies and operations. It is anticipated that there could be substantial changes on staff at State hospitals, affected State offices and Area Programs that will require a specific human services approach.

Products (examples)

- human resource impact analysis for employees in the State hospitals, State offices and Area Programs.
- transition policies and process for employees at state hospitals
- transition policies and process for Area Program employees
- financial impact of human resource changes
- proposal for further legislative changes, if necessary, to protect the State and Area Program employees during the transition.

Task D – Division Structure and Operations

The purpose of this task is to review and propose changes in the DMHSAS's organizational structure, its operational roles and responsibilities, and relationships with the Counties, DMA and DDD.

Products (examples)

- revised central office organizational structure and job descriptions
- creation of regional offices, structure, responsibilities, staffing pattern and job descriptions
- Memorandum of Understanding between the DMHSAS, DMA, DDD and the Counties.

TASK E – COUNTY CONTRACT DOCUMENTS AND PROCUREMENT PROCESS

The purpose of this task is to prepare the necessary procurement and management documents required for implementation.

Products (examples)

- State/county contract model
- Request for Application (RFA) documents for county procurement process
- Procurement process and timelines
- Evaluation criteria
- Award and start-up process
- Readiness review protocol

TRACK #2 – DEVELOPMENTAL DISABILITIES RESTRUCTURING AND SERVICES

During implementation the developmental disabilities system will need to simultaneously address two critical topics: how developmental disabilities services are managed in the new county program structure, and the final design and implementation of the new developmental disabilities structure. It is anticipated that both will be addressed during the eighteen months implementation plan. *Senior staff from developmental disabilities services should be fully involved in all of this work.* In a separate track, the restructuring of developmental disabilities management will be finalized for the central office. The following tasks and products will be required.

Task A - Organizational Structure and Personnel Actions

- search process for new Developmental Disabilities Division director
- roles, responsibilities and staffing pattern in the division
- functional job descriptions; schedule of existing or new positions

Task B – Future of Developmental Disabilities Services

- final plan for community based developmental disabilities services and finances that will become part of the MOU with Medicaid and the contract with the County Programs
- study of the role and future of the Regional Centers, with particular attention to compliance with the Olmstead decision.

Task C – Financial Analysis

- FY 2002 budget of new agency
- financial analysis of service and Regional Center recommendations

Task D – Office Plan

- Office space plan
- equipment purchases
- renovations
- moving contract and schedule

TRACK #3 – STATE HOSPITALS AND FACILITIES

The primary focus of this track is planning the changes required at the four State hospital campuses. However, it is possible that additional facilities may become involved. In particular, university affiliated teaching hospitals and local general hospitals should become the site of certain inpatient care now provided at the State's four hospitals. This could involve renovation and/or construction at sites other than the state hospitals, as well as a competitive bid selection process designed to meet DMHSAS requirements.

It is important that the facilities are viewed as the capital side of the State's restructuring of the mental health system. All hospital design, renovation and construction decisions, and timetables must be directed by the service, structure and financial tasks and products discussed above. In particular, the closure of Dorothea Dix Hospital, will require centralized system wide planning to ensure that services are available and resources are appropriately allocated throughout implementation before clients and staff are moved. It should also include the creation of the Dorothea Dix Mental Health Transfer Fund, designed for the purpose of providing bridge funds for the start up of community services aimed at reducing the size and role of state hospitals. The following tasks are listed as a starting point for work to be done.

Task A - Facility Masterplans for Umstead, Broughton and Cherry Hospitals

The purpose of this task will be to finalize decisions on the future use of buildings at Umstead, Broughton and Cherry Hospitals consistent with the planned changes in local services and use of Dorothea Dix Hospital. The masterplans should address the long term improvements at all three hospitals, ensuring the State's commitment to quality public psychiatric inpatient care. The masterplans will lead to new construction and renovations at all three campuses.

Task B - Closure Plan for Dorothea Dix Hospital

The purpose of the closure plan for Dorothea Dix Hospital is to support the planned movements of clients and staff. Capital planning should follow service planning. The State should make building decisions that are in the state's long term interests and that will ensure a safe environment throughout the process, protecting the public health and safety of its clients and staff. It is assumed that this task will include representatives from the Cherry and Umstead Hospitals so that all inpatient resources will be appropriately used and coordinated.

Task C – Dorothea Dix Mental Health Transfer Account

The purpose of this track is to establish a special transfer account and the policy and budgetary guidelines for how it will be used. It should include funds transferred from the state hospitals due to downsizing as well as potential revenue earned from the Dorothea Dix land and buildings.

Task D - Private Psychiatric Facility Improvements

Plans to move acute inpatient services to the community will require a business relationship between the State, counties and local hospitals. The purpose of this task is to determine the State's policies that may support renovations at community and/or university affiliated hospitals. This support could come from capital investment in the form of service reimbursement rates, loans, direct financial investment or in the case of public universities, inter-state agency agreements.

TRACK #4 – PUBLIC INFORMATION AND COMMUNICATIONS

The primary focus of this track is to provide ongoing public information and communication on the State's MH/DD/SAS goals and progress reports on restructuring the community delivery system. The public communication process should focus first on re-establishing trust. It will be critical for the State to re-establish the confidence of consumers, advocates, families, providers, administrators and other stakeholders in the system. Secondly, but just as critical, an outreach effort to counties will be needed to make the case for their participation in the new system. This case will need to be made directly to the County Commissioners and County Managers across the State. Both processes will create interaction with stakeholders and county officials that will contribute to further ideas and suggestions for the implementation group to consider.

Task A – Public Information

Products (examples)

- Legislative Oversight Commission public hearings
- press releases and interviews
- Newsletter
- Web site

Task B – County Communication

Products (examples)

- Presentations to Commissioners/Managers
- Regional meetings among counties
- County briefings and proposed working documents

PHASE III – ROLL OUT PROCESS

The purpose of Phase III is to administer the process by which counties, working singularly and in groups, enter into long term (3 – 5 year) contracts with DMHSAS and DDD by which they will assume State funds, authority and responsibility for providing MH/DD/SAS. It is assumed that not all counties will be prepared to enter into contracts initially, and that the state will have to administer a dual system for several years while the County Program model is phased in. During this time, DMHSAS and DDD will continue to administer a system that is comprised of a declining number of Area Programs and a growing number of County Programs.

The heart of the process will be a Request for Application (RFA) in which counties will demonstrate their interest, commitment and capacity to enter into contracts with the State. They will be measured against state-wide standards, not against each other, hence an RFA process, not a competitive bidding process.

The RFA will encourage counties to form voluntary associations with each other. This could be done under different auspices such as local inter-county agreements, new county authorities, councils of governments, contracts and other legal mechanisms, so that eligible residents will have access to a wide range of services and the Counties will be able to establish a full range of cost effective administrative functions. It is anticipated that most single Counties will not be able to meet the State's service, management and financial standards and that partnerships of counties will need to be formed across the State. In some cases, they will be based on current Area Program configurations, in others, new partnerships of counties will emerge. The State will determine the criteria that drives counties to form these associations voluntarily. The state will not independently determine the boundaries.

Pre-Qualification

The purpose of pre-qualification is twofold: 1) for the State to assess whether the counties are prepared to become County Programs, where they may need help, and how many are ready to successfully respond to an RFA process; and 2) for the Counties to assess whether they wish to take over these management responsibilities, and how they will achieve it. This will give the counties the opportunity to initiate discussion among commissioners, county managers and current Area Programs. They will learn how they can come together for the RFA, and begin developing new partnerships, or retooling existing ones. This should create an active learning process for the counties as they will gain a more detailed understanding of how they can develop proper organizational responses for the new County Programs, including the nature of county partnerships and the models of management, within, or outside of county government. The Counties' responses must show how consumers, families and advocates were involved in the process and how the Counties plan to continue their involvement. This step will allow trust to develop and emerge among the new local partnerships. Trust which will be the product of working together towards defining goals and learning first hand the interests and concerns that must be addressed by all parties. These issues must be decided before the state issues the RFA.

The pre-qualification process will request that the counties respond to the following topics:

- identify participating counties;
- develop agreements used (or under consideration) to bind the counties together to become County Programs;
- initial consideration of the transition of Area Program management and services;
- total mental health, developmental disabilities and substance abuse budgets to meet state service requirements;
- inventory of management functions provided by participating counties;
- preliminary plan for what services are to be provided directly by the Counties and what services are to be purchased;
- documentation of the County planning process with particular attention to the involvement of mental health, developmental disabilities, substance abuse consumers, families, advocates and stakeholders; and
- pre-qualification document signed by all Commissioners of participating counties.

The State should use the results of the pre-qualification process to determine: (1) which counties are prepared to go ahead; (2) what work will be required to get the remaining counties prepared and (3) how the RFA process (and contract) can be improved to reflect county concerns and issues. At the end of pre-qualification, the state will determine which counties will be included in the first round RFA process, and which will be held for the second round. The pre-qualification process is expected to take six months. We recommend it begin during the last three months of Phase II.

First Round Application Process

The first round procurement will focus on the counties the State has determined are ready to enter into contracts with the state to become County Programs. Only counties identified as ready during pre-qualification will be invited to bid as County Programs. The process will require counties to respond to the following sample of topics:

- County commitment evidenced by letters of commitment from the Boards of Commissioners of all participating counties;
- County Program proposed management team;
- County Program organizational structure, staffing and implementation process;
- County Advisory Council structure including proposed membership, responsibilities, authority and implementation process;
- the roles and responsibilities of consumers, family members and advocates in the new structure;
- detailed plan to provide the basic benefit package for eligible residents;
- detailed plan to provide services to target populations;
- detailed plan to provide substance abuse services;
- detailed plan to provide alternatives to hospitalization including a schedule for bed reduction goals to be achieved over three years;
- detailed plan for the provision of developmental disabilities services (per the requirements of the new Developmental Disabilities Division);
- plan for implementing and maintaining quality assurance standards and processes including a grievance process and commitment to ensuring clients rights, meeting state standards and data requirements;
- plan for financial operations including contracting, billing and claims processing, maximizing third party revenues, financial reports, and Medicaid Compliance monitoring;
- documentation of administrative costs;
- plans for utilization management that will satisfy DMA, DMHSAS and DDD requirements;
- supporting documentation from local stakeholders including community groups, advocates, consumers, families, etc;
- three years operations budget that demonstrates how the County Programs will meet State requirements within the financial allocations available to the member counties;
- transition plan for Area Program services and management responsibilities;
- plan for the transfer of Area Program assets and liabilities;
- demonstration of county financial commitment including cash, in-kind services, facilities, and other resources contributed to draw down state dollars for target populations and other new initiatives;
- willingness to sign the State contract; and
- documentation of the county process and its participants.

The application will not be price competitive. The state will clarify the resources available to the participating counties including: State hospital bed days available; funds for the basic benefit package, target population services, and developmental disabilities services; other state resources to be included in the RFA, calculated specifically for the populations included under contract. The RFA will include the dollars available for county matches for additional services to target populations.

Counties should have sufficient time to assemble the proposals with detailed supporting material. The State may request additional information or clarification before a final determination is made. Also, the state, in partnership with the NC County Association and NC Council, should make technical assistance grants and other resources available to counties in need of assistance in this process. We recommend that all counties must participate in this process, including counties with populations in excess of 425,000 (Wake and Mecklenberg Counties).

The State's review process should be organized to analyze all components of the application. It will include presentations and interviews, as well as site visits to counties and programs. The State should plan to contract with County Program's covering approximately one half the population by the end of the first round. It is expected that the RFA process would take nine months.

Once the State awards the contracts, the counties will be engaged in an implementation process that will require close coordination among the members of the county partnership, and the Area Programs involved in the transfer that may include staff, real estate and other assets and liabilities. The plan for this transfer will have been detailed in the RFA and approved by the State.

A key to an effective start-up of services under the new County Programs will be a formal readiness review by the State. The readiness review will be conducted under the auspices of DHHS and will have State managers representing mental health, developmental disabilities and substance abuse services, finance, Medicaid, information systems and other disciplines determined by DHHS. The purpose of the reviews will be to determine the counties ability to provide services, operations and governance as detailed in their contract. The DHHS readiness review team will provide technical assistance and help the counties complete their implementation process. The site visit should be conducted 90 days before the contract is scheduled to start. In most cases, it will be followed up by a second visit, close to the start date to determine final contract compliance. In some cases the readiness review team may recommend to the Secretary and the Counties that the start date should be rolled back to allow time for all aspects of the services, operations and governance plan to be fully functional. It is expected that the contract negotiation and readiness process would take six months following contract award, for a total of eighteen (18) months in the first roll-out round.

Second Round Application Process

The second round application process should complete the RFA process statewide. It would focus on the population not covered in the previous round. The steps in round two would be substantially the same as round one. We would expect modifications and improvements in the process determined at the end of the first round. The second round should be scheduled to take eighteen (18) months, comparable to the first round.

Counties Not Participating

We anticipate that a number of counties will not be prepared to meet the State’s requirements, or will not have sufficient resources to do so. This will be monitored from the pre-qualification process, ongoing communication and briefings with County governments and responses to the RFA process. It will be critical for DHHS to watch these situations closely to ensure that people served by these Area Programs do not lose access to services during implementation and that the financial and management integrity of these administrative entities is maintained.

In these cases, the State may exercise one of two options. The first is to explore the possibility of alignment with other groups of contiguous counties preparing RFA responses. This will be particularly helpful where the problem is primarily inadequate local resources. In this case, the State would play a “matchmaker” role, most likely with neighboring counties.

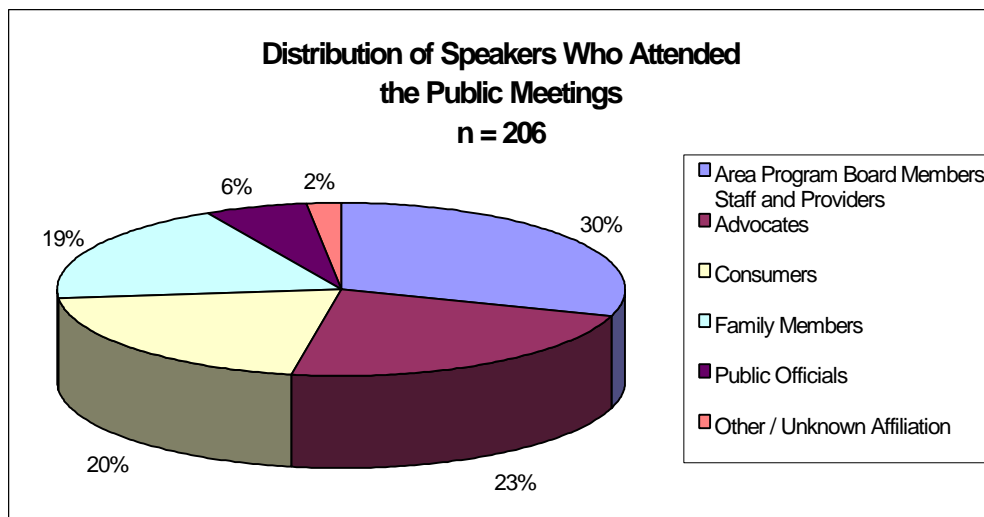
Where the counties appear unwilling to participate, the State should exercise its option to organize State administered programs for these counties. They would meet identical standards, but doing so under the auspices of the state DHHS. County Commissioners would have no authority, or responsibility for management functions or MH/DD/SA services. However, they should be expected to maintain their cash contributions at current levels. In fact, consideration should be given to having the State charge these counties an additional management fee for playing the role of the county administering agency, as well as closing the resource gap for target populations. This will not be an attractive option for many counties.

OVERVIEW

In June, July and August of 1999, the Office of the State Auditor sponsored a series of eight meetings to obtain input from the public on the availability and quality of mental health services offered at the local level. Approximately 520 people attended the meetings, which were held throughout the State, according to the following schedule of dates and locations:

Date	Location
6/15/99	Raleigh
6/17/99	Fayetteville
6/23/99	Greensboro
7/13/99	Asheville
7/15/99	Charlotte
7/20/99	Greenville
7/27/99	Wilmington
8/5/99	Newton

In total, there were 206 speakers, including consumers, family members, advocates and providers. As the chart below illustrates, there was a fairly even distribution of representation among these prominent groups, with Area Program Board members, staff and providers being the most numerous. Public officials, including current and former county commissioners, were among the other speakers who offered their input.



In addition to receiving input through the verbal statements presented by the speakers at the public meetings, many individuals, including some who were unable to attend the meetings in person, submitted written statements documenting their opinions and perspectives. Some also submitted journal articles, newspaper articles, provider annual reports, bylaws and budgets, as supporting documentation. Numerous individuals offered comments by phone.

Participants in this process offered notable comments in the following areas: System Governance and Structure, Financing, Clinical Services, Clinical Infrastructure, Access and Population-Specific Considerations.

SYSTEM GOVERNANCE AND STRUCTURE

1. *Many suggest that change in the system should be incremental and client-focused; it should support ongoing services and be adequately funded.*

“Changes in the current system need to be done incrementally, as services must continue while changes are made. We should seek input from other States before making changes in the current system.”

“Redesigning and restructuring will not work unless funds are provided to implement changes.”

“Put the client first in any decisions made about mental health.”

2. *There is a tension around the number, size and consistency of the Area Programs. Some believe that more consistency in access to programs and services is needed throughout the State, while others express strong interest in retaining local decision-making authority and personalizing services.*

“There needs to be a single clear integrated plan for the entire State, although it is a challenge undertaking to have plans that will work for all 100 counties.”

“The provision of services should be consistent Statewide; service availability and access to medications across the State are not equal.”

“Thirty-nine local area programs are too many.”

“A decision to make the mental health catchment area larger will depersonalize services and hurt the quality of services.”

“Each county is different; one size does not fit all. Decision-making should occur as close to the service level as possible.”

3. *State reporting requirements are burdensome and highly time consuming.*

“The State should decrease the paperwork demands on local programs, or at least provide financial support for the administrative costs required to meet these demands.”

“Paperwork requirements need to be reduced as they currently overwhelm the local programs. The State requires too much documentation.”

“A cost analysis should be performed on the administrative work required of the Area Programs by the State.”

4. *There is inadequate capacity for monitoring.*

“The current ratio of 4 inspectors to 2,995 mental health facilities is inadequate.”

FINANCING

1. *There is inadequate funding for the public behavioral health service system, and variation in Medicaid payments to public and private providers.*

“State funding does not keep up with inflation. The State should integrate the community and State institutional resources.”

“Medicaid and Medicare coverage for mental health services is inadequate. There is an inconsistency between Medicaid payments for public and private facilities.”

2. *The allocation of funding needs to be reconsidered.*

“The categorical nature of funding limits the ability to tailor use of funds to local needs.”

“The State has traditionally allocated funds to local area mental health programs on a per capita basis, a practice which works against the poor and people in sparsely populated areas.”

“Urban areas are able to supplement State resources more easily than the rural areas.”

3. *Consider private sector providers and private insurance in the restructuring of the system.*

“Currently, the public sector is the only choice for consumers and families with no resources or private health insurance. The State needs to take advantage of the private sector and try to promote an integrated partnership.”

“Private providers should share the responsibility of caring for people in need of mental health and substance abuse services, even if it is not profitable to do so.”

CLINICAL SERVICES

1. *More capacity in the provision of certain services is necessary. In-home services to clients, the clubhouse model, and substance abuse services are highly valued as elements that must be included in the new design.*

“Reducing hospital stays dictates that more inpatient time is dedicated to crisis stabilization, leaving little time for patient education, problem resolution and treatment-related goal attainment.”

“Area programs could reduce the no-show rates by providing in-home services to clients.”

“Core services such as the clubhouse model, long-term care, crisis respite services, community-based facilities and residential programs must continue to be provided.”

“Clubhouse programs make clients aware of other available services, prepare them for independent living and assist in the development of social skills.”

“Expanded substance abuse emergency intervention, 24 hour crisis services and detoxification facilities are needed. Crisis service availability 24/7 is weak.”

2. *Improvements are needed in the coordination of services, communications and discharge planning.*

“There needs to be better coordination of services and improved communications between the mental health and judicial systems.”

“There is a lack of communication and coordination between the State and local programs.”

“There are weaknesses in the services provided to the chronically ill upon release from hospitals, and there is a need for supervised housing as clients are being released from hospitals with no place to go.”

CLINICAL INFRASTRUCTURE

1. *Appropriate training and continuing education for clinical staff is needed.*

“Private providers do not adequately train staff and staff turnover rates are high.”

“All mental health professionals should have ongoing education and training.”

2. *Systems aimed at eliciting and responding to client input need strengthening.*

“There is a need for more client’s rights. Currently there is no avenue for service complaints.”

“The Statewide client satisfaction survey is flawed and the resulting data is not valid.”

3. *The State’s decision to use the Council on Accreditation (COA) is a good one.*

“We need COA – agencies will get better through accreditation.”

ACCESS

1. *Parity in private insurance is needed.*

“Parity in legislation and insurance for mental health, developmental disabilities and substance abuse services is essential.”

2. *The lack of health insurance coverage for portions of the population has a negative impact on access to needed services.*

“The State system is moving toward excluding from services the working poor and other low income groups, leaving only Medicaid eligible clients who can access care.”

“Forty-one percent of clients served at the community mental health facilities have no health insurance.”

3. *Waiting lists and inadequate numbers of qualified staff work against the system's efforts to provide timely, appropriate care.*

“Waiting lists of up to 6 weeks to get services at the local area programs leave clients without the care they need. There are waiting lists for halfway houses and other residential facilities.”

“Timely access to core services, including substance abuse treatment, is critical.”

“Therapists caseloads are too large. In addition, because behavioral health diagnoses are becoming more complicated, there is an increased need for more mental health professionals.”

4. *Access to appropriate housing designed for special needs is critical.*

“Moratorium on new group homes may precipitate crisis in housing options.”

“There is a need for safe and affordable housing that is age and diagnosis appropriate.”

“Group homes for the deaf/ multi-handicapped are non-existent.”

“Separate residential facilities would better serve clients with different disabilities.”

5. *Certain laws and regulations work against the common objectives of family involvement and access to care.*

“The State should bring current mental health statutes up to date.”

“Confidentiality rules prohibit mental health professionals talking with family members about adult clients.”

“Current laws prohibit long-term substance abuse treatment facilities for adolescents.”

6. *There are transportation issues, limited operational hours and barriers to obtaining medication.*

“The coordination and provision of transportation for clients is essential, and is particularly problematic in rural areas.”

“Because mental health services are only available 8-5 Monday through Friday, substance abusers often end up in jail.”

“Clients may be forced to skip or reduce dosages because of the lack of financial assistance for medication.”

POPULATION-SPECIFIC CONSIDERATIONS

1. *More services and funding are needed for individuals with substance abuse disorders.*

“There need to be more resources allocated and early intervention services in the area of substance abuse.”

“More detoxification, halfway houses, and outpatient services for substance abusers are needed. Many area programs have closed detoxification programs for financial reasons.”

“Substance abuse services are not sufficient in the northeastern part of the State; there are no halfway houses in a 13 county area.”

2. *While some argue for a categorical program for substance abuse services that is distinct from mental health programs, others advocate for better integration of these services for dually diagnosed individuals.*

“More substance abuse services are needed and these programs should be under one umbrella and not mixed with mental health programs.”

“Services for the dual-diagnosed client need to be better integrated.”

3. *On mental health services for the Elderly:*

“There are few mental health services for the growing elderly population.”

4. *On services for Children and Adolescents:*

“There is a lack of acute community-based services for children and adolescents.”

“Continue funds so that area programs can continue to provide services for children.”

“Education programs for children are needed.”

5. *On services for Sex Offenders:*

“The State should consider developing more regional services for people with very complex problems, such as juvenile sex offender programs.”

“North Carolina is behind in the treatment of sex offenders.”

6. *On services for Incarcerated Individuals:*

“Incarcerated adults with serious mental illness should not be ignored; this population goes largely untreated.”

7. *On other special populations:*

“Persons with brain disorders should be treated as aggressively as if they had cancer or diabetes.”

“Homeless adults with serious mental illness should not be ignored.”

“More programs are needed for pregnant women.”

INTRODUCTION

The cornerstone of our review of the capacity and issues facing the community mental health system was an intensive on-site visit of eight (8) Area Programs. The purpose of these on-site visits was to gain a thorough understanding of the issues and challenges facing the community-based system.

The eight Area Programs were selected based upon the criteria that two Area Programs from each of the four hospitals' catchment areas were to be included. Additionally, the selection of Area Programs included single-county and multi-county Area Programs, rural and urban locations, as well as large and small Area Programs. The selected Area Programs were intended to provide a representative cross-section of the community system. The Area Programs that were reviewed include:

- Rockingham County Area MH/DD/SA Program
- CenterPoint Human Services
- Sandhills Center for MH/DD/SA Services
- Wake County Human Services
- Southeastern Center for MH/DD/SA Services
- Wayne County Mental Health Center
- Mecklenburg County Health, Mental Health and Community Services
- Blue Ridge Center for MH/DD/SA Services.

These on-site reviews were multi-disciplinary covering clinical, financial, governance, and operational aspects of the Area Programs. Our team of six to eight consultants spent one to two days at each Area Program conducting interviews, visiting clinical programs, and analyzing data. During the site visits our staff conducted interviews with the Area Program Director, Finance Director, Board Chairperson, Board Members, County Manager or representative, Clinical Program Directors, clients, and various staff members. In order to cover the required scope of the on-site reviews, we divided our team into three units: services, financial/administration, and governance. The following summarizes our findings.

Finding 1: The overall governance of the Area Programs depends heavily on the make-up of the board and the amount of influence exerted by the member-counties on the operations. While some counties maintain a consistent and active role in the monitoring of financial activities and the delivery of services, other counties choose to afford the Area Programs a more autonomous operating structure stepping in only in times of crisis. As detailed in our findings, the counties with single county Area Programs tend to play a more active role in guiding the direction of the service delivery system as each feels more accountable for the financial stability and the quality of the clinical outcomes. Despite the structure, the Area Program boards and administrative staff work closely with each other to direct the provision of care. Often the quality of services and the Area Program's financial status greatly depends on the quality of staff available to operate the program and the resources available to maintain a consistent level of skilled staff.

Finding 2: The current structure – except in Wake and Mecklenberg Counties – creates no sense of county accountability for Area Program operations or financial issues. During our site visits, we attended several Board and Committee meetings where the current local financial crises were discussed. In addition, we followed up with several county managers to discuss county financial responsibilities for Area Programs. It was striking to us that most county officials feel little responsibility for assisting Area Programs in financial distress, even though they are current funders of Area Programs, and their constituencies receive services.

Finding 3: The MH/SA continuum of care varies greatly as Area Programs strive to provide more services to more people with less unrestricted dollars available in the system. Some Area Programs are able to provide a wide variety of services to all clients including high-end services such as Day Treatment and Residential. Other Area Programs are incapable of expanding service delivery beyond basic outpatient treatment services provided by professional and paraprofessional staff due to the lack of funds available for expansion of services. In many cases, the continuum of care available to the child mental health population exceeds that of the adult mental health population primarily due to the availability of court-ordered funds such as Willie M. Across the board, substance abuse is the most underdeveloped continuum of care offered at the local level as limited Medicaid and third-party reimbursement prevent Area Programs from expanding the capacity of care.

Finding 4: Area Program budgets range from \$6M to \$66M illustrating the vast differences in resources available to support the provision of services. The budgets are comprised of Federal, State and Local funds including State allocated funds, fee-for-service funds and county contributions ranging from \$87K to \$26.5M. Overall, these on-site visits clearly displayed the substantially wide variation in the funding level of Area Programs which creates widely varying financial, operational, and clinical capacities. Many Area Programs are simply “making do” with significantly less funds than others, resulting in very different levels of services available across the state.

Despite the tremendous resource disparity, the requirements of each Area Program are consistent as detailed reporting requirements and limited technical resources prevent smaller Area Programs from gaining significant economies-of-scale. With little growth in unrestricted state funding and the uncertainty provided by recent financial issues such as the dissolution of Carolina Alternatives, the Medicaid Match Reserve requirement and Title IV-AEA, Area Programs are faced with difficult financial issues resulting in a limited capacity to expand the delivery of care.

AREA PROGRAM PROFILE: SOUTHEASTERN CENTER

Administration

Operating Structure

Southeastern Center is a multi-county program with three counties: New Hanover, Brunswick and Pender. New Hanover, which contains Wilmington, is the dominant county, with 60% of the clients served. The Program is a local political subdivision of the state, and operates autonomously of the counties under the Board’s direction. Southeastern is mid-sized both in terms of population and budget among the 8 programs surveyed.

The central office is located in New Hanover County, with satellite offices and staff in Brunswick and Pender Counties. Besides services, the satellite offices are responsible for administrative functions such as medical records, data collection and appointment scheduling. The satellite offices are connected to the central office by a shared computer system.

Employees: 325 FTEs

Budget: \$30M (Mid-sized among the 4 multi-county programs surveyed)

Area Program Statistics: Southeastern Center receives 6% of its budget from member county contributions. County contribution per capita varies among the three with New Hanover at \$7.88 per capita, Pender at \$11.22 per capita and Brunswick at \$6.48 per capita. See the table on following page:

Area Program Statistics

	Population			Clients		County Contribution		Board Membership	
	# ¹	% of Total	% Medicaid Eligible	# ²	% of Total	\$ ³	% of Total County \$	# Members	% of Total
New Hanover	149,832	58%	10.3%	7,200	60%	\$1.18M	67%	8	40%
Brunswick	68,416	27%	12.6%	2,640	22%	\$0.44M	25%	6	30%
Pender	39,510	15%	12.2%	1,440	12%	\$0.14M	8%	6	30%
Total	257,758	100%	11.2%	12,000	100%	\$1.76M	100%	20	100%

1 - June 98 estimate

2 - June 99 actuals

3 - FY 99 actuals

*720 clients (6%) were not assigned to a specific county.

Governance

The Southeastern Center is an example of an autonomous program, with an active board and a clear reporting relationship between the Program and Board. The member counties provide a financial contribution without exercising undue management influence.

Role of the Counties

The counties do not play an active role in the governance of the Program, and do not view the Program as their ultimate responsibility. The Program Director reports to the Board, not the counties. The county directors are most closely involved with county commissioners and managers in the two small counties. In Brunswick, the manager is often treated as a department head in terms of being included in county-wide initiatives. In New Hanover, the Program is more autonomous, and the county manager allows the Program to make independent decisions. In all cases, the Program is considered an independent entity for funding purposes.

Mental health does not appear to be a funding priority for the counties, and the program director does not consider them a payor of last resort. Even if the counties were willing to increase their support, their capacity is limited as evidenced by Pender's past financial difficulties. For the first time this year, separate funding requests for county-specific needs were successfully submitted to the county commissioners. This reflects the counties' willingness to increase their contributions for county-specific purposes, but not to cross subsidize services in the other counties. Despite this outlook, the Board has never denied a county service for lack of independent funding.

Role of the Area Board

The Area Board, which meets monthly, is comprised of 20 members, including one county commissioner from each of the three counties. As the table on the previous page illustrates, the apportionment of board members among the counties is somewhat inconsistent with their funding levels. For example, New Hanover provides 65% of the county contribution, but only has 40% of the board members. Unlike some of the other programs visited, the Southeastern Center's board members are more closely aligned with their respective counties in their interests and votes. This year for the first time the respective county board members advocated and received funding based on county-specific requests.

A direct reporting relationship exists between the Program director and the Board; however, the Director is given a large amount of operational autonomy.

Capacity to Manage Change & Meet Future Demands

The multi-county structure allows the Program operational flexibility to manage change, yet the autonomy limits the financial responsibility felt by member counties. In times of financial instability, this arrangement may cause a detrimental effect on the Program's services due, in part to the member counties' limited accountability for budget shortfalls.

Additionally, the county outlook is more parochial here than in other programs with an unwillingness by the respective counties to increase their financial contributions unless the benefit effects them directly. Existing counties would worry about protecting their resources if additional counties were to be included under the Center's management.

Service System: Continuum of Care

Southeastern Center (SEC) is a large multi-county area program serving the suburban environment around Wilmington (New Hanover) and two largely rural counties, Brunswick and Pender. There are many services located in and around Wilmington and a core services centers in each of the outlying areas. Limited public transportation makes it difficult for some residents who live in rural locations to access some of the elements of SEC's continuum of care. Overall, however, it appears that the rural counties have access to a broader range of services than would otherwise be possible.

The Area Program has a large staff of clinicians and support personnel including a Medical Director and medical staff of about seven full time equivalents serving adults and two serving children and adolescents. Both of the rural centers have regular clinic hours with adult and child psychiatry. One of the psychiatrists is also board certified in addiction medicine, and he plays a leadership role in the treatment of individuals with substance abuse and co-occurring disorders.

SEC operates a busy psychiatric emergency service, the Crisis Station, 24 hours per day, 365 days per year. This center, essentially a psychiatric emergency room, provides evaluation, crisis intervention and psychopharmacology, and crisis stabilization for up to 23 hours to individuals in distress. A registered nurse and a county sheriff are on duty 24 hours per day. The Crisis Station works with individuals in all disability groups on both a voluntary and involuntary status and was originally conceived in collaboration with the sheriff's department to deal with a growing substance abuse problem. The center assists area residents during emergencies and has provided crisis debriefing services to hurricane victims.

SEC operates a broad range of treatment services for children and adults about half of which are provided through the agency directly and half through contracts with a network of private providers. The agency has begun to transform its Carolina Alternatives utilization management team into a mechanism for better monitoring this provider network. SEC was awarded a three year accreditation by the Division of Mental Health, Developmental Disabilities, and Substance Abuse in October 1998 and will be reviewed by the Council on Accreditation within the next year.

Child Mental Health

SEC was a participant in the Carolina Alternatives Program and its continuum of care of child mental health services is in transition now that the program has been terminated. SEC provides a range of treatment services directly including core outpatient and case management services, a developing in-home program, innovative services for youth involved with the Office of Juvenile Justice and youthful sex offenders, and a specialized continuum of Willie M. services. SEC also contracts with a network of private providers for residential care, in-home services and inpatient treatment.

Outpatient and case management services are offered from the main location in Wilmington and two satellite programs serving Brunswick and Pender counties. There are two child psychiatrists shared among the three locations and active involvement of SEC clinicians in the school and juvenile justice systems in each county. Brunswick County clinicians are directly involved in a school substance abuse program in which any child with known involvement is referred for evaluation and treatment. Each center employs a complement of child trained clinicians to provide assessment and treatment services including the services of doctoral level psychologists and clinical social workers in each location.

SEC has successfully collaborated with the Office of Juvenile Justice in New Hanover to develop a court-based evaluation and treatment program. This program, staffed by a doctoral level psychologist and two masters prepared clinicians and is co-located with the Juvenile Justice counselors (probation department). SEC clinicians conduct specialized assessment of referred youth and provide consultation to the counselors handling the case on a variety of issues including placement and treatment options. SEC clinicians also provide some direct treatment of individuals and families.

SEC is also in the process of developing a specialized program for adjudicated sex offenders and “at risk” youth. Eventually, the program will include a full continuum of specialized treatment services for the child and family. Current program offerings include group and family treatment for adjudicated offenders ages 12-17 and group treatment for an “at risk” cohort of six to nine year olds. A range of assessment, consultation and education services are also provided to SEC clinicians providing ongoing treatment services to these and other individuals returning from residential placements.

SEC provides intensive services to approximately 60 children in its Willie M. program and has seen a surge in referrals over the past six months. The program director believes that the termination of the Carolina Alternatives program leaves certification as Willie M. as the best route to accessing intensive services whether the individual child meets the strict definition of Willie M. or not. There appears to be an increase in referrals for services for youth with sex offenses and an increase in the number of girls. The Special Youth/Willie M. program operates a full continuum of services directly and additional residential services through its provider network. It has developed its own network of therapeutic foster homes as well as a number of group homes including a small program for sex offenders. A major concern for the program is the development of transitional residential environments for older Willie M. youth as they age out of the service system.

SEC has difficulty accessing inpatient, partial hospital, and residential substance abuse treatment, as there are few resources in the three counties. Since the closing of the program at “The Oaks” in New Hanover, the closest inpatient programs are in Jacksonville (Bryn Mawr) or at Cherry Hospital.

Adult Mental Health

Southeastern Center has developed a comprehensive adult service system of care that is consumer oriented and incorporates a managed care philosophy. The Center has a full continuum of adult services available to their community with an emphasis on providing access to services in each surrounding county. There is a wealth of experienced clinical managers that utilize their financial resources in creative ways to meet the needs of the community across all disabilities. Cross county integration of core programs and services has been a goal. Clinical review teams coordinate and conduct utilization management throughout the service area. Acute inpatient services are available in community based hospitals. The state hospital utilization for mental health inpatient bed days is consistently under budget. The Center has established positive working relationships with the community providers which has enabled access for indigent clients to community based acute services. A major strength of the organization is the Crisis Station that is available 24 hours per day 7 days per week to provide crisis evaluations and crisis stabilization services to community residents. This Station has nurses and a deputy onsite 24 hours per day and is capable of managing all age groups. The organization is looking to obtain

funding to start an ACT team, which will enhance services to the SPMI population. Geriatric services include access to locked, medically sophisticated, long-term care facilities within the community that can manage behaviorally disruptive individuals. The Center provides psychiatric consultation services to the surrounding nursing homes, rest homes and home-bound geriatric residents. Case management services are available but limited.

Substance Abuse

Southeastern Center offers a continuum of substance abuse services that provides a full spectrum of treatment options in a community based setting. The Center operates a 10- bed detox program that has access to medical and psychiatric coverage daily. This program is located adjacent to the crisis station. This allows for ease of access to treatment for clients requiring crisis evaluation, crisis stabilization and detoxification. Clients requiring a more acute medical setting are transferred to the local community hospital and returned to the Center for referral to ongoing outpatient care. Outpatient services are comprehensive. They include an intensive outpatient treatment program that offers a day and evening treatment track, weekly continuing care groups, a women's recovery group and individual substance abuse counseling. Specialty services for dual diagnosis clients are available through coordination with the state hospital for inpatient detox and extended rehabilitation. Communication between Southeastern Center and the state hospital is a priority to ensure that client's transition from the hospital to community-based treatment. The center is planning to provide outpatient detox services. Gaps in the continuum include a need for increased resources to address the needs of the Hispanic community, clinicians with an expertise in working with deaf and hearing- impaired individuals and increased specialized services for adolescents.

Management Infrastructure

Southeastern's infrastructure to manage its full continuum of services has been extensively developed utilizing a formal billing compliance department, specific utilization management procedures and enhanced Quality Assurance and Quality Improvement initiatives. While the majority of services are provided either within or contracted through the main center in Wilmington, necessary service offerings are available to clients in the remote counties of Pender and Brunswick. Although transportation issues limit the access of many of the clients in need of services, the facilities in the outlying areas increase the opportunities to provide services to clients who might otherwise not have the ability to receive them.

Contract Monitoring

In order to ensure the validity of the internal and external Medicaid documentation, Southeastern utilizes a two-pronged approach. For the internal and external clinicians, a formal billing compliance department has been established that reviews the 17 Division of Mental Health (DMH) billing criteria necessary for appropriate Medicaid billing. This unit identifies non-compliant activities and provides training to appropriate staff to correct the issues. Combined with the billing compliance department, Case Managers are responsible for monitoring their own records and keeping the necessary requirements current. The current review procedures have been recently been developed as a result of a poor compliance rating at the most recent DMH audit in February 1999.

Quality Management

Southeastern Center has an established Quality Assurance Plan, which includes provisions for the composition, organizational position and meeting frequency of the Quality Assurance Committee. The Clinical Director chairs the Committee. Most of the work is accomplished through the many subcommittees, which cover the following areas: 1) Privileging, 2) Medical Records Monitoring, 3) Suicide/Fatality, 4) Restraints, 5) Accreditation, 6) Risk Management, 7) QI Outcomes, 8) Orientation, and 9) MIS. In addition, Ad Hoc committee meetings are scheduled by the chair on an as-needed basis.

Utilization Management

Southeastern utilizes specific clinical review teams who apply the State's Level of Care Criteria established in conjunction with Carolina Alternatives to authorize services provided by its external vendors. The review teams track clients throughout the various clinical episodes and ensures medical necessity of the services provided. The proposal to provide statewide utilization review would need to be implemented in conjunction with Southeastern's current UM process.

Accreditation

As with other Area Programs, Southeastern Center went through an extensive review process in order to earn State accreditation. This accreditation was granted for a three year period. Senior staff at Southeastern Center express optimism about the upcoming involvement of the Council on Accreditation in future reviews, and see COA as an independent party offering an objective perspective. Furthermore, COA is viewed as being process oriented, focused on how providers identify problems and solutions. However, Southeastern's COA self-study process is scheduled to begin 14 months into the State's three year accreditation. In reflecting on the enormity of the effort put forth in the State accreditation review process, this is a point of frustration at the Area Program.

Formerly, individual program directors managed contract provider accreditation. In addition, Southeastern used to accept accreditation by another Area Program as adequate. However, this function has become more centralized and is managed by the Accreditation subcommittee of the QA Committee, which no longer accepts external accreditation as evidence that a contract provider meets Southeastern's criteria. The Accreditation subcommittee is charged with writing and monitoring contracts, and has developed an informational packet for prospective contract agencies. The initial accreditation involves an on-site review by members of Southeastern's subcommittee.

Privileging and Credentialing

Southeastern's Privileging subcommittee manages the privileging process for internal providers. In addition, contract provider staff are required to meet the privileging criteria established by Southeastern. The Area Program suggests that clarification from the State with regard to its expectations around privileging would be helpful.

Outcome Evaluation

Outcomes are another area managed by a subcommittee of the Quality Assurance Committee. A new chair of the subcommittee took over in February 1999. He initiated a collaborative process through which goals were identified at each Center location, based on perceived needs. Outcomes measures identified not only for clinical functions, but also in administrative areas, including personnel, medical records and finance, as well as County Center specific outcomes for Brunswick and Pender. In total, forty-one separate project outcomes were identified, and six were prioritized for initial ongoing focus and measurement.

Consumer Rights and Input

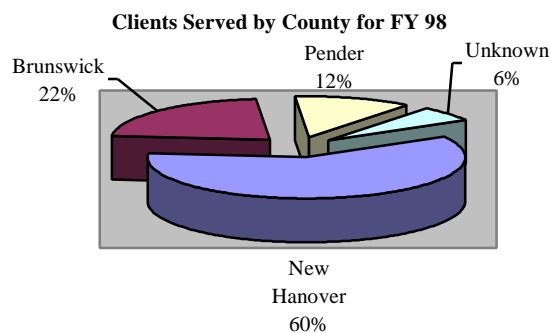
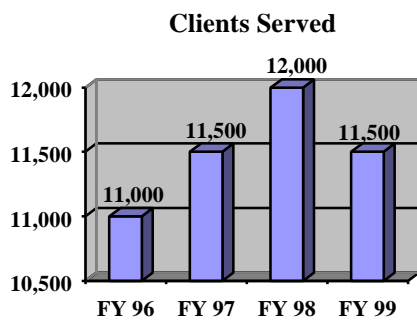
The Client Rights Committee is a subcommittee of the Area Board of Directors. This Committee is accessible to all clients of Southeastern Center and to all clients receiving services through the Center’s contract agencies. The established client rights policy delineates provisions for the composition, responsibilities and policies of the Committee, as well as standards for the confidentiality of information subject to review by the members.

At Ocean House, a supportive psychosocial rehabilitation program, PCG was received by about 25 consumers who had prepared a presentation about the services they receive and their experiences. They described long histories of serious and persistent mental illness and of being on and off medications. They were very committed to and thankful for the program at Ocean House, and highlighted the lack of transportation and inadequate housing as areas for improvement.

In addition, PCG met with a woman in her mid twenties, accompanied by her baby, who was in a residential treatment program for pregnant women and women with children. Her experience included having had many children at a young age, jail time, a history of alcohol abuse and difficulty getting connected for treatment. She was grateful to be in the program where day care was provided while she attended an outpatient treatment program and maintain the ability to stay with her baby. Staff explained that there is much more demand for this services than they are currently able to accommodate; therefore, they are trying to build additional sites and capacity.

VI. Financial Overview

The financial team at Southeastern is adapting to the changing landscape of mental health delivery in North Carolina. Overall, the staff is educated, knowledgeable and committed to improving the system. They are challenged by the operational requirements of a large mental health center with contract management representing the most time and resource consumption. Cash flow issues, a budget deficit for FY 00, a growing client base and increased compliance requirements from funding sources are the top concerns of the financial team.

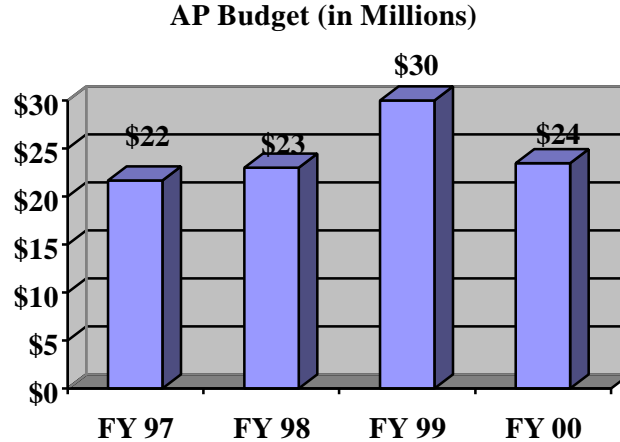


2.9 Area Program Site Visits

Chief Financial Officer

Vicki Steele is the Chief Financial Officer. She has been at Southeastern for over seven years. Prior to joining Southeastern, Ms. Steele was with Gaston-Lincoln Area Program.

FY 1999 Operating Budget



* FY 00 Projected

Southeastern's FY 99 Operating Budget was \$30M, a 13% increase from the FY 98 budget (\$23M). The increase was a direct result of the Program's increase in Medicaid revenues used to fund their general programs. FY 99 operations saw roughly \$3.5M of their resources coming from the fund balance, however, revenues exceeded expenditures by \$1.9M. Their proposed FY 00 budget anticipates a significant decrease in operating expenditures with a total budget of \$23M, a 22% decline.

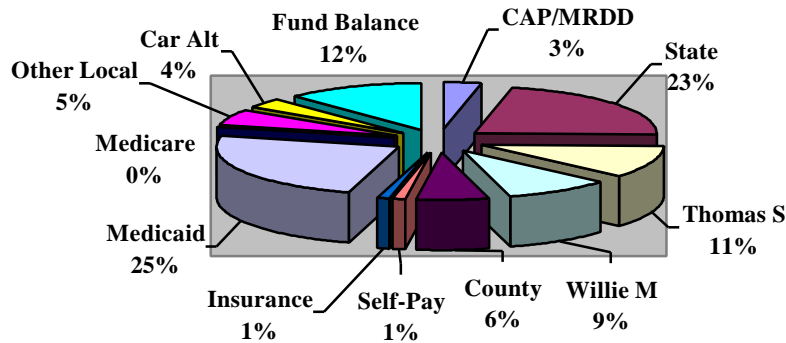
Currently, 25% of Southeastern's revenue is generated through Medicaid representing a significant funding source for the Area Program. Over the last three years, Medicaid reimbursement has remained stagnant while other State funds have decreased significantly resulting in a greater dependence on other revenue sources such as Medicaid, commercial insurance and self-pay to cover additional operating expenditures. With the combination of Medicare, commercial insurance and self-pay receivables constituting less than 2% of the FY 99 actual revenue, obtaining significant increases in these funding sources present a notable challenge for the Area Program. The projected FY 00 budget includes a \$2.5M decrease of Carolina Alternatives funding which a major reason for the decrease in budget. This budget also requires that \$1.6M of the fund balance be used to balance the operating budget.

2.9 Area Program Site Visits

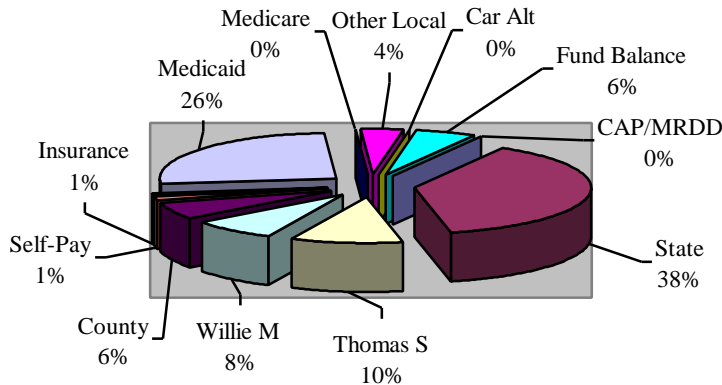
Revenue Summary by Payor Source

	FY 98	FY 99	FY 00 (Projected)
County Contributions	\$1,757,591	\$1,765,713	\$1,765,713
Private Insurance / Medicare	\$369,865	\$311,044	\$255,731
Medicaid	\$3,499,298	\$4,733,666	\$6,400,377
CAP/MRDD	\$1,051,636	\$930,407	\$1,023,036
Thomas S.	\$3,794,669	\$3,227,681	\$2,911,204
Willie M	\$2,561,883	\$2,709,432	\$2,259,959
Carolina Alternatives	\$4,324,299	\$4,428,318	\$0
State Funds	\$7,736,721	\$6,274,280	\$5,850,093
Client Fees	\$376,828	\$380,819	\$376,075
Other Local	\$822,172	\$1,562,652	\$1,068,082
Fund Balance Appropriation	\$250,000	\$3,465,074	\$1,909,097
Total	\$26,544,962	\$29,789,086	\$23,819,367

Breakdown by Revenue Source (FY 99)



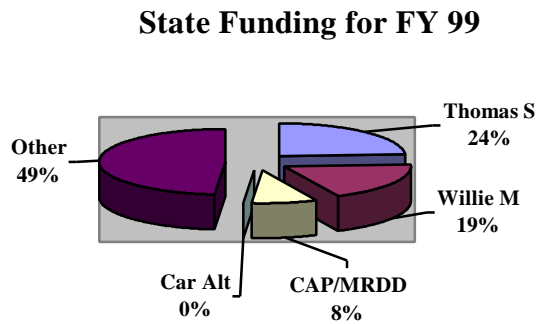
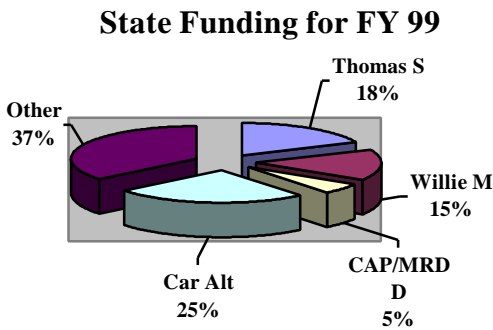
Breakdown by Revenue Source (FY 00)



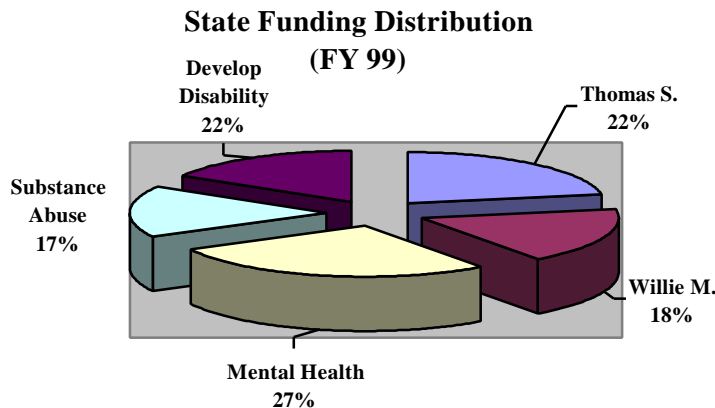
2.9 Area Program Site Visits

State Funding

	FY 98	FY 99	FY 00 (Projected)
Thomas S.	\$3,794,669	\$3,227,681	\$2,911,204
Willie M.	\$2,561,883	\$2,709,432	\$2,259,959
CAP/MRDD	\$1,051,636	\$930,407	\$1,023,036
Carolina Alternatives	\$4,324,299	\$4,428,318	\$0
Other State	\$7,736,721	\$6,274,280	\$5,850,093
Total	\$19,469,208	\$17,570,118	\$12,044,292



Restricted funds account for 38% of the total state funding with Thomas S. at 18%, Willie M. at 15% and CAP/MRDD at 5%, limiting the opportunity for Southeastern to expand service delivery for the unclassified populations. With the elimination of Carolina Alternatives' funding, the reliance on restricted State Funds increases to 51% of projected revenues for FY 00.



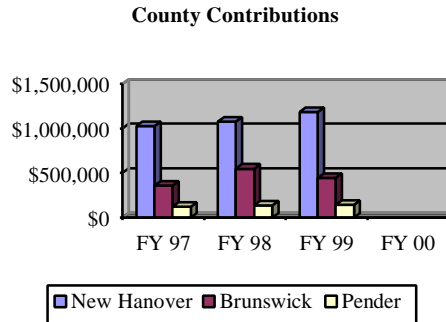
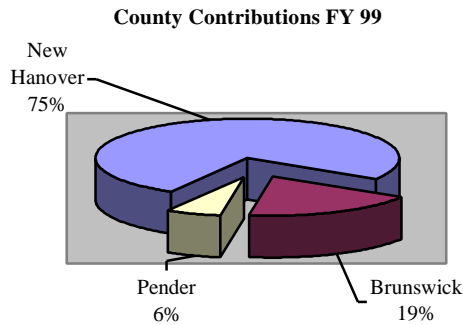
The breakdown of Southeastern's State funding for FY 99 demonstrates the equity of total State dollars for each of the disability groups of Developmental Disabilities, Substance Abuse and Mental Health with additional funding for Willie M. and Thomas S. consumers. Further analysis of the State funding distribution reveals a different view when Thomas S. funds and Willie M. funds are incorporated into DD and MH respectively; thereby demonstrating the actual disparity between DD and MH as compared to SA.

2.9 Area Program Site Visits

County Funding

	FY 97	FY 98	FY 99	FY 00 (Projected)
New Hanover	\$1,022,699	\$1,073,834	\$1,181,349	\$1,181,349
Brunswick	\$356,678	\$546,869	\$443,369	\$443,369
Pender	\$121,357	\$136,888	\$140,995	\$140,995
Total	\$1,500,734	\$1,757,591	\$1,765,713	\$1,765,713

County contributions comprise about 6% of the total budget for Southeastern. The FY 99 County funding per capita varies greatly among the three counties with New Hanover funding at \$7.18 per capita, Brunswick at \$6.48 and Pender at \$3.57 per capita. Over the last three years, County contributions to the Area Program have remained relatively static. All contributions represent strictly cash, yet the Counties do provide Southeastern with office space.



2.9 Area Program Site Visits

Per Capita Financing

FY 99	Population	Operating Expenditures	Per Capita Expenditures	County Funding	Per Capita Funding
Southeastern	257,758	\$30,077,378	\$116.69	\$1,765,713	\$6.85

Division Funding

The aggregate division funding of the Area Program ranked Southeastern thirty-ninth among the forty-one Area Programs in FY 97. Southeastern ranked fortieth in Mental Health funding with per capita funds averaging \$6.55, in comparison to a state average of \$10.56. Similarly, Southeastern ranked thirty-ninth in Developmental Disability funding with per capita funds averaging \$8.21, as compared to a state average of \$11.51. In contrast to MH and DD funding, Southeastern ranked seventh in Substance Abuse funding with a per capita funding of \$7.57 and a state average of \$6.03.

Cash Flow Analysis

Southeastern employs tight cash controls on their contractors, and as such will not reimburse these contractors until they have been reimbursed by the appropriate third parties. As a result of this policy and a rather efficient patient accounting process, Southeastern is not experiencing significant problems related to their cash flow position.

A/R Balance

As of 6/30/99, the A/R Balance is approximately \$4.5M net of any reserves. The agency routinely write-off accounts and all reduced fee clients are booked to the A/R at the net receivable. As a result, the A/R trial balance is reasonable making it easy to decipher the true value.

Fund Balance

Despite the need to allocate significant portions of their fund balance to cover operating expenses, Southeastern does have a significant positive fund balance. As of FY 99, Southeastern had an ending unrestricted fund balance of \$9.2M. This fund balance level represents 30% of their operating budget.

Front-End Management/Client Registration

Client entry into Southeastern is well-documented and roles and responsibilities are appropriately assigned. The intake staff enforces a strict income and residency verification procedure to determine the client's ability-to-pay. Clinical staff have integrated the clients need to pay for their care as a treatment goal associated with progress. While clinical staff does get involved in reimbursement issues, self-pay collection totals, representing less than 1% of total revenue, do not reflect the intervention of the staff. In addition, the process to identify and track potential Medicaid eligible clients is not clearly defined.

Cost Allocation Plan

The Area Program has identified the need for a comprehensive cost allocation plan but does not have the resources to complete this analysis. The financial management team relies heavily on the cost-finding report prepared and submitted to the Division each year to monitor costs.

Clinician Productivity Tracking

Southeastern currently does have a clinical productivity-tracking plan in place to monitor individual clinician productivity.

MIS

Southeastern uses CMHC for client registration and billing. The MIS department works independently of the county's system and uses the accounting systems of CMHC to run their operations. A new managed care module is being contemplated to better manage outside contracts.

AREA PROGRAM PROFILE: CENTERPOINT

Administration

Operating Structure

CenterPoint is a multi-county program with one large county, Forsyth, and two smaller counties, Stokes and Davie, with about 80% of the catchment area population residing in Forsyth County. With a population of more than 285,000 including the city of Winston-Salem, Forsyth County is the largest urban county that is not a single county program. Serving more than 350,000 residents, CenterPoint is the largest multi-county program by population among the 8 that were surveyed. Davie County was part of the now disbanded Tri-County Program, and merged with CenterPoint in 1998 after one year of operation under management control. The Area Program is a local political subdivision of the State, and operates independently from the governance of the three counties.

The Area Program is organized in a corporate structure, with the central office located in Forsyth County. Administrative functions for all counties and in-house services are provided at this location. Each of the smaller counties has a dedicated director and staff that utilize central office administrative and clinical resources.

Employees: 464

Budget: \$35M (Third largest of the 8 programs surveyed)

Area Program Statistics: CenterPoint receives 17% of its budget from member county contributions, the highest among the multi-county programs surveyed, and the third highest overall. County contribution per capita varies among the three with Forsyth at \$16.37 per capita, Stokes at \$10.98 per capita and Davie at \$5.71 per capita. See the table below:

Area Program Statistics

¹ June 98 estimate

² June 99 actuals

³ FY 99 actuals

	# ¹	% of Total	Medicaid Eligible ²	#	% of Total	\$ ³	% of Total County \$	# Members	% of Total
Forsyth	287,701	79%	24,508	9,803	81%	5.01M	88%	11	58%
Stokes	43,292	12%	3,475	1,382	11%	.52M	9%	5	27%
Davie	32,095	9%	2,404	943	8%	.20M	3%	3	5%
Total	363,088		30,387	12,128		5.73M		19	

Governance

CenterPoint is an example of a multi-county program that has different governance relationships with each of the member counties. Forsyth County exercises limited influence over the Area Program. Stokes County treats CenterPoint as a department during its budget process and their ability to influence CenterPoint on governance issues remains constricted. An active board exists with a clear reporting relationship between the Area Program and the Board.

Role of the Counties

The three counties interact with CenterPoint differently, and require various levels of accountability. Forsyth County is an especially active supporter of the Area Program, both in terms of financial and in-kind contributions, providing most of CenterPoint's buildings rent free, operating the pharmacy, providing support to the vehicle fleet, janitorial services and risk management services. Despite this, the County Manager does not exert undue influence on the Area Program or have a formal reporting relationship with the Area Program Director. The County is financially supportive of the Area Program, but does not view itself as the payor of last resort.

Alternately, Stokes County views the Program and the service continuum available for its residents as a department of the county. The Stokes County Director participates in the County budget process in much the same way as a county head and is expected to respond to County requests. Davie County has a less direct relationship, and is considered a contracted service by the County.

Role of the Area Board

There is a direct and routine reporting relationship between the Area Program Director and the Board Chairman, currently a Forsyth County citizen. The Board meets once per month. The number of area board members is not proportional to the respective counties' sizes or financial contributions. Forsyth County provides 88% of the County contribution, yet only 50% of the board members. Each county has one commissioner on the Board, who in turn appoints other members. The total members are shown in the table on the previous page. Board members generally do not vote in county blocks.

Capacity to Manage Change & Meet Future Demands

CenterPoint's management team possesses experience in providing clinically appropriate services accompanied by sound financial decisions in an efficient manner. Based on the positive experience of expanding services while participating in Carolina Alternatives, CenterPoint would like to continue the practice of initiating new ventures to enhance the existing service continuum. The management team considers the recent merger with Davie County "invigorating" and believes that the corporate structure is capable of supporting additional service delivery systems.

The autonomous multi-county structure allows the Program operational flexibility to manage change. This autonomy, however, limits the financial responsibility felt by member counties and could have a detrimental effect on the Program's financial stability if financial projections are not realized

The involvement of three counties on the Area Board may create problems that limit the Program's adaptability to change. Commissioners in different counties may have divergent opinions and philosophies on the expansion of services. County Commissioners are automatically appointed to the Board, and may not always be sympathetic to the Program.

Service System: Continuum of Care

This large multi-county program has a wealth of clinical/medical leadership and talent and ready access to a private provider network that includes a major teaching hospital and medical school. While it is constantly focused on improving its continuum of services, this Area Program has most of the major building blocks in place or in development. A functional and improving emergency service (Access Center) and center-operated inpatient unit anchor the system of care and provide a “safety net” for county residents. Innovative efforts to secure pharmaceutical scholarships for indigent consumers are one example of this center’s motivation and initiative. This center, also, performed quite well under Carolina Alternatives and was able to develop numerous hospital diversion/alternative programs in a cost-effective manner.

Access to services is somewhat more limited in the smaller counties (Stokes, Davie), but on the whole still probably better than they would be if those same counties were to stand alone. Considerable attention has been paid to the development of clinical infrastructure, as well, suggesting the possibility of a larger regional role should the state decide to go in that direction.

Child Mental Health

Child mental health services are ample and well organized and seem to be well integrated in the broader community. Clinical services are organized around a two team approach with each team specializing in several clinical areas: one team focuses on acute situations and substance abuse involvement while the other team has a caseload of more long-term, chronic and developmentally delayed situations. Each team has a full complement of attending psychiatrists, clinicians, and case managers. The child service would like to develop increased resources for the large Hispanic population in the area and has some bi-lingual (Spanish) capacity in its clinical staff. Substance abuse services including an active group therapy program for dually diagnosed adolescents are readily available.

Several local hospitals have child inpatient units and provide most of the acute care for Area Program clients. Case managers have ready access to treatment planning through a series of formal affiliation agreements. The program is a major referral source for both Charter and Baptist Hospitals. CenterPoint, a Carolina Alternatives participant, has referred few children to the state hospital over the past several years.

CenterPoint provides an array of school-based, home-based, and residential services. The Consultation and Training Team is focused on the needs of young families and children, three to six years of age. Services provided to day care programs, pre-schools, and public schools include a range of consultation and education for families and child care workers. A therapeutic pre-school program is located at the center. The Crest Day Treatment Program services grades one to nine through collaboration with the Winston-Salem/ Forsyth County Schools. The Program would like to develop similar services with the Davie and Stokes school systems, as well.

Additional intensive services are provided in the community. The Home and Community Team provides a range of family preservation/intensive family treatment and high-risk intervention to families identified as “at risk” for hospitalization or residential placement. The team, also, provides a “bridge” for hospitalized children coming back to their home or community placement through case management. A variety of residential services have also been developed through contracts with local providers. These include therapeutic foster care, respite care, and group home settings. Additional capacity for short-term crisis stabilization and long term secure treatment for sex offenders is needed in the treatment system.

Adult Mental Health

The adult mental health services at CenterPoint are wide and varied. The Center operates a full continuum of services from acute inpatient psychiatry through traditional outpatient treatment. The organization is rich in access to psychiatry and utilizes physicians in multiple expanded roles throughout the clinical programs. The Medical Director is Board Certified in adult mental health and addiction medicine. She has extensive experience in the area of dual diagnosis treatment for those consumers with chronic mental illness and substance abuse disorders. Clinical programs are integrated mental health and substance abuse services. CenterPoint has several clinical services operating that allow for the organization to function in an expanded regional capacity. These services include:

- An acute adult inpatient unit onsite that treats patients with acute psychiatric and substance abuse disorders. This unit has the capability to manage severely ill individuals and is the primary provider of inpatient care for patients within the counties.
- An extensive and clinically well developed emergency service that operates 24 hours per day/ 7 days per week. The service provides face to face evaluations and has physicians onsite 24 hours per day. The team has the capability to divert patients from hospitalization by offering crisis stabilization beds and easy access to outpatient appointments. The philosophy of the organization is built around utilizing the least restrictive level of care. The team currently does not provide mobile capacity. Patients from surrounding counties are transported to the center for evaluation.
- A full continuum of step down services is available for adults including respite, partial hospitalization, day treatment, ambulatory detox, intensive outpatient programs and
- Extensive specialty programs exist for women, bilingual services for the Hispanic population and dual diagnosis programs.
- An ACT Team provides outreach services to a large number of severe and persistent mentally ill consumers countywide.

Of special note, the Center has devoted significant resources to developing a strong utilization management department. The UM department has the responsibility for initial authorization and concurrent review for acute care services. The state hospital bed day utilization is minimal, and the total bed days utilized within CenterPoint's system are below the current annual allocation. Although there currently is minimal specialized geriatric programming, CenterPoint has identified this as an area for growth. There are private provider organizations within the county that operate long-term care beds. For those with the ability to pay, these resources are easily accessed. For those geriatric patients currently residing at the state hospital, there is limited availability of community based services which would allow for discharge from the state hospital.

Substance Abuse

CenterPoint offers arrangements for the full continuum of substance abuse services, primarily through contract. Medical and social setting detoxification beds are readily available. The Center provides a locked setting for intoxicated individuals who are suicidal and/or homicidal. This unit provides local access to acute treatment for the substance abuser who requires acute stabilization and transition to a less restrictive setting when clinically indicated. There is significant competition within the counties for referrals to detoxification. The contracted detox providers have experienced a reduction in utilization, which has put these programs at risk.

2.9 Area Program Site Visits

CenterPoint has strong, collaborative relationships with the court/judicial system. Substance abuse services are linked to the emergency services program. There is capacity to provide crisis stabilization and intensive outpatient programs.

The Center operates an award-winning program for women and children called WISH. This program provides case management services for recovering women and their children. The goal is to provide critical support services to allow for the mother to continue treatment. This program provides outreach to the three counties through screenings. Services are primarily provided in Forsyth County.

Increased funding for additional residential beds, halfway houses and transportation services is needed to enhance the continuum of services being provided.

Management Infrastructure

The infrastructure at CenterPoint Human Services is much more extensive than that of a smaller, single-county program due to its access to resources and its ability to place qualified personnel in key positions throughout the organization. Extensive QA/QI teams, formalized internal Professional Services Organization (PSO) processes, and an extensive external provider network is evidence of this fact. CenterPoint incorporates representatives from Stokes and Davie counties into its internal structure by participation on committees and subcommittees. It is apparent, however, that the majority of management activities are conducted by the headquarters in Winston-Salem.

Contract Monitoring

CenterPoint's capacity to provide services has been greatly enhanced by its ability to effectively contract with external provider organizations. CenterPoint's current service continuum includes approximately 225 contracts with 170 providers, totaling approximately \$9.5 million dollars, representing 31% of the total FY 98-99 budget (\$31M). While the capacity to provide additional services is improved by contracting with external vendors, the exposure to risk is also increased due to the diffusion of responsibility across the network. The increased exposure is forcing CenterPoint to develop extensive contract monitoring practices centralized under the Manager of Healthcare Network Development and the staff of Service Managers. In addition, CenterPoint has implemented a policy of delaying payment to contract providers until revenue is received from Medicaid. This policy has allowed the area program to decrease the risk of paying for services without receiving Medicaid reimbursement.

The Director of Network Development sees services provided by contract providers as an extension of CenterPoint's own capacity. As such, relationships with contract providers are collaborative with CenterPoint staff providing technical assistance to enable contractors to meet specified requirements. Contract monitoring is incorporated into the Center's QI process with established standards, including extensive reporting requirements that outside providers must meet. Before contracting with any external agency, CenterPoint requires that the Service Managers accredit each of its vendors. The general accreditation review provides an opportunity for CenterPoint to ensure that effective policies and procedures exist to govern each of the contracted entities.

CenterPoint utilizes two separate processes to monitor contracted direct service providers. CenterPoint contract providers perform a 100% retrospective self-review of all claims and report any documentation deficiencies to the Accounts Payable department for the appropriate adjustments to be made. CenterPoint's MIS system has the capability of automating much of the contract monitoring function; however, the current Accounts Payable piece of the system does not include effective claims adjudication software.

Quality Management

CenterPoint maintains a structured, committee-driven QI system that is integrated throughout the organization. The QI Executive Committee combined with a number of QI Sub-Committees resolve issues and promote improvements throughout all departments including, but not limited to, billing compliance, infection control, no-show rates and consumer satisfaction. CenterPoint's internal Medical Records department and the internal PSO provide necessary support to review records for required State criteria.

Utilization Management

CenterPoint has developed a formal Utilization Management (UM) department that authorizes all externally provided services for its contract provider network. This process has been effective in reducing unnecessary services as evidenced by the reduction of CBI clients from 165 to 65 after UM was applied. The UM team authorizes services based on the Level of Care Criteria set forth by the State in conjunction with Carolina Alternatives. The staff's primary concern with the concept of incorporating a statewide UM program is the growing number of authorization numbers required by managed care payors. A North Carolina required authorization number would add yet another step in the process without a guarantee of improving results.

Privileging and Credentialing

Internally, CenterPoint has a formalized process to privilege and credential new clinicians through its internal PSO prior to the delivery of service by that clinician. The privileging process consists of approval from a supervisor, a PSO sub-committee, a PSO Executive Committee, and the Executive Director before privileges are granted for any internally provided service. Also during this process, the Personnel Department verifies the clinician's credentials including the licensure and transcripts to ensure competency and qualifications required to deliver the service. In contrast to the internal process, the external staff are privileged and credentialed by the individual agencies with the monitoring of this process provided by CenterPoint's Service Managers.

Outcome Evaluation

In 1996, CenterPoint began tracking clinical outcome measures to monitor the delivery of care across all departments. The outcome measures include maintaining and improving the lifestyle of the client, gaining and maintaining employment, and reducing inpatient hospital stays. By linking the outcome results to staff compensation, CenterPoint has instilled a feeling of responsibility in each staff member to provide quality care across the organization. By earning Substantial Equivalents under the State Personnel System, CenterPoint is allowed more flexibility and performs more like a private-sector firm to incentivize the staff based on the results of the outcome measures.

Consumer Rights and Input

CenterPoint's Client Rights Committee, a committee of the Area Board, includes not only board members, but also consumers, advocates and an attorney. The purpose and responsibility of the Committee includes overseeing the development, implementation and evaluation of all applicable client rights standards throughout services of the area program and its contract providers. CenterPoint has an established Client Rights Policy and Directives as well as a Grievance Policy, which distinguishes distinct courses of action for the resolution of concerns, complaints and formal grievances.

2.9 Area Program Site Visits

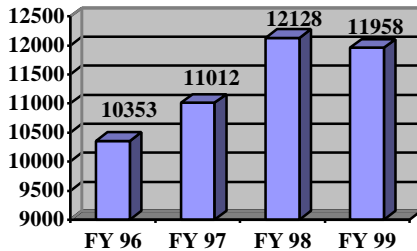
A full set of Client's Rights information is included as part of the Employee Handbook, which is distributed to all employees; it includes standards for reporting abuse and neglect, confidentiality, making sure people are safe and reporting requirements for seclusion and restraint. Clients are informed of their rights upon intake through documentation that is provided at that time.

At an on-site meeting with six consumers, many expressed a sense of satisfaction and appreciation for the services offered at CenterPoint. Services are accessible due to bus passes and transportation provided by the Area Program. Consumers reported utilizing a range of services including physical health services, the WISH program (adolescent drug education), and STEP One (intensive women's program) and expressed appreciation for CenterPoint's philosophy of providing care before asking for payment.

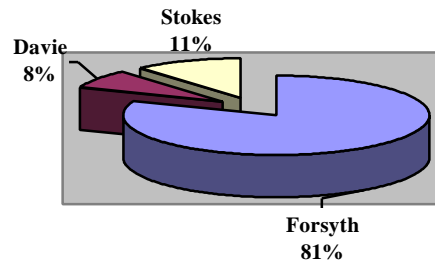
Financial Overview

The financial team at CenterPoint is struggling with the changing landscape of mental health delivery in North Carolina. Overall, the staff is educated, knowledgeable and committed to improving the system, however, they struggle daily with operational requirements of a large mental health center with contract management representing the most time and resource consuming. Cash flow issues, a budget deficit for FY 2000, a growing client base and increased compliance requirements from funding sources are the top concerns of the financial team.

Clients Served



Clients Served by County for FY 98

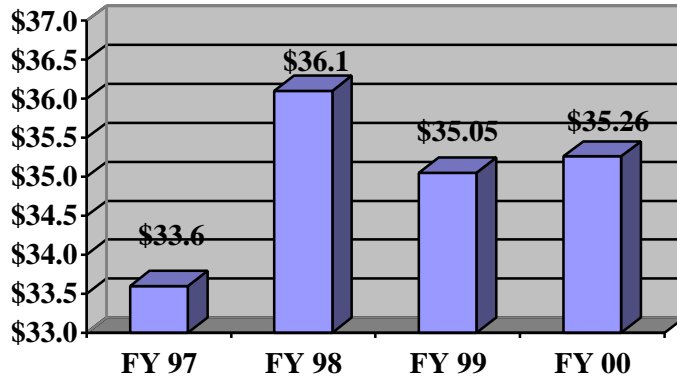


Chief Financial Officer

Robert Gaines is the Chief Financial Officer. He has been in that role for over fifteen years. (Since our site visit, he no longer holds this position within the organization.)

FY 1999 Operating Budget

AP Budget (in Millions)



* FY 00 Projected

CenterPoint's FY 99 Operating Budget was \$35.05M, a 3% decrease from the FY 98 budget (\$36.1M), representing \$1.05M loss of revenue. The decrease partially stemmed from the State's disbandment of Carolina Alternatives and the Area Program's inability to find additional funding sources to maintain a consistent revenue level. A temporary FY 2000 budget was approved with a deficit of \$1.3M with the understanding that substantial cuts must occur by September 1999 in order to ensure a balanced budget. Ron Morton is leading this effort and all finance areas will report to him until the budget is balanced.

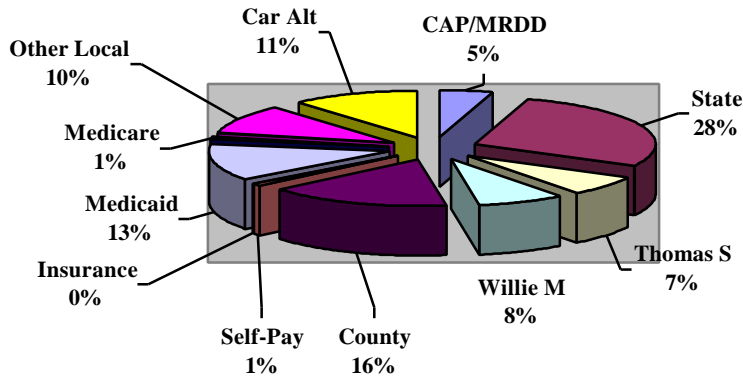
Currently, 17% of CenterPoint's revenue is generated through Medicaid representing a significant funding source for the Area Program. Over the last three years, Medicaid reimbursement has remained stagnant while other State funds have decreased significantly resulting in a greater dependence on other revenue sources such as Medicare, commercial insurance and self-pay to cover additional operating expenditures. With the combination of Medicare, commercial insurance and self-pay receivables constituting less than 2% of the FY 99 actual revenue, obtaining significant increases in these funding sources present a notable challenge for the Area Program. The projected FY 00 budget includes a \$3.6M decrease of Carolina Alternatives funding combined with a projected \$3M increase in Medicaid reimbursement from the previous fiscal year. The additional Medicaid funding equaling approximately an 80% increase from FY 99 actual reimbursement will be difficult to attain; a problem that is compounded by the budget deficit resulting in a limited capacity to expand service offerings.

2.9 Area Program Site Visits

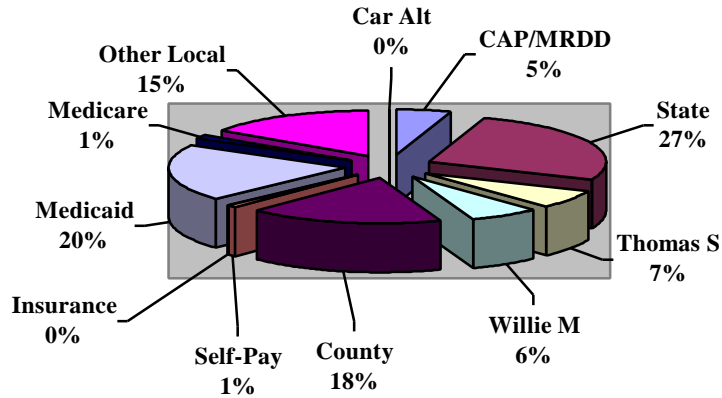
Revenue Summary by Payor Source

	FY 97	FY 98	FY 99	FY 00 (Projected)
Self-Pay	\$193,717	\$96,971	\$291,024	\$265,354
Medicaid	\$2,780,499	\$3,816,929	\$4,474,790	\$7,040,122
CAP/MRDD	\$2,026,445	\$1,717,488	\$1,633,262	\$1,748,643
Carolina Alternatives	\$3,761,231	\$4,023,326	\$4,008,359	\$0
Medicare	\$471,712	\$450,170	\$271,300	\$521,197
Insurance	\$120,823	\$140,011	\$54,337	\$42,292
Other Local	\$6,022,380	\$4,632,062	\$3,579,156	\$5,448,942
County Contributions	\$5,592,110	\$5,409,266	\$5,725,430	\$6,291,100
Thomas S.	\$2,117,812	\$2,452,293	\$2,405,790	\$2,346,964
Willie M.	\$1,013,809	\$1,719,305	\$2,712,657	\$2,234,953
Other State	\$9,506,181	\$11,630,820	\$9,895,850	\$9,320,592
Total	\$33,606,719	\$32,065,315	\$35,051,955	\$35,260,159

Breakdown by Revenue Source (FY 99)



Breakdown by Revenue Source (FY 00)

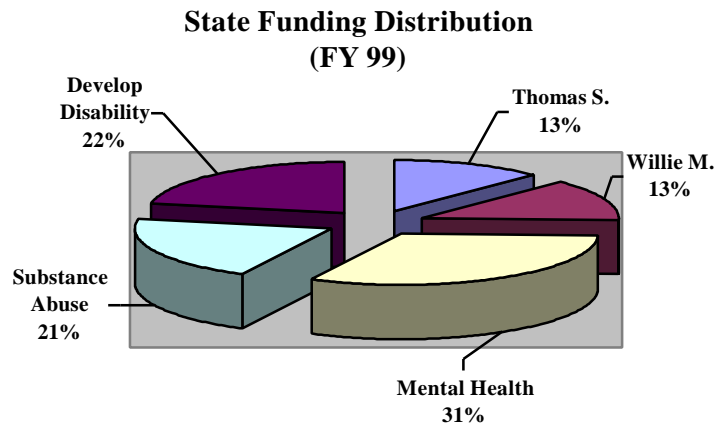


2.9 Area Program Site Visits

Further analysis of State funding illustrates the increasing predominance of restricted funds in the overall total of the State fund allocation. Funds received from Thomas S., Willie M., and CAP/MRDD comprised 32% of the total State allocation for FY 99 and are projected to increase to 40% for FY 00. The restricted funds limit CenterPoint's ability to expand services beyond these designated populations, thus placing the burden on an increase in unrestricted Medicaid reimbursement to facilitate service expansion.

Revenue Summary by Disability

The breakdown of CenterPoint's State funding for FY 99 demonstrates the equity of total State dollars for each of the disability groups of Developmental Disabilities, Substance Abuse and Mental Health with additional funding for Willie M. and Thomas S. consumers. Further analysis of the State funding distribution reveals a different view when Thomas S. funds and Willie M. funds are incorporated into DD and MH respectively; thereby demonstrating the actual disparity between DD and MH as compared to SA.

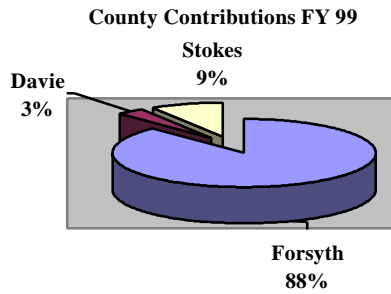


County Funding

	FY 97	FY 98	FY 99 Actual	FY 00 Budget
Forsyth	\$4.99 M	\$4.38 M	\$5.01 M	\$5.47 M
Stokes	\$0.52 M	\$0.52 M	\$.52 M	\$.53 M
Davie	N/A	\$0.06 M	\$.20 M	\$.23 M
Total	\$5.51 M	\$4.96 M	\$5.73 M	\$6.23 M

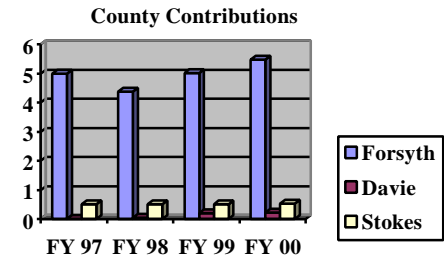
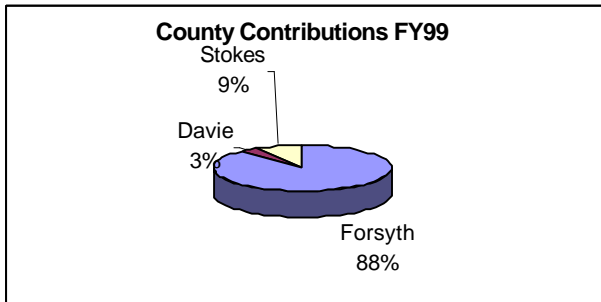
The County contribution is based on a fixed, per capita contribution per county resident. Comprising about 16% of the total budget, CenterPoint's reliance on local funding is significant. The county funding per client served varies greatly among the three counties with Forsyth at \$511 per client, Stokes at \$376 per client and Davie at \$212 per client. In addition to \$5.01M from Forsyth County, CenterPoint also receives housekeeping, groundskeeping, fleet services, security risk management and pharmacy services from the county worth approximately \$1.51M. In addition, Forsyth County provides "rent-free" space with a market value of approximately \$1.4M. Davie's contribution does not include the fair market value of rent for the facilities in Davie County, which include the outpatient clinic, case management offices and the sheltered workshop, totaling approximately \$.20M. Stoke's contribution also includes "rent-free" space with a current market value between \$.07M and \$.11M.

2.9 Area Program Site Visits



Over the last three years, Forsyth's contribution to the Area Program has both decreased and increased, while the contribution from Davie has more than doubled and Stokes' contribution has remained relatively static.

VII.



In millions

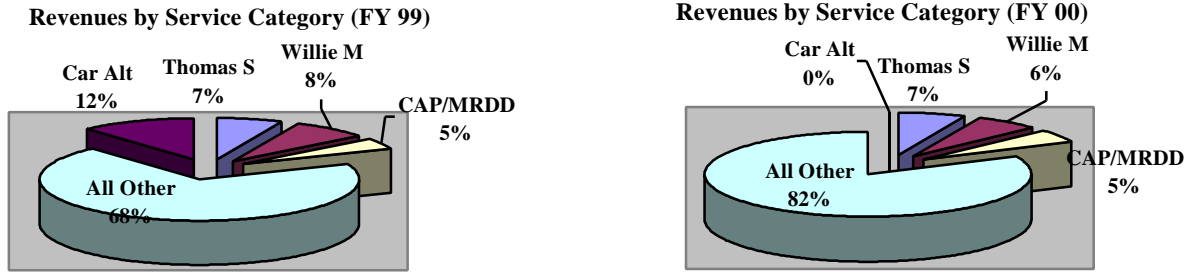
FY 99	<i>Per Capita Financing</i>				
	Population	Operating Expenditures	Per Capita Expenditures	County Funding	Per Capita Funding
CenterPoint	363,088	\$35,051,955	\$96.54	\$5,725,430	\$15.77

Division Funding

The overall division funding of the Area Program ranked CenterPoint thirty-second among the forty-one Area Programs in FY 97. CenterPoint ranked thirty-fourth in Mental Health funding with per capita funds averaging \$8.83, in comparison to a state average of \$10.56. Similarly, CenterPoint ranked thirty-sixth in Developmental Disability funding with per capita funds averaging \$9.17, as compared to a state average of \$11.51. In contrast to MH and DD funding, CenterPoint ranked fifth in Substance Abuse funding with a per capita of \$8.09 and a state average of \$6.03.

Revenue Distribution

In FY 99, 20% of CenterPoint’s revenues were reserved for restricted programs, such as Thomas S., Willie M. and CAP/MRDD. This distribution will shift slightly in FY 00 with the loss of funding from Carolina Alternatives. The restrictive nature of these funds will make it more difficult for CenterPoint to implement changes to their services as these funding streams limit their ability.



* FY 00 projected

Cash Flow Analysis

Due to the fact that CenterPoint is not a county government department, cash flow is a major concern. The Finance Director closely manages payables and performs a weekly cash flow analysis. At times, the Area Program cash shortfall can run as high as \$700K. The largest cash flow issue concerns outside vendors used by CenterPoint that depend on a quick turnaround to meet their immediate payroll needs. As a result of the cash flow problems, the Finance Director devotes most of her time managing cash and dealing with vendors and past due payables, and is unable to conduct necessary financial monitoring and analysis.

A/R Balance

As of 6/30/99, the A/R Balance is approximately \$23M with a reserve of \$21M. The agency does not routinely write-off accounts and all reduced fee clients are booked to the A/R at the full charge. As a result, the A/R trial balance is enormous and difficult to decipher the true value. In spite of cash flow issues, the A/R is not aggressively worked and denials are not pursued on a regular, coordinated basis.

Fund Balance

A positive Fund Balance does not exist at CenterPoint despite the Division's 8% requirement for minimum reserve levels resulting in an inability to deal with funding emergencies should they arise. This Area Program has made Fund Balance a top priority for FY 2000 and has a three-year plan in place to correct this deficiency. With a projected \$1.3M shortfall for FY 00, CenterPoint faces a major challenge unless the three counties are willing to increase their contribution to cover the additional cash requirement.

Front-End Management/Client Registration

Client entry into CenterPoint is well documented and roles are appropriately assigned. The intake staff enforces a strict income and residency verification procedure to determine the client's ability-to-pay. While clinical staff does get involved in reimbursement issues, self-pay collection totals, representing less

2.9 Area Program Site Visits

than 1% of total revenue, do not reflect the intervention of the staff. In addition, the process to identify and track potential Medicaid eligible clients is not clearly defined.

Cost Allocation Plan

The Area Program has identified the need for a comprehensive cost allocation plan but does not have the resources to complete this analysis. The financial management team relies heavily on the cost-finding report prepared and submitted to the Division each year to monitor costs.

Clinician Productivity Tracking

A well-designed clinical productivity-tracking plan is in place and has been accepted by the clinical staff. Individual productivity is monitored and has been incorporated into each clinician's annual performance evaluation.

MIS

CenterPoint uses CMHC for client registration and billing. A new managed care module is being installed to better manage outside contracts; full implementation is expected by the fall of 1999.

AREA PROGRAM PROFILE: BLUE RIDGE

Administration

Operating Structure

Blue Ridge Center is a multi-county program with four counties: Buncombe, Madison, Yancey and Mitchell. Buncombe County, containing Asheville, is the largest with over 75% of the total population. The Center is a local political subdivision of the state that receives minimal county funding, and operates autonomously under the Board's direction.

The central office is located in Buncombe County, with offices and staff in Yancey, Mitchell and Madison Counties. The county staff reports on day-to-day administrative issues to the respective county directors, rather than to the director in the central office. Business and MIS functions are centralized in Buncombe County

Employees: 400

Budget: \$30M (This is the middle of the range of the 4 multi-county programs surveyed)

Area Program Statistics: Blue Ridge receives only 2% of its budget from member county contributions, with 93% from Buncombe County. Blue Ridge's county contributions is among the lowest of the 8 programs surveyed. The Buncombe County contribution has not increased in 6 years, and Madison County is currently 3 years in arrears on its payments. Per capita contributions for each county are \$3.10, \$1.06, \$1.45, and \$1.23 for Buncombe, Madison, Yancey and Mitchell, respectively.

2.9 Area Program Site Visits

See the table below:

	Population			Clients		County Contributor		Board Membership	
	#	% of Total	% Medicaid Eligible	#	% of Total	\$	% of Total County \$	# Members	% of Total
Buncombe	193,284	79%	11%	6,795	62%	\$600	93%	10	42%
Madison	18,792	8%	14%	668	6%	\$0	0%	5	21%
Yancey	16,580	7%	13%	745	7%	\$24	4%	5	21%
Mitchell	14,625	6%	14%	586	5%	\$18	3%	4	17%
Outside Res.	N/A	N/A	N/A	2,240	20%	\$0	0%	0	0%
Total	243,281		11%	11,034		\$642		24	

Governance

Blue Ridge Center is an example of an autonomous program, with an active board and a clear reporting relationship between the Area Program and Board. The member counties provide a minimal financial contribution and do not exercise management influence.

Role of the Counties

The counties do not play a role in the governance of the Center, and do not view the Center as their responsibility, which falls in line with their extremely small financial contribution. While the Counties are generally supportive of human services, most new funding in this area is dedicated to non-profit providers of specialty services. The Area Program Director reports to the Board, not the counties. The Center is independent of county personnel and budget processes. The Director's interaction with county commissioners is limited, but includes appearances before them to advocate for salary increases. (Although multi-county programs are independent of the county personnel systems, their highest salary levels typically cannot exceed the respective counties'.) County Commissioners must approve increases in the annual salary plan in order for Blue Ridge Center employees to receive across-the-board salary increases. He does not have formal meetings with any county managers. The county program directors in Yancey and Madison believe that the local responsibility and authority that results from their on-site presence in the counties is key to maintaining services and relationships with county commissioners.

The Area Program Director does not view the counties as a payor of last resort, and does not expect them to increase their contributions beyond the current amount. The counties have indicated that they will not entertain increases until the current fund balance is spent down.

Role of the Area Board

The Area Board is comprised of 24 members, including one county commissioner from each of the four counties. There are special advisory councils composed of advocates, providers, interested citizens, with area board members representing a small minority of the membership. The Board meets 10 times per year, but interacts more regularly with Center staff through special advisory councils that make policy and funding recommendations related to specific disability/service areas. As the table on the previous page illustrates, Buncombe has only 40% of the board members, which is inconsistent with its dominant size and financial contribution. This discrepancy has not been raised as an issue by Buncombe or the other counties. Board members generally do not vote in county blocks, and have recently been supportive of new construction throughout the counties.

2.9 Area Program Site Visits

There is a direct reporting relationship between the Area Program Director and the Board. The Chairman of the Board meets with the Director regularly.

Capacity to Manage Change & Meet Future Demands

The Director is interested in greater regionalization in western NC counties. Blue Ridge Center has been meeting with Smokey and Trend Area Programs over the past 4 years to discuss financial and service consolidations, and recently completed the consolidation of employee assistance programs with them. Blue Ridge appears to have the management interest to consolidate further, but recognizes the potential governance problems associated with bringing up to 13 counties together, and more specifically, with attempting to create consensus among 13 groups of county commissioners.

The autonomous multi-county structure allows the Center operational flexibility to manage change; however, the autonomy limits the financial responsibility felt by member counties. For example, the counties did not increase their contributions to help alleviate the fiscal problems resulting from the disbandment of the Carolina Alternatives Program, and as a result, Blue Ridge's budget has been cut by 10%. The lack of county support could have a detrimental effect on the Center's financial stability in times of change, that is, the counties will not necessarily increase their current contributions, or "bail out" the Center.

Service System: Continuum of Care

Blue Ridge Center is a medium sized area program that serves a population of approximately 250,000 spread across four mostly rural and mountainous counties (Buncombe, Madison, Mitchell, and Yancey) and the urban center of Asheville. Basic outpatient and case management services are delivered through programs located in each county and specialty and intensive care options in Asheville. The distances involved and the lack of public transportation create an imposing obstacle for individuals who might benefit from programs located in Asheville which is the administrative and programmatic center.

While efforts are made to overcome this problem especially when acute care is needed, it is often impossible for consumers and staff to carry out an extended treatment plan that involves frequent travel to Asheville from the outlying counties. The continuum of care is less developed in the three rural counties than in Buncombe County, as specialized services tend to be concentrated in Buncombe County.

Overall, a range of both mental health and substance abuse services are available through Blue Ridge Center though the mental health side appears to be much further along in its development. The adult mental health continuum serves the priority population through a tightly knit service array that includes a large psychosocial rehabilitation program and an assertive community treatment team in addition to its medication clinic, outpatient treatment, and case management capabilities. The substance abuse continuum has a number of specialty programs and operates its own small detoxification program in Asheville, but is ill equipped to deal with complicated clinical situations. While there is access to the state operated ADATC (Black Mountain) for residential rehabilitation, that program has very limited medical support. Broughton Hospital is the default provider of treatment for individuals with co-occurring disorders or exhibiting impulsive or aggressive behavior.

Primary responsibility for emergency services remains with the Center or county that is already involved in the care of the individual or, in the case of a new patient, by the service that will provide aftercare. During normal business hours, each service handles urgent care requests directly through their main phone number. After hours requests generally come through a toll free number and a program specific (adult mental health, child mental health, developmentally disabled, substance abuse) or county specific (Buncombe, Yancey, Mitchell) on-call system. The toll free telephone number is managed by a mental

2.9 Area Program Site Visits

health worker who has access to on-call psychiatrists and disability specialists to assist in disposition of the emergency situations. If a face-to-face evaluation is necessary, it is performed by the disability specialists in Buncombe County and on-call staff in rural counties. Evaluations can also occur in The Mission-St. John Hospital emergency department for individuals in the Asheville area while the outlying counties make use of their local hospitals. Clinical staff often responds in person in the rural counties as the hospitals have limited coverage by trained behavioral health clinicians. Charter Hospital's crisis stabilization program is a frequent referral for local acute care. Broughton is used if Charter is full or the situation requires a secure setting.

Child and Family Services appears to have been quite successful in implementing a full continuum of care, but is in danger of losing ground given the termination of Carolina Alternatives. They expect to lose approximately 25% of their budget and have already closed a day treatment program that was serving approximately 30 individuals. In-home services will also be adversely affected. These changes will likely result in increased usage of Broughton State Hospital (hospital utilization was reported to have been reduced by more than 60%).

Child Mental Health

The continuum of care of child and family services developed by Blue Ridge Center is a good example of what Carolina Alternatives was supposed to be at least in regard to service system development. In fact, development of this continuum has been ongoing for some time aided greatly by its receipt of a Robert Wood Johnson grant (1989-1994). This is a well-conceived and seemingly well-organized system of care, very possibly a model program. It claims to have reduced hospital utilization quite significantly through a combination of aggressive care coordination/management and use of a range of hospital alternatives including school-based day treatment, in-home services, and a wide range of residential programming. There is considerable concern (and demoralization) among staff that many of the innovations recently created will have to be dismantled without funding provided through Carolina Alternatives. A review of the service system before and after termination of Carolina Alternatives (requested by PCG) itemizes some 20 affected areas including:

- Mobile emergency services
- Specialized substance abuse outpatient treatment
- In-home hospital diversion
- Inpatient discharge aide and case manager
- School-based therapeutic aides
- Day Treatment
- Partial Hospital
- Group home for youthful sex offenders
- Various specialized residential and respite services

Despite the recent upheaval and the likelihood of a drop-off in service continuity and efficiency, the Center will still be able to provide a service array that is among the best in the state. Though some control over quality and provider practice patterns will be lost (since they are no longer the payer), Child and Family Services intends to retain at least part of its Carolina Alternatives management capacity to monitor contracted providers.

Outpatient services are generally provided through a short-term (6 to 12 sessions) model and some "specialty clinics" (i.e. ADHD, substance abuse) have been or are in development. There are a variety of in-home services including an intensive family preservation program for families with runaway children and a Multisystemic Therapy program for families that present complex situations and services requests to numerous agencies. A network of some 100 private providers offer additional outpatient, wrap-around,

day treatment and residential services to the entire client population including Willie M. and youthful sex offenders. Child and Family Services has also developed 15 Therapeutic Foster Care homes, some of which provide crisis stabilization. Inpatient services are generally accessed at private hospitals often in Winston-Salem or other distant locations.

The service system appears to be integrated in the community through its in-home services and working relationships with schools, health clinics, and social service agencies. Blue Ridge provides substance abuse services on contract to the local training school (Juvenile Justice operated) and is part of a community initiative, “Families, Agencies, Communities Together (FACT)” funded through the Center for Mental Health Services (SAMSHA).

Adult Mental Health

In the area of adult mental health services, Blue Ridge Center offers a comprehensive and creative approach to the delivery of community based mental health care. The Center has an impressive clinical leadership team that has designed treatment programs to meet the needs of their community and to ensure access to treatment for residents in all 4 counties. The population served is severely disabled with limited economic resources. The continuum of services is inclusive of a full range of treatment options. Some of these services are provided through contractual arrangements with local providers. Community support programs are well established that enable clients to remain in the community for ongoing outpatient care. The availability of the following key services demonstrate how The Blue Ridge Center has the capacity to assume a wider role in the management of mental health care.

- The Center operates a centralized after-hours psychiatric emergency services program 24 hours per day 7 days per week. The service provides to face to face evaluations with on-call psychiatrists and serves as the portal of entry for residents referred to Broughton State Hospital.
- The Center has contracted with local hospitals to provide easy access to acute inpatient psychiatric beds and 72-hour crisis stabilization beds. Clients referred to the crisis stabilization beds are reviewed daily by the liaison clinician to determine whether the client is ready to step down to a lesser level of care.
- The Center has well integrated community support services that include a community based ACT Team and an active psychosocial rehabilitation program. These programs manage over 900 clients.
- In response to the wait time for first appointments, the Center has developed a daily orientation group for clients to bridge the time between initial intake and treatment. Clients are contacted and encouraged to attend.
- In order to meet the capacity needs of the community, the Center has created an extensive group program. Cases are routinely reviewed by the clinical supervisors and in consultation with the therapist transitioned to group treatment.
- Productivity standards for clinical staff have been developed and are rigorously reviewed by the leadership team. Access to clinician data is available through the Case Management Report system.
- There is coordination with primary medical care providers for the SPMI population.

Acute geriatric services are available in the community as well as an adult day treatment program. The Center provides consultation services to nursing homes for their mentally ill residents.

Substance Abuse

Blue Ridge offers a rich continuum of substance abuse treatment services. The Center operates an 11-bed social setting detoxification program that can be locked and is certified to take commitments. Clients who become highly agitated or aggressive are transferred to a 72-hour crisis stabilization bed, which is available through a contractual agreement in an acute psychiatric facility nearby. When the client is stabilized they are then returned to the detox to complete their program and to arrange aftercare services. The detox center has some limitations on the ability to manage clients with concurrent medical problems or who need benzodiazapine withdrawal. Blue Ridge has developed a strong belief in providing integrated mental health and substance abuse outpatient services. Staff have been cross-trained and specialty programs have been designed and implemented to address this population. The outpatient treatment focus is primarily group treatment with intensive family involvement. This treatment modality has helped to ensure access to substance abuse services for the community. The major barrier to treatment for substance abuse clients is the limited availability of transportation services or public transportation from the more rural counties to the treatment locations.

The Center has adopted a culture of thinking of least restrictive treatment options first and of stepping clients down through multiple levels of care during a treatment episode. This philosophy will allow the agency to take a leadership role in incorporating managed care principles in daily clinical practice.

Management Infrastructure

Blue Ridge Center is a former Carolina Alternatives site in the process of modifying policies and procedures to accommodate the change from a capitated reimbursement scheme to a fee-for-service structure. This change in reimbursement has limited the Center's ability to expand services within and beyond its current continuum of care. In addition, the management infrastructure has tightened as the reduction of gross revenue has caused some administrative functions to be disbanded. A number of support services remain, however, that provide the service continuum with a sufficient amount of assistance to service a large number of clients in the western part of North Carolina.

Contract Monitoring

Blue Ridge Center has not developed a specific unit responsible for monitoring the contracts of its external vendors. Contractor issues are addressed and resolved within the QI committees and its subcommittees led by the Clinical Director. Coupled with a limited capacity to monitor the contracts of external providers are the inadequate internal processes of the Center to monitor billing compliance within the provider network. The most recent DMH audit illustrates this issue as the Center achieved moderate compliance results as both internal and external provider records were reviewed. As the mental health environment changes and as more services are contracted to external provider organizations, Blue Ridge has identified the necessity of developing more refined procedures to more closely monitor the quality of services and the documentation standards of its contract providers.

Quality Management

Blue Ridge has a free standing Quality Improvement Committee that meets on a monthly basis. The committee is chaired by the same individual that chairs the Clinical Operations team, representing all programs. He is the Deputy Area Director who attends meetings of the Area Board. This individual's active involvement in these groups provides a mechanism through which Quality issues can be communicated through many levels of the organization.

2.9 Area Program Site Visits

Specific QA activity includes medical record review and peer review, while QI activity includes focused peer review, program evaluation and risk management. Much activity related to quality occurs at the program level. Peer review committees exist for all programs; their function involves a focus on two areas: general issues around quality and treatment planning, and specific issues addressing particular problems. Areas for improvement are identified, documented and reviewed by the Program Evaluation Committee.

The Risk Management subcommittee of the Quality Improvement Committee focuses on three areas: future clients of the centers, staff issues and program issues. This group is charged with determining what can be learned from critical incidents, defined as suicide or homicide by a client occurring within six months of receiving treatment. Blue Ridge recorded 13 critical incidents in a year, whereas having 6-8 per year is considered more the standard. A lead person on the subcommittee team reviews the events leading up to the critical incident, often working with law enforcement, to understand the course of events and to develop a report with lessons learned and recommendations for improved performance on a prospective basis.

Utilization Management

During Carolina Alternatives, a complete staff with formalized policies and procedures existed which provided Utilization Management support for both internally and externally provided services. Once the State concluded the Carolina Alternatives initiative, Blue Ridge Center was forced to dissolve its formalized Utilization Management procedures as a means to adhere to tight budget mandates. This change in practice has placed a greater emphasis on appropriate case management for high-end service recipients to ensure that the capacity to continue to provide services throughout the continuum remains constant. Without additional funds and/or operational assistance provided directly to Blue Ridge Center, the capacity to implement a formalized Utilization Management department to review and authorize medically necessary services would not be possible given the current budget status.

Privileging and Credentialing

Blue Ridge withdrew from the ASO, which formerly handled credentialing. As a result, the credentialing process is now handled through recruiting in Human Resources.

The Center expresses confidence in having a strong supervisory staff, and that people are adequately trained and supervised, yet the Center has put forth a substantial effort to minimize paperwork. As such, Blue Ridge reports doing the absolute minimum required for internal privileging. Supervisors review individual's qualifications and handle privileging for specific services. Privileging for subcontracted agencies is managed by the Contract Provider Committee as part of QI.

Accreditation

Blue Ridge has State accreditation that was granted as the result of a process involving a three day review by 33 State representatives. In December 1999, Blue Ridge will begin its yearlong self-study through the Council on Accreditation. Accreditation for external providers is managed by each individual program area within the Center.

Outcome Evaluation

Blue Ridge reports that outcome evaluation is an area needing improvement. They anticipate that the Client Outcomes Inventory (COI) will be useful in that the process generates informative data that can be directed back to a particular area where change can be made, if

necessary. Blue Ridge, at the time of the PCG site visit, had a newly appointed Program Evaluation Committee, which is charged with organizing internal pilot studies to determine if changes are needed.

Consumer Rights and Input

Blue Ridge's area wide Client Rights Committee meets on a quarterly basis. The area wide subcommittees meet twice a year and are based on the major disability areas: 1) Child Mental Health and Substance Abuse, 2) Developmental Disability and 3) Adult Mental Health and Substance Abuse. A client rights policy is in place and clients are informed of their rights upon intake, and asked to sign a form indicating that they have been informed of their rights. All new staff members are trained on client rights.

For resolution, client complaints can proceed through a series of designed staff members, but an effort is made to resolve such matters at the lowest level possible. Complaints can be directed to the caseworker, followed by the involved person's supervisor, then the program director (if different), then to the QI Director and then on to the Deputy Area Director, and then to the Area Director. Unresolved complaints could go as far as to the Areawide Client Rights Committee, but, to date, no unresolved complaints have progressed that far. Many complaints go directly to the QI Coordinator, who receives 16 – 24 per year from all four counties. Customer satisfaction survey activity consists exclusively of the State's biannual survey.

PCG met with several consumers and parents of consumers at the Blue Ridge site visit. A 25 year old mother of an 8 year old diagnosed with ADHD reported having had a difficult struggle : Her child had been kicked out of daycare for biting and in kindergarten was often in trouble for misbehavior. He used to light matches and talked of suicide at age 4 or 5. As a consequence of the time required for her to respond to these many concerns, the mother lost her job. She reported that she formerly had some bad experiences in the system with calls going unreturned, and when a staff person suggested foster care, this was particularly disempowering because she felt she'd tried everything and that no foster parent could do better. In-home services provided through Blue Ridge proved to be "a Godsend". Her son's behavior improved dramatically during that time, and she believes that having a clinician see how her child functioned in his home environment was critical. Changes in funding that are expected to affect the availability of this service prospectively are a major concern to her; this sentiment was also reflected in conversations with the Medical Director. The mother also expressed concerns about long waiting lists and observed that the caseworkers have very large caseloads.

PCG also met with three women, in their late twenties/ early thirties, participating in the intensive outpatient program, who explained that consumers are enrolled in scheduled cycles, not on a rolling basis. As a result, there can be a long wait to receive services, sometimes as long as four to six weeks. One consumer who was involved with the criminal justice system was locked up and couldn't be released before entering the program; consequently, the wait time was particularly problematic for her. The program is well regarded by these women, though they observe that space is limited.

Finally, PCG also met with a woman with serious and persistent mental illness and her mother, as well as with a second woman with the same condition. Both consumers were in their mid- to late thirties. The mother discussed her experience of formerly not understanding what was wrong with her child and regularly calling the Sheriff for assistance. She was very vocal about the need for family members to be educated about mental illness and insisted that there needs to be more awareness. The second consumer was affected by depression and had a long history of suicide attempts. She expressed the importance of being able to live independently and the staff at Blue Ridge supported her to be able to accomplish that. She expressed appreciation for having someone to call in the middle of the night to help calm her down.

2.9 Area Program Site Visits

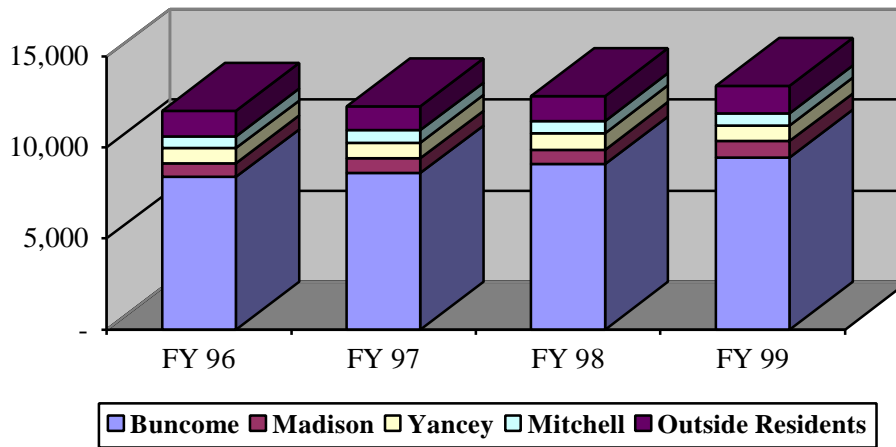
In addition, after having missed an appointment and spending the day in bed, a home visit by a member of the ACT team enabled her to get up; this was a tremendously effective service for which the consumer was very appreciative.

Financial Overview

Blue Ridge faces the same sorts of hurdles as seen in other area programs but takes a difference approach at solving problems. Through creative accounting management and accounting structures, Blue Ridge has been able to maintain levels of service and expand MIS capabilities in the agency.

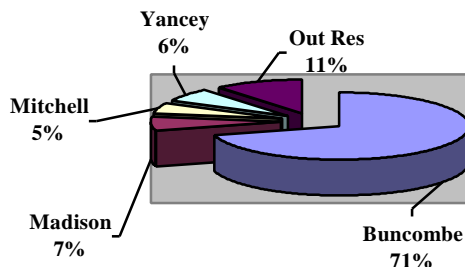
Blue Ridge Area Program has seen an operating budget in flux for the past three years and the FY 00 budget appears to continue this trend. Their operating expenditures have increased from \$29.4M in FY97 to \$32.1M in FY98, but decreased to \$30.2M in FY99, and is expected to fall to \$29.7M in FY00. The variation in expenditures is in part due to the reduction of the CAP MR/DD Program and the ending of the Carolina Alternatives Program. Despite a fluctuating budget, they have been able to serve an increasing number of clients, from 12,247 clients in FY 97 to 13,373 clients in FY 99. They have experienced a dramatic increase in clients served over an eight-year period from FY 91 to FY 99 going from 7,434 to 13,373. Blue Ridge has projected an increase of \$3.9M in Medicaid funds for FY 00 to offset the loss of \$4.7M in Carolina Alternative funds. Although the Area Program has experienced an increase in clients served over the past three years, an increase from 13,373 to an estimated 25,504 in total clients served would be necessary to achieve projected Medicaid revenue.

Clients Served



The majority of Blue Ridge's clients reside in Buncombe County constituting 79% of the Center's consumers in FY 99. Blue Ridge serves similar percentages from Madison, Mitchell and Yancey at 8%, 6% and 7% respectively.

Clients Served in FY 99



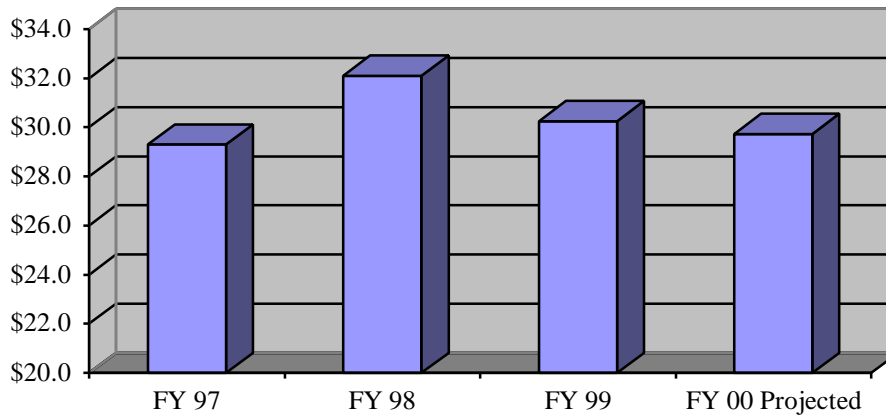
Chief Financial Officer

Jack Parsons is the Finance Officer for Blue Ridge. He has been in this capacity since September 1, 1986.

Operating Expenditures

Blue Ridge operated with a \$30.1M budget in FY 99. This is budgeted to decrease slightly to \$29.7M in FY 00 as a result of the termination of Carolina Alternatives. As a result of decreasing revenues, Blue Ridge is budgeted to spend \$1.9M of their fund balance due to insufficient revenue to support current operations.

Area Program Operating Expenditures (in



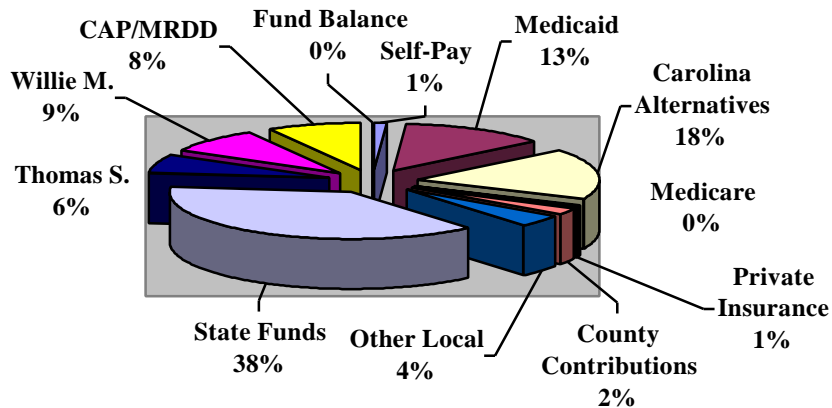
Blue Ridge relies heavily on State funding and Medicaid, representing approximately 50% of the operating budget in FY 99, to support clinical service programs. The Area Program has seen a significant decrease in their Medicaid revenues over FY 98, which is primarily due to a significant decrease in the CAP / MRDD funding (see below). County funding remains at only 2% of their revenues, the lowest of all Area Programs reviewed. In summary, Blue Ridge receives only two percent of their funding from private insurance, Medicare and client fees.

Blue Ridge has experienced a 5% decrease in revenues from FY 98 to FY 99. This decrease is largely attributed to a reduction in the CAP / MRDD funding which decreased by 53%. The Area Program was able to offset some of the shortfall from CAP / MRDD through an increase in funding of the Thomas S and Willie M programs by more than 20% each. Blue Ridge also experienced an increase in funding of the Carolina Alternatives program, however, this creates a significant problem as the funding of this program has ended as of 6/30/99.

2.9 Area Program Site Visits

Revenue Summary - by Payor Source	FY 98	FY 99	FY 00 Budgeted
Self-Pay	\$407,782	\$352,176	\$370,848
Medicaid	\$3,372,034	\$3,883,222	\$7,485,817
Carolina Alternatives	\$4,893,342	\$5,324,308	\$0
Medicare	\$232,384	\$69,857	\$75,713
Private Insurance	\$152,628	\$154,837	\$153,230
County Contributions	\$662,000	\$642,000	\$734,000
Other Local	\$1,346,958	\$1,310,885	\$1,395,247
State Funds	\$11,869,867	\$11,303,271	\$10,664,213
Thomas S.	\$1,427,802	\$1,934,497	\$2,073,930
Willie M.	\$2,047,968	\$2,620,052	\$2,863,487
CAP/MRDD	\$5,308,847	\$2,485,009	\$2,020,562
Fund Balance	\$0	\$0	\$1,897,614
Total Revenue	\$31,721,612	\$30,080,114	\$29,734,661

Breakdown by Revenue Source (FY 99)

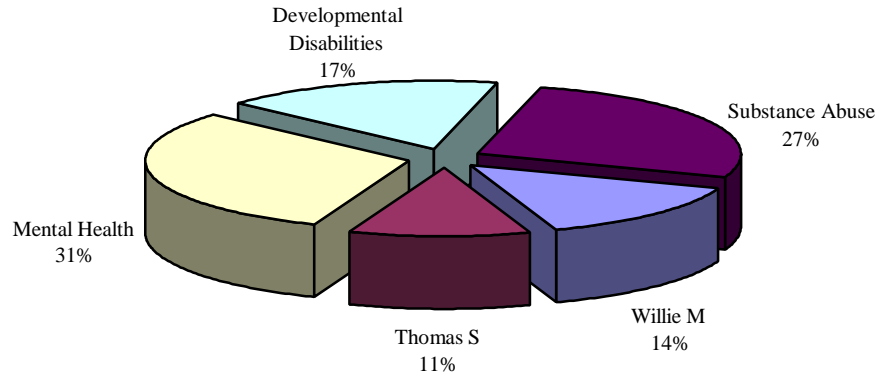


Revenue Summary by Disability

Further analysis of Blue Ridge's State Funding for FY 99 illustrates the equity in funding across the disability groups of substance abuse, mental health and developmental disabilities, including additional funding for Thomas S. and Willie M. consumers. Restricted funds account for 25% of the total state funding with Thomas S. at 11% and Willie M. at 14%, limiting Blue Ridge's opportunity to expand service delivery for the unclassified population.

2.9 Area Program Site Visits

State Funding Distribution for FY 99

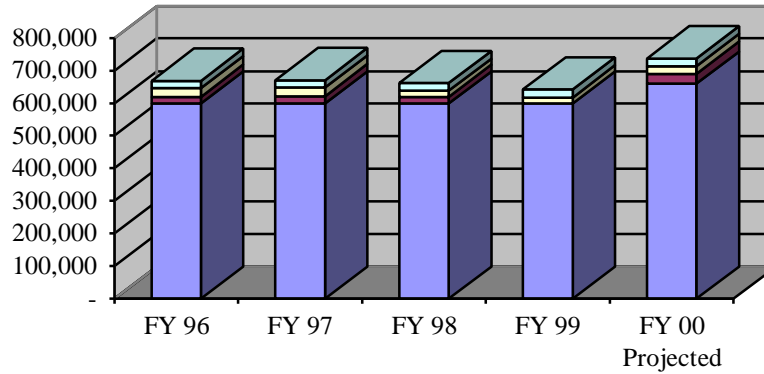


County Funding

	FY 96	FY 97	FY 98	FY 99	FY 00 (Projected)
Buncombe	\$600,000	\$600,000	\$600,000	\$600,000	\$600,000
Madison	\$20,000	\$22,000	\$20,000	0	\$30,000
Mitchell	\$21,400	\$21,400	\$18,000	\$18,000	\$20,000
Yancey	\$27,231	\$27,121	\$24,000	\$24,000	\$24,000
Total	\$668,631	\$670,521	\$662,000	\$642,000	\$674,000

County contributions are based on historical performance and have no bearing to population or client needs by county. The County contribution varies widely among the four counties and as a percentage of total revenue, is the lowest of all area programs visited. During FY 99, Madison County made no contributions to the operations of the Area Program due to insufficient revenue capabilities. Blue Ridge is currently constructing a new \$900K site for Madison; however the county's funding remains the lowest per capita of the four counties. Over the past four years, County contributions have decreased while the number of clients served has increased by 10%. FY 00 budget includes a substantial county contribution increase of 14% necessary to cover a portion of the loss caused by the disbandment of Carolina Alternatives.

County Contributions



Per Capita Financing

FY 99

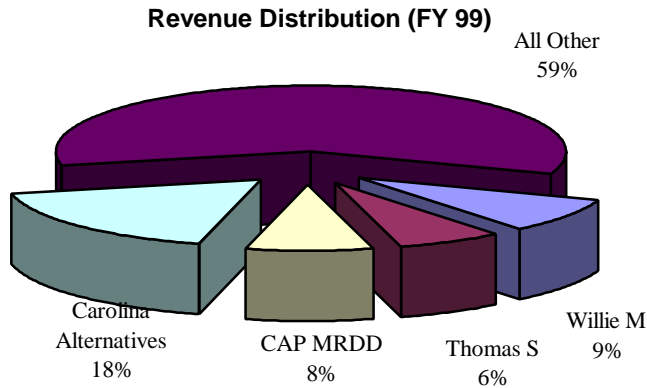
	Population	Clients Served	County Funding	Per Capita Funding	County Funding Per Client Served
Buncombe	193,284	9,438	\$ 600,000	\$ 3.10	63.57
Madison	18,792	905	-	-	0.00
Yancey	14,625	851	24,000	1.64	28.20
Mitchell	16,580	681	18,000	1.09	26.43
Outside Residents		1,498			
Total	243,281	13,373	\$ 642,000	\$ 2.64	48.01

Division Funding

The overall division funding of the AP ranked Blue Ridge twenty-second among the forty-one programs that existed in FY 1997. This ranking was consistent for the Mental Health and Developmental Disabilities, however the division provided Blue Ridge with one of the highest per capita funding for Substance Abuse programs. Blue Ridge ranked twenty-fourth in Mental Health funding, with per capita funds averaging \$10.27. Developmental Disabilities funding ranked twenty-fifth, at \$ 10.92 per capita. However, Blue Ridge ranked third in the state in division funding for substance abuse, with per capita funding of \$8.48. Substance Abuse currently represents 27% of total division funding. This is in contrast with the average state Area Program funding of Substance Abuse programs at a 12% of total state funding.

Revenue Distribution

In FY 99, twenty-three percent of Blue Ridge’s revenues were reserved for restricted programs, such as Thomas S., Willie M. and CAP/MRDD. This distribution will shift dramatically in FY 00 with the loss of funding from Carolina Alternatives. Without the funding of Carolina Alternatives in FY 99, restricted funds would have represented nearly one third of the total funding. The restrictive nature of these funds will make it more difficult for Blue Ridge to implement changes to their services as these funding streams limit their ability.



Fund Balance

As of June 98, Blue Ridge has a fund balance of \$6.3M. This is roughly \$400K less than the FY 97 fund balance. During FY 97, Blue Ridge appropriated \$3.9M of their fund balance to cover operations but still managed to increase their net fund balance by nearly \$1.1M. In FY 98, Blue Ridge was able to bring in revenues over expenses by \$1.2M, however their equity transfer, related to an increase in contributed capital of \$1.6M, is the cause for this decrease in fund balance.

Blue Ridge struggles to meet Division requirements to maintain an adequate fund balance. In spite of this, the agency was able to fund substantial MIS improvements through transfers between companies created and held by the area program.

Front End Management/Client Registration

Blue Ridge has a decentralized intake that is well documented with roles and responsibilities appropriately assigned. Intake workers systematically verify and update demographics upon every visit.

Cost Allocation Plan

The Area Program has identified the need for a comprehensive cost allocation plan but does not have the resources to complete this analysis. They rely heavily on the cost finding prepared and submitted to the Division each year to monitor costs.

Clinician Productivity Tracking

The MIS department has developed a comprehensive clinical tracking program that is utilized by management during performance evaluations.

MIS

Blue Ridge's MIS department rivals that of a small to mid sized acute care hospital. System access is available to all staff. A flexible and dynamic Intranet serves as a powerful tool to inform and educate staff. A seasoned team of IS professionals have been recruited to manage the system and the physical layout of the computer operations is impressive. Blue Ridge uses CMHC for billing and registration; this AP is the dominant user of this application in the state.

AREA PROGRAM PROFILE: MECKLENBURG
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Administration:

Operating Structure

The Mecklenburg County Mental Health Authority (AMH) is a single county program which operates as a department of the county. It is the largest of the 8 programs surveyed, both in terms of population and budget. In fact, it is the largest program in the state. The nine-member Mecklenburg Board of County Commissioners (BOCC) serves as the Area Authority Board. The Assistant County Manager, Marie Shook, responsible for the Health and Human Services Core business, serves as the Area Director. The day-to-day management of the Authority is handled by the Assistant Director, Sheila Swift. The integration into the county occurred in the mid-1980's.

There are two advisory boards that provide advice and guidance to the Area Authority and the BOCC. The first is the Human Service Council. It serves as the primary citizen advisory board for human service programs. It is composed of 19 members appointed by the BOCC. The second is the Mecklenburg Area Authority Advisory Committee. It is established by invitation from the Area Director. Its purpose is to bring representatives from stakeholder groups together to provide advice on service delivery in a managed care environment. The Mecklenburg AMH operates under a hybrid structure organized around population groups which cross disabilities. These groups are referred to as service continuums and include Infant/Toddler and Preschool Services, Child and Adolescent Services, Adult Services and Centralized Services. The majority of services provided in Mecklenburg are contracted to outside entities as the Authority is moving away from directly providing services. Case Management and Assessment & Referral will remain internal in order to control the depth and breadth of services provided. The Authority is negotiating with the Division of MH/DD/SAS to implement a locally managed system of care. This project will involve Mecklenburg becoming a Management Service Organization (MSO). All funding sources currently received by Mecklenburg are included in the plan, plus institutional funding for State Hospitals, Mental Retardation Centers, Adult Drug and Alcohol Treatment Centers and State Schools.

Employees: 626

Budget: \$72.3M - This is the largest budget of the 8 programs surveyed.

2.9 Area Program Site Visits

County Financial Participation : The mental health program is 41.8% county funded, the highest county contribution in the state. This contribution has been annually maintained or increased in recent years, including a \$2M increase this year. See the table below:

	Population			Clients		County		Board Membership	
	#	% of Total	% Medicaid Eligible	#	% of Total	\$	% of Total County \$	# Members	% of Total
Mecklenburg	630,848	100%	17.8%	25,631	100%	\$30.2M	100.0%	9	100%

Governance

The Mecklenburg County Area Program is an example of a county-run MH/DD/SAS department with a high amount of county funding, a direct reporting relationship to the County and an emphasis on local control. The Board of County Commissioners serves as the Area Authority Board. The Authority reports to an Assistant County Manager.

Role of the County

Human services are considered a core part of county government in Mecklenburg receiving widespread support from commissioners and the County Manager alike. For example, they maintain acute care contracts with the Carolina Health Care System and provide indigent care at the County's expense (approximately \$5M per year). AMH is a full department of county government; all are employees of the county, and it operates under all personnel, purchasing, disbursement and budget processes established by the County. The Assistant County Manager serves as the Area Director.

Role of the Area Board

The BOCC serves as the Area Authority Board. It is made up of 9 members, six district representatives and three members who serve at large. The Human Services Council operates at the behest of county commissioners. It meets monthly and has 19 members who are appointed by the county commissioners. The Council was established to allow for community input into service provision in the mid-1980's, when the independent boards of public health and mental health were disbanded. The council maintains only advisory authority, yet asserts a high lever of influence on the policy-making process. AMH requests for County Commissioner action must be approved by the Council before proceeding to the Commissioners. The Council has full access to staff and information resources, annually reviews priorities and providers and makes recommendations directly to County Commissioners on the budget. In addition, the Council also conducts independent studies and proposes initiatives that have been implemented.

Capacity to Manage Change & Meet Future Demands

Over the last three years, the Mecklenburg Area Authority has invested heavily in infrastructure changes which position it well to take on new projects. A number of major positions were created and filled, including directors for Managed Care, Finance and Information Systems. The Authority has also purchased and is in the final stages of implementing a sophisticated information system to manage its clinical and financial operations. Mecklenburg AMH receives a high level of support from the County; it can leverage its on-going partnership with Carolinas Healthcare System to establish new programs; and the management staff have expressed a willingness to engage in pilot projects both within the County and with others in the region. The key to any new initiative in Mecklenburg will be to recognize the unique

2.9 Area Program Site Visits

level of support by the County, and to ensure that local control is maintained commensurate with the local financial contribution.

Service System

Mecklenburg is a single county program serving the Charlotte metropolitan area. It is the largest in the state in terms of population served and annual budget.

The continuum of care is largely provided through an extensive network of contracts with private providers coordinated by agency-based Case Managers, Service Analysts and Utilization Review Analysts. Mecklenburg has invested heavily in the development of a utilization management department. Originally intended to support the agency's entry into the Carolina Alternatives program, the department will eventually perform functions for all ages and disability groups using a software platform that has been customized for this purpose. Improved contract monitoring and system-wide quality management initiatives will become crucial as Mecklenburg seeks to meet the state mandate for national accreditation.

Central to the operation of Mecklenburg's system of care is their relationship with Carolinas Medical Center (CMC). CMC Behavioral Health is the primary provider of emergency, acute care, physician and outpatient services. These services are largely delivered by CMC in a county-owned building located on the same campus where the Area Program operates its administrative offices and some other programs. CMC offerings include a 24-hour psychiatric emergency service, brief crisis stabilization/observation beds, acute inpatient treatment for children, adolescents and adults and a range of outpatient services. The Area Program employs no physicians, instead purchasing all services from CMC. Efforts to improve continuity of care and quality management throughout the provider system would seem to benefit from greater involvement of the CMC medical staff in the planning and monitoring functions of the Area Program.

Infant/Toddler and Preschool Services

The Infant/Toddler and Preschool Services Program provides treatment to children from birth to age 5 who have or are at risk for developmental disabilities or atypical emotional development. Services include Early Childhood Intervention, Child Service Coordination and Consultation and Education. Early Childhood Intervention includes assessment and therapeutic services to help children birth to age three who have developmental delays and to provide support and counseling to families. The Child Services Coordination area assists families to plan and access services across systems (i.e., the Departments of Health and Social Services and the Charlotte-Mecklenburg Schools). Lastly, consultation and education services are provided to parents, day care and preschool teachers and other community care givers.

Child and Adolescent Services

Child and Adolescent Services provides a full continuum of care for all youth requiring mental health or substance abuse treatment. The system of care for children and adolescents includes a wide array of services across the following areas: prevention/education, outpatient and in-home treatment, case management, vocational and day treatment, residential services, crisis intervention, and inpatient care. Many of the services are provided through contracts with a large network of private providers; however, the Area Program provides virtually all the case management and much of the continuum of services for Willie M. clients through its own programs and staff. The Willie M. continuum includes the Tom Ray Center, a residential environment that provides crisis beds and long-term residential care to this population and others requiring a secure treatment setting. A number of group homes that serve as step-down settings from secure treatment are also operated directly by the Area Program for Willie M. clients.

2.9 Area Program Site Visits

Acute care services are largely provided in the community through a contract with Carolinas Medical Center (CMC). Carolinas Medical Center provides all of the emergency services, most of the acute inpatient care and some crisis stabilization beds for the system. CMC professional staff also provide most of the clinic-based outpatient care including medication management, psychiatric services, and outpatient evaluation and therapy. Mecklenburg rarely refers to Broughton State Hospital placing just one adolescent there in the past twelve months. Additional crisis intervention services are provided by the Tom Ray Center, Alexander Children's Center and New Hope (sexual offenders) Treatment Center.

Mecklenburg contracts with several large vendors who provide specialized care to a particular sub-population. Alexander Children's Center provides in-home services, after school and day treatment, crisis stabilization and residential treatment to young children latency through approximately 10 years old. McLeod Center provides residential services and Willows (subsidiary of Carolinas Medical Center Behavioral Health) residential and partial hospital services to adolescents with substance abuse diagnoses. New Hope Treatment Centers, Charter Asheville and Charter Winston-Salem provide secure residential services to youthful sex offenders

Adult Services - Mental Health

Mecklenburg County operates a wide array of mental health services for adults. The continuum of services includes a range of options: acute inpatient treatment, crisis intervention, residential placement, vocational and day programs, outpatient treatment, case management and education programs. The organization has a well-defined management structure which allows for the ongoing development of community based programs that are responsive and accessible to the community. The agency has been proactive in the area of managed care and has devoted significant resources to define an integrated care management system. Strengths within adult mental health that enable this agency to play a more expanded role in the delivery of care are:

- The availability of acute psychiatric beds onsite that are equipped to manage severe and persistent mentally ill consumers during the acute phase of their illness. Utilization of state hospital beds is minimal. These beds are primarily utilized for clients that require long-term inpatient treatment.
- A centralized intake system that includes emergency services, crisis intervention/management, crisis stabilization beds and an acute partial hospitalization program. These services can be readily accessed 24 hours per day, 7 days per week through an 800 line.
- Timely access to outpatient treatment services with a reasonable wait time for an initial appointments. Reasonable availability of psychiatrists for medication management. A belief in cross-training of clinical staff across disabilities in order to promote more comprehensive and less fragmented outpatient treatment.

A state funded pilot program for the provision of mental health services to geriatric patients in nursing homes has been underway for ten years. This program provides access to psychiatric nurses for nursing homes, making an impact on managing behavioral issues in the nursing home setting. The agency has a strong geriatric service component that includes a geriatric team of nurses and psychiatrists that provide wraparound services to elderly psychiatric clients living at home or in rest homes.

Adult Services - Substance Abuse

The Area Authority has adopted the mission to provide comprehensive and coordinated community based substance abuse treatment options for all residents of Mecklenburg County. In keeping with this mission of community based treatment, Mecklenburg County operates a 44-bed social setting detox program for

2.9 Area Program Site Visits

adults. This program has an open door policy that is geared toward reducing barriers to treatment. Clients are triaged through the centralized emergency service program and offered services to meet the level of care required. Those clients that require a more medically based program are referred, under contract, to an acute general hospital in the area.

Within Mecklenburg County Substance Abuse Services, there is a limited capacity to offer more extended rehabilitation programming beyond the initial detoxification phase. Clients requiring this level of care are typically referred out of area or transferred to the local shelter for ongoing treatment. Significant gaps in resources exist within the county for availability of programs that offer active treatment in a sober environment promoting recovery. Treatment for dual diagnosis clients can be fragmented and require treatment interventions in a variety of settings. Clients in detox whose psychiatric illness becomes unstable are transferred to the psychiatric emergency services for observation and stabilization and are then returned to the detox for their substance abuse treatment. Although there is an effort to cross-train staff and build coordinated treatment for the dually diagnosed, rehabilitation and/or residential services are limited to the community based shelter programs. The agency supports the community programs by providing outreach to the shelters. Clinicians are onsite at each shelter providing educational groups and individual counseling. Mecklenburg has developed specialized programming for priority populations which include residential programs for pregnant women and women with children. “Cascade Services” also offers childcare and has integrated treatment for women who have been sexually abused into the core treatment program.

Adult Services -Developmental Disabled

Mecklenburg County provides a number of services for clients who are developmentally disabled. Case management is offered to assist clients in problem solving and in linking, coordinating and monitoring necessary services. Services offered include vocational, residential, behavioral support, counseling, diagnostic, psychiatric (including medication evaluation and monitoring), respite and various support services to help consumers remain in the community. Mecklenburg also operates a CAP-MR/DD Program which provides an array of services for those consumers who are eligible.

Centralized Services

This area includes the Crisis Stabilization Unit, Treatment Alternatives for Women, Prevention/Wellness, and the Centralized Assessment and Referral Center, Mecklenburg’s single point of entry for access and assessment of mental health, substance abuse and developmental disability issues. The center offers 24 hours/seven-day per week telephone triage, face-to-face assessment in order to appropriately match individuals to needed services. It is staffed by licensed and/or certified professionals. The Crisis Stabilization Unit (CSU) is designed to offer clients an alternative to inpatient hospitalization, which until its creation in 1991, was the only alternative. Round-the-clock monitoring is provided and the program is far less disruptive to clients.

Management Infrastructure

The infrastructure at Mecklenburg County Area Mental Health boasts one of the most comprehensive mental health management infrastructures in the State with smooth access to a wide array of services and qualified staff in key positions throughout the organization. Mecklenburg’s extensive provider network, state of the art information systems, Centralized Intake, Utilization Management and a focused unit developed to handle all contracting and provider issues demonstrate the Area Program’s capacity to provide additional services. Mecklenburg utilizes a combined committee-driven system with individualized departments responsible for addressing issues of contract monitoring, quality management and utilization management.

Contract Monitoring

Mecklenburg utilizes a vast number of contract providers that allow the most efficient use of its limited resources to provide needed services to the largest number of individuals. Mecklenburg AMH's current service continuum includes contracts with 180 providers totaling approximately \$42 million dollars representing 58.7% of the total FY 98-99 budget (\$72M).

In order to manage Mecklenburg's large provider network an internal unit called the Service Analysis and Outcomes (SAO) unit was created. SAO Analysts are responsible for monitoring all contracts and act as a liaison when specific issues arise. Issues addressed by SAO Analysts include negotiating rates, reviewing documentation standards, reviewing contract compliance and providing training as new local and state guidelines are introduced. The goal of SAO is to provide each of the contract providers with a single contact for all contract issues and questions. Mecklenburg's MIS system, BCMS, has the capability of automating much of the contract monitoring function, however, the current Accounts Payable piece of the system does not include effective claims adjudication software. In the coming fiscal years, BCMS will be programmed to handle multiple tasks in claims payable and accounts receivable, tasks that currently are performed manually.

To ensure quality throughout its provider network, Mecklenburg's SAO Analysts are also responsible for conducting general accreditation reviews of each of the external vendors. These reviews verify that effective policies and procedures exist to govern each of the contracted entities. Many of Mecklenburg's contract providers are utilized extensively by other Area Programs with duplicative accreditation procedures applied. The multiple accreditation reviews enhance overall monitoring functions, thus ensuring quality services; however, serve as a large cost burden for the Area Programs.

Quality Management

A Quality Assurance/Quality Improvement Administrator and the SAO unit interweave quality initiatives throughout Mecklenburg Area Mental Health. SAO is responsible for ensuring quality services to each of the consumers for all internal programs and, as mentioned previously, for all externally provided services. The QA/QI Administrator directs the decentralized Behavioral Health Information Services Unit and addresses issues of confidentiality, proper record keeping and storage and appropriate documentation standards and guidelines. In addition, the QA/QI Administrator is playing an integral role in transitioning the organization to an electronic clinical record within the new BCMS information system.

Mecklenburg AMH has also developed three separate Network Development Teams (NDT) to address issues that arise from contracting with various external providers. Membership on NDTs is comprised of staff from SAO, Fiscal, Clinical and Utilization Review. These teams have been divided into Child and Adolescent, Adult Mental Health, and Substance Abuse/Detox and handle issues specifically related to their own functional areas. The NDTs meet on a weekly basis to discuss service quality events among each of the contract vendors including documentation deficiencies, behavioral outcomes and alternative provider opportunities. NDTs make recommendations to the Strategic Leadership Team comprised of the Assistant Director of the Area Program, the Director of Client Services and the Chief Operations Officer. The recommendations can range from enforcing a corrective action plan to the suspension of referrals and even the ending of a contract. As more services are contracted by the Area Program in the coming years, the NDTs will play a more vital role of addressing specific contracting issues to ensure quality services throughout the provider network.

Utilization Management

Mecklenburg's Utilization Management (UM) department authorizes all high-end externally provided services for its contract provider network. This pre-authorization process has been effective in reducing unnecessary services and has allowed Mecklenburg to sign more open-ended contracts with its providers. Open-ended contracts grant each contract provider the ability to provide more services to more clients than would be available under the typical total budget contracts and forces Mecklenburg to closely manage its pre-authorization process. The UM team authorizes services based on the Level of Care Criteria set forth by the State and reviews a sample of clients each month for medical necessity. The UM management team has worked extremely hard to develop policies and procedures that direct the provision of only medically necessary services while increasing the total number of services available to all consumers.

Accreditation

Mecklenburg earned a three-year State accreditation through a process involving 26 State representatives reviewing on-site for an array of monitoring activities, including record reviews and discussions with Area Board members. In addition, as part of the process, Mecklenburg held open forums for consumers and other interested parties to come and provide comment on the Area Program

Privileging and Credentialing

Mecklenburg has a Privileging and Credentialing team which is a subset of the QI team. Most Program Directors hire clinical staff with a B.A. degree and at least four years of experience, or with an M.S. degree and at least two years of experience. Those who hire personnel with less experience must take a very active role in supervising those staff members. Privileging is updated annually.

Mecklenburg has developed specific policy language regarding credentialing, privileging and reprivileging for both internal and external providers. This language is maintained as part of the Quality Improvement Plan.

The Human Resources department obtains staff credential information and sends it to an external Credentialing Verification Organization (CVO) to be verified. Verified credentialing information is then presented to the QI administrator and to the Credentialing and Privileging team. Notably, Mecklenburg requires that contract providers use an external CVO in their credential verification process for staff who serve Mecklenburg's clients. This review of credentials by an independent party is viewed as a critical component of responsible hiring, yet represent a vast administrative burden for the Area Program.

Outcome Evaluation

Mecklenburg is among ten Area Programs who started collecting outcomes data for the State in March; this data was submitted, but as of the time of the PCG site visit, feedback from the State had not yet been provided. The outcome indicators offered by the State through this process are seen as useful by the Area Program.

In addition to participating in outcome evaluation activity required by the State, Mecklenburg is developing a system based on the Program Logic Model, which was pulled together through a national effort and extensively tested. This model will be piloted at Mecklenburg through an eight month process involving four groups of internal and external providers. Information gathered by external providers will be reported back through the Network Development team and directed on to the QI team. For internal providers, information will come to the QI team directly.

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In addition, contracts with external providers include outcome indicators in the core contract tailored to the individual service being contracted. Other outcomes activity includes medical record reviews, the Global Assessment of Functioning (GAF) and the Child and Adolescent Functioning Assessment Scale (CAFAS).

Consumer Rights and Input

Mecklenburg has a Client Rights Committee, which reports up to the Area Board. The Committee, at the time of the PCG site visit, was actively reviewing an amended Client Rights Policy. The Client Rights Committee has several subcommittees, including Rights Violations, Rights Promotions and Restrictive Interventions.

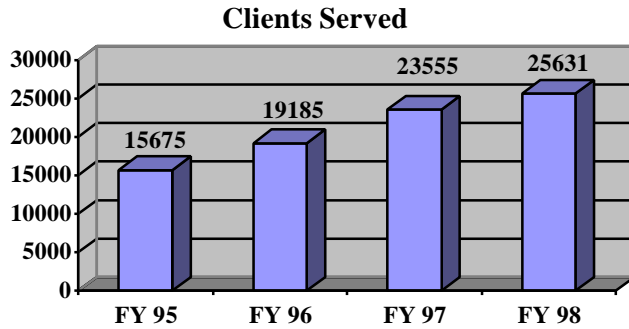
Upon intake, clients are given information about their rights, including the right to file grievances and appeals, and sign a form attesting to their receipt of this information. Among the more common complaints reported are those related to access to specific levels of service; in some cases, clients and/or their families or guardians request more or less restrictive levels of care than the clinical team recommends.

PCG was afforded the opportunity to meet with a 49 year old male client who, at the time of the site visit, had relapsed three times as a consequence of an addiction to crack cocaine. A former police officer, he had lost his wife and house as a result of his addiction. Though he needed to wait 15 days to receive treatment because of the waiting list, Mecklenburg offered him structured activities during that time to keep him occupied; the client expressed appreciation for this level of involvement, even before space opened up to enable him to receive the treatment he needed. The client explains that the facility is accessible by bus, with the bus stop just half a block away. He was very complimentary of the staff, stating that the counselors are excellent and very sensitive and that the new relapse program is great. He felt that the program could use more staff.

In addition, PCG met with a girl in a group home who had a history of fighting. Due to a change in the population eligible for the services she had been receiving, with 3 or 4 weeks left in her treatment plan, she would not be able to complete her stay. This represented a substantial interruption in her treatment.

Financial Overview

Mecklenburg's financial team is a highly experienced group of managers facing the challenge of directing a constantly changing mental health financial environment combined with the implementation of a new care management system which includes Claims Adjudication and Billing/Accounts Receivable. Overall, the staff is educated, knowledgeable and committed to improving the system; however, the operational requirements of a large mental health center with contract management representing almost 60% of the Area Program's service delivery proves a difficult task. Decreased Medicaid revenue, a growing client base, a new venture into the capitated marketplace and increased compliance requirements from funding sources are the top concerns of the financial team.

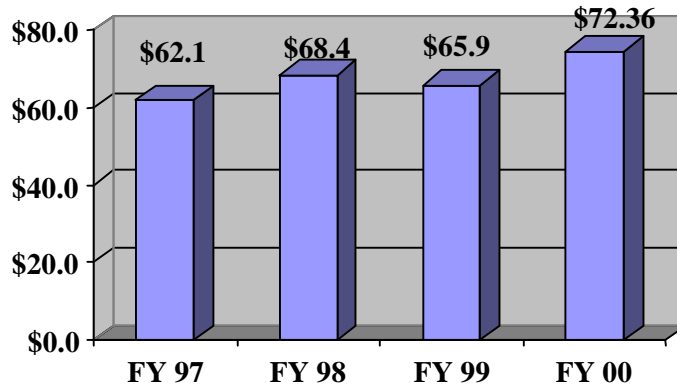


Chief Financial Officer

Jesse Garland is the Director of Finance. He has a Master’s degree in Accounting and has been in his position for three years. He has approximately 25 years experience in the public finance sector.

FY 97-99 Operating Expenditures

Note: FY’s 97-99 do not reflect spin-off of community service programs to Health Department.
 AP Operating Expenditures (in Millions)



Mecklenburg's FY 99 Operating Expenditures were \$65.9M, a 4% decrease from the FY 98 total (\$68.4M). The decrease was primarily attributable to a loss of more IRDD Medicaid billing and the Area Program’s difficulty in identifying additional funding sources to maintain a consistent revenue level. The FY 00 budget includes an additional \$700K reduction in CAP/MRDD as more services are provided and billed by contract entities. The Finance Division is aggressively pursuing increases in other revenue sources, such as private insurance and client fees, in order to increase revenue for the organization.

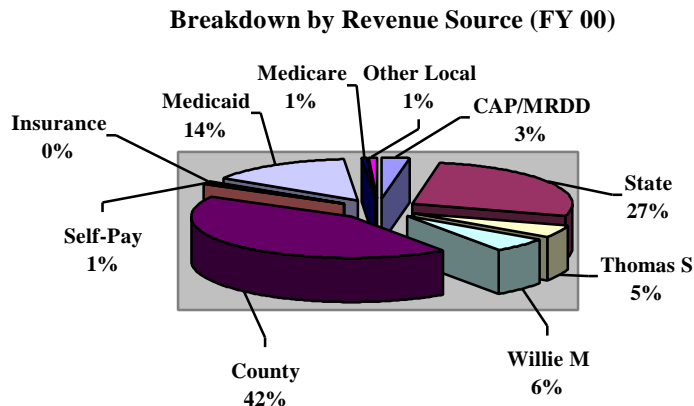
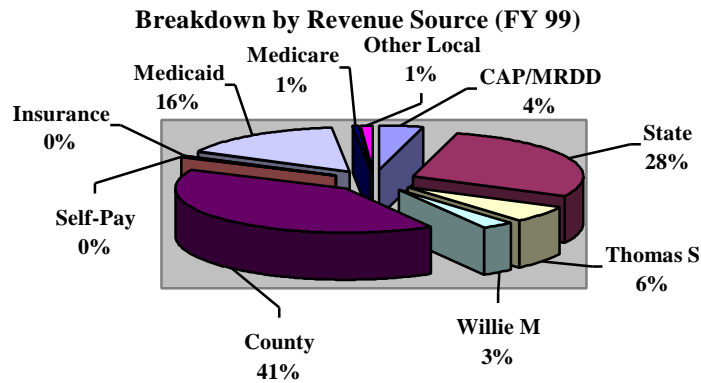
A new and more aggressive billing and collection policy was recently approved by the BOCC. Although total Medicaid billing has decreased over the last several years because of the CAP providers billing Medicaid direct, Medicaid “Fee for Service” reimbursement continues to represent a significant revenue source for Mecklenburg, representing approximately 18% of the FY 2000 budget. State/Federal funds have remained stagnant causing a greater dependence on other revenue sources such as county funding, Medicare, commercial insurance and self-pay to support new service initiatives. With the combination of Medicare, commercial insurance and self-pay receivables constituting about 1% of the FY 99 actual total revenue, obtaining significant increases in these funding sources present a notable challenge for the Area Program and may provide little impact on the overall financial picture. The minimal projected self-pay

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and Medicare increase and the limited use of restricted funds forces Mecklenburg to rely more heavily on the County's contribution for service continuum expansion.

Revenue Summary by Payor Source

	FY 97	FY 98	FY 99	FY 00 (Projected)
County Contribution	\$20.1M	\$21.4M	\$26.5M	\$30.2M
State/Federal Funds (incl. WM/TS)	\$27.8M	\$29.5M	\$24.7M	\$27.5M
Medicaid (incl. CAP)	\$12.4M	\$14.7M	\$13.2M	\$12.9M
Other Local	\$1.4M	\$2.1M	\$689K	\$538K
Patient Receipts	\$269K	\$313K	\$248K	\$661K
Private Ins/Medicare	\$156K	\$425K	\$445K	\$675K
Total (Rounded)	\$62.1M	\$68.4M	\$65.9M	\$72.3M



Further analysis of State funding illustrates the increasing predominance of restricted funds in the overall State fund allocation. Funds received from Thomas S., Willie M., and CAP/MRDD comprised 25% of

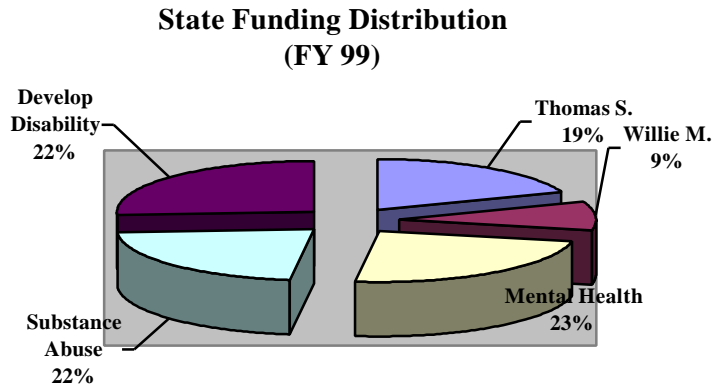
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the total State allocation for FY 99 and are projected to increase to 28% for FY 00. The restricted funds limit Mecklenburg's ability to expand services beyond these designated populations, thus placing the burden on an increase in unrestricted Medicaid reimbursement and more predominantly on the County's contribution to facilitate service expansion.

	FY 97	FY 98	FY 99	FY 00 (Projected)
Thomas S.	\$3,577,790	\$3,566,573	\$4,014,916	\$3,626,000
Willie M.	\$4,020,337	\$3,934,539	\$2,096,920	\$4,186,404
CAP/MRDD	\$7,256,009	\$7,163,730	\$2,779,873	\$2,088,936
Other State	\$20,219,934	\$21,985,824	\$18,624,176	\$20,076,403
Total	\$35,074,070	\$36,650,666	\$27,515,885	\$29,977,743

Revenue Summary by Disability

The breakdown of Mecklenburg's State funding for FY 99 demonstrates the inequity of total State dollars for each of the disability groups of Developmental Disabilities, Substance Abuse and Mental Health with additional funding for Willie M. and Thomas S. consumers. Further analysis of the State funding distribution demonstrates the even larger disparity of State funding when Thomas S. funds and Willie M. funds are incorporated into DD and MH respectively, with DD at 41%, MH at 32% and SA at 22%.



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County Funding

	FY 97	FY 98	FY 99	FY 00 (Projected)
Mecklenburg	\$20,059,946	\$21,363,486	\$26,520,130	\$30,203,514

Mecklenburg County's contribution is the largest in the State both on a total dollar and percentage of budget basis. Comprising over 40% of the total FY 99 budget, Mecklenburg's reliance on local funding is significant. Over the past three years (FY 97-99), the County contribution has increased by 32% as the population in Mecklenburg County continues to rise. With the total county population equal to approximately 625,000, the per capita County funding equals \$42.43, the highest among the eight programs surveyed.

Per Capita Financing

FY 99		Operating	Per Capita	County	Per Capita
	Population	Expenditures	Expenditures	Funding	Funding
Mecklenburg	624,527	\$65.9M	\$105.52	\$26.5M	\$42.43

Division Funding

The overall division funding of the Area Program ranked Mecklenburg thirty-fourth among the forty-one Area Programs in FY 97 in total per capita funding. Mecklenburg ranked twenty-third in Mental Health funding with per capita funds averaging \$10.43, in comparison to a state average of \$10.56. Similarly, Mecklenburg ranked thirty-third in Developmental Disability funding with per capita funds averaging \$9.65, as compared to a state average of \$11.51. In addition, Mecklenburg ranked twenty-third in Substance Abuse funding with a per capita of \$5.67 and a state average of \$6.03.

Cash Flow Analysis

Mecklenburg Area Mental Health is a county government department which prevents cash flow from becoming a major concern until year-end. The Finance Director along with the team of financial managers closely manages payables and performs routine analysis of budgeted dollars vs. actual receipts. The Area Program utilizes the Utilization Review function to continue to control costs and manage care in the most efficient manner and will extensively utilize the new MIS system, BCMS, to manage payables and receivables as it is implemented.

A/R Balance

As of 6/30/99, the A/R Balance is approximately \$11.6M with a reserve of \$9.8M. The agency has not routinely write off accounts; however, they begin doing so as old accounts are transferred to BCMS. Currently, the A/R trial balance is enormous and difficult to decipher the true value. Due to the large number of private insurance denials and the immense volume of Medicaid claims submitted, the Accounts Receivable department has had little time to work the accounts to maximize revenue.

Fund Balance

As a local government entity, Mecklenburg Area Mental Health utilizes the County's fund balance to account for the Division's 8% requirement for minimum reserve levels. If the Area Program were

2.9 Area Program Site Visits

required to maintain a fund balance separate from the County, Mecklenburg would have a difficult time sustaining the more than a \$5M operating surplus.

Front-End Management/Client Registration

Client entry into Mecklenburg operates under a centralized process in multiple portals. The management team has established one department responsible for collecting income and residency verification data, determining the client's ability-to-pay, gathering insurance and third party payer information and performing a clinical screening and assessment to determine the client's appropriate need for service. The ultimate goal of this new unit is to refer clients to medically necessary services and to increase the self-pay collections and insurance collections.

Cost Allocation Plan/General Ledger

The Area Program falls under the County's cost allocation plan. The AP also utilizes the County's General Ledger System to record revenues and expenditures and write checks. All expenses are classified into various expense categories with roll-ups to larger funding categories. Program dollars are tracked and monitored by the financial managers. There are extensive reports available on-line at the desk-top to facilitate the tracking and monitoring process.

Clinician Productivity Tracking

A specific clinical productivity-tracking plan exists, however, the results are not formally incorporated into the annual review function. Clinician's productivity is utilized for cost-finding between each of the functional areas. The implementation of BCMS will provide new capability to track clinical productivity.

MIS

Mecklenburg is implementing a new care management software program called Behavioral Care Management System (BCMS) for client registration, utilization management, service reporting and billing. The system is being tailored to meet the specific needs of Mecklenburg County in conjunction with the Willie M., Thomas S., Medicaid and Pioneer financial systems. Full implementation is expected by the fall of 1999.

AREA PROGRAM PROFILE: ROCKINGHAM COUNTY

Administration

Operating Structure

Rockingham County Area Program is a single county program, representing the smallest area program in terms of population and budget among the eight programs surveyed. Officially, the program is a local political subdivision of the State, not a county department; however, it operates as a de-facto county department in many ways, with the Area Program Director reporting to the County Manager rather than the Area Board on most management issues. The Area Program facilities are located on the same campus with county offices.

The Area Program's primary management staff, including the Director, Finance Officer and DD Director, have all been with the agency for over 30 years, and operations are heavily guided by long-standing personal relationships.

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Employees: 135

FY 99 Operating Expenses: \$8.6M (The smallest of the 8 programs surveyed)

Area Program Statistics: In FY 99, Rockingham received 11% of its budget from the County, in the middle of the range among the programs surveyed. Rockingham County contributes \$12 per capita to the Area Program. See the table below:

FY 99	Population			Clients		County Contribution		Board Membership	
	#	% of Total	% Medicaid Eligible	#	% of Total	\$	% of Total County \$	# Members	% of Total
Rockingham	89,651	100%	12%	2,363	100%	\$1.08M	100.0%	17	100%

Governance

Rockingham Area Program is an example of a single county area program that is technically independent of the local governing body but operates as a department of county government. With the Board’s approval, the Area Program Director reports to the County Manager rather than the Board. This contradicts the independent legal status of the Area Program, but favored by all parties who believe the Area Program benefits from its close relationship with the County.

Role of the Counties

The County Manager reports that the County “embraces” the Area Program. While he recognizes that the Area Program is legally independent, the relationship has evolved such that the Area Program operates much like a county department, as evidenced by the following:

- Both the Area Program and County Staff indicated that the Area Program will serve as the payor of last resort.
- Funds allocated to the Area Program that are not spent may revert to the county's general fund.
- Area Program property is provided by the County, sometimes through reversions of the original county contribution to the Area Program.
- The Area Program is located on the same campus as the county offices.

In recent memory, no incidences have arisen to challenge the current governance structure. For example, no disagreements have occurred between the board members and the County Manager on the Area Program’s operations. Partially due to employee tenure, the Area Program does not require extremely active oversight from the County or the Board. A high degree of personal trust exists among Area Program staff, board members, and county managers.

Role of the Area Board

Approximately 17 members serve on the current Area Program Board with a minimum of 15 required. One member is a county commissioner, who rotates with other commissioners. While the Board plays an active role in guiding the Area Program and evaluating the Area Program Director yearly, it delegates routine management decisions to the County. The Board recognizes its authority to hire the Area Program Director, but that position has not opened up in over 30 years.

Capacity to Manage Change & Meet Future Demands

- Rockingham currently offers a set of core services limited by a lack of additional revenue sources to expand services. A lack of trust of state funding commitments and a high degree of cynicism generally towards the Division of Mental Health (DMH) makes the Area Program, Board and County reluctant to participate in new state initiatives.
- There is an inherent weakness as the de-facto county authority and the board authority governance structures conflict. In an atmosphere of new demands, this is likely to create conflict. For example, if a situation arises in which the Board and the county management disagree, there is little precedent for the Board to exercise its legal authority to overrule county preferences and/or decisions regarding Board operations.
- The Area Program has built its foundation upon long-standing personal relationships, some exceeding 30 years. The current staffing and structure adequately serve the Area Program's needs, but could be viewed as a long-term weakness as the delivery of mental health services faces future challenges.
- The close relationship and high degree of accountability between the Area Program and the County may be beneficial to change since single county programs tend to be more willing to modify county contribution amounts than multi-county programs.

Services System

Rockingham is a small single county program that appears to function at the outer edge of its available resources to provide a limited range of clinical services. It is the primary provider of mental health and substance abuse services in the county. Most of the clinical services address the mental health needs of two priority populations, adult seriously mentally ill and Willie M. Acute services for all ages, substance abuse services and child mental health services are less well developed and less accessible. Major obstacles to delivering services include transportation and availability of trained professionals, especially psychiatrists, in the area.

Child Mental Health

Internal planning documents address the need for increased capacity and a broader continuum of child mental health services in Rockingham County. Presently, three clinicians and two case managers attempt to provide a range of outpatient treatment and education services with approximately six hours per week of child psychiatry support. The program works closely with the Department of Social Services to identify children at-risk and provides periodic parenting classes.

Intensive treatment services are essentially unavailable anywhere in the county. The outpatient team handles emergency service requests during the day and through area hospitals after hours. Most of these after hours calls result in inpatient admissions to private psychiatric hospitals whose staff perform all evaluations in the hospital emergency rooms or John Umstead Hospital if a bed is not available or the child is severely out of control. A plan to upgrade the County's emergency and crisis stabilization capacity through the development of a community-based residential program that would provide a range of acute services has not come to fruition.

Other identified needs include family preservation/in-home services, day treatment and partial hospitalization, expanded case management, treatment for youth sex offenders and local residential options. There are no residential programs available in the county and most of the contracted beds are devoted to Willie M. designated children. Generally, two to four children are at Umstead with

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approximately six children waiting for residential placement and about the same number in residential care who could be in the community if a day program was available.

Adult Mental Health

Adult Mental Health services are provided within the county for routine outpatient services that include individual, group and family therapy and medication management. The Unit Director is a PHD psychologist who provides, in conjunction with the Medical Director, clinical supervision and program oversight. Being a rural county, a major issue that the Area Program faces is ensuring access to services for many residents. The Area Program makes a strong effort to provide outreach services for their clients who are severe and persistent mentally ill, home bound or physically disabled. The caseloads of the therapists are overall high and qualified staff can be difficult to recruit. The Medical Director is retiring at the end of this year and it is likely that recruitment for his replacement will be a slow process. Psychiatric clients requiring hospitalization are primarily referred to the state hospital for treatment. Bed utilization does not routinely exceed annual allocation for psychiatric clients despite minimal diversion services available for crisis stabilization. Clients referred to the state hospital are case managed by Area Program staff who coordinate the scheduling of the outpatient appointment upon discharge. There is little financial incentive for the Area Program to divert patients from hospitalization, as the penalty for over-utilization of bed days is not strictly enforced. The Area Program has a fully staffed medication clinic that is supervised by a Clinical Nurse Specialist.

Geriatric Services are limited due to scarce resources available in the county. The primary care physicians in the community are the primary providers of mental health services for the geriatric population. Residents requiring hospitalization are referred out of the county while long-term care beds are limited to those with the ability to pay. The Area Program has a full time geriatric clinician who is actively involved in the geriatric provider system. There are no facilities available to move the medically complicated or behaviorally difficult patient out of the state hospital to community based services. Limited capacity exists to provide home visits to the frail elderly. Patients referred to the state hospital remain at the state hospital for an extended length of stay.

Substance Abuse

The Area Program has developed a strong commitment to providing quality substance abuse services. The Director, Carl Britton-Watkins, is an experienced clinician who provides supervision, program development and leadership. The continuum of services includes a wide range of mid-level programs that are accessible to the community. These services are Intensive Outpatient Programs, Continuing Care groups and outpatient counseling for individuals and families. The Intensive Outpatient Program is located at the local community college and the Area Program provides transportation daily for clients who are enrolled. This co-location of the program on the college campus is a unique method of service delivery and has assisted in reducing the fear associated with receiving treatment. The county has serious limitations in the ability to provide acute substance abuse services. Detoxification services are unavailable in the county. Residents are referred out of county and at times out of state for detox. There are two acute care hospitals in the county that will evaluate and at times admit patients for medical stabilization. The state hospital is regularly accessed for individuals that are suicidal and/or homicidal and under the influence of a substance. Transportation to the state hospital is provided by county law enforcement that at times is unavailable to transport for extended periods of time. These clients are generally housed in the jail until the sheriff is available. There has been an over utilization of the state hospital bed day allocation each year. Private facilities are available for those individuals with insurance. There are no county-based acute services available for adolescents, resulting in the necessity of the Area Program to contract for adolescent services on an as-needed basis.

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Other community-based services include a school-based program MAJORS—Managing Access for Juvenile Offenders and Services. TASC, Treatment Alternative to Street Crimes, serves the adult population who are referred from the court system and whose offense is substance abuse-related. Prevention programs have been established in the K-6 grades for high-risk children. Residential substance abuse services are not available in the county.

The Area Program has a strong employee assistance component and serves as the EAP for the county employees as well as local businesses.

Identified needs include the development of specialty services for Dual Diagnosis (MI/SA), programs for women and children, pregnant women, IV drug users and bilingual clinicians for the large Hispanic population.

Management Infrastructure

The infrastructure at Rockingham County Area Program is less structured than some of the larger Area Programs yet provides adequate support to manage the delivery of Mental Health services under the current system. While resources are not necessarily abundant, the management and clinical staff of the Area Program have developed a system of care that effectively services the clients within its Catchment area.

Contract Monitoring

Rockingham County Area Program has only a limited number of external vendors who provide mental health services and, without adequate resources, the Area Program's capacity to increase the quantity of services is restricted. The Area Program currently maintains over 150 contracts with service agencies totaling \$3.9 million in direct service contracts and \$67K in professional service contracts, representing 47% of the total FY 99 Operating Expenditures (\$8.6M). Of the total contracted expenditures, \$1.6M is directly contracted to outside programs, while the remaining \$2.6M consists of contracted agencies/individuals providing services within Rockingham programs. Rockingham County Area Program depends extensively on the program directors and/or the case managers and the area administration office to monitor contract compliance. The monitoring function includes billing compliance, patient complaints and other vendor-specific issues.

Quality Management

Rockingham County Area Program's quality assurance process is effective in ensuring the quantity and quality of service notes found in the client record. For internally provided services, quantitative record items are reviewed by an outside agency while a formalized peer review process reviews the qualitative criteria. Rockingham generated one of the highest overall compliance percentages in the State during the most recent Medicaid audit performed by DMH. In contrast, the QI process is poor due to the lack of staff available to research and implement changes within the organization.

Utilization Management

Rockingham does not maintain a formal Utilization Management (UM) function. Weekly clinical team meetings are utilized to determine medical necessity for each of the clients. Case Managers provide authorization numbers for the provision of contracted services; however, this has a limited impact on the monitoring of medical necessity. Current resources cannot support a separate UM department, nor does the existing staff have excess time to develop and maintain a standardized Utilization Review capacity.

Privileging and Credentialing

Internally, Rockingham maintains a clear privileging process by requiring the supervisors to update all privileging forms during the employees' annual performance review. Rockingham employs approximately 135 people, 85 to 90 of whom need to be privileged on a yearly basis. A regional office in Winston Salem, NC verifies the credentials of the internal providers. In contrast, Case Managers are responsible for privileging external providers. This process is not standardized, yet, has been effective in ensuring privileged staff as evidenced by a 100% privileging compliance rate in the most recent DMH audit.

Outcome Evaluation and Consumer Input

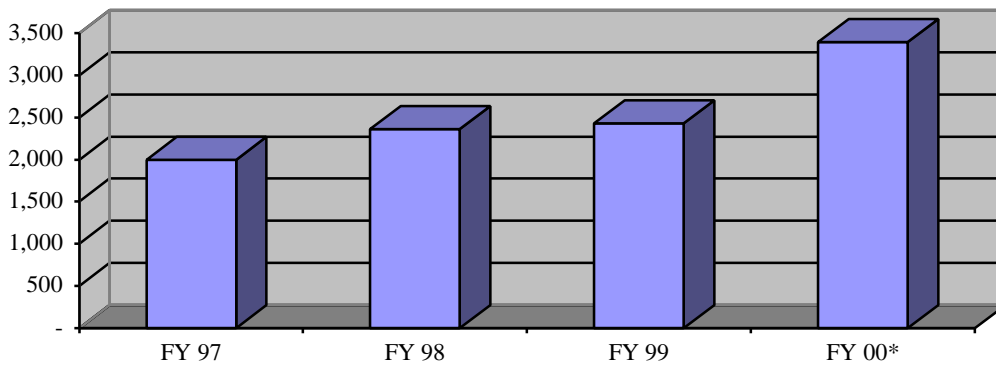
Rockingham depends on the State to track clinical outcomes through the COI initiative. The COI results, however, have had limited impact on the enhancement of clinical services in Rockingham County. Case Managers sporadically capture a small amount of data regarding client satisfaction directly from the client, yet no formal internal mechanism exists to track clinical outcomes.

The consumers generally like services offered at Rockingham. Accessibility to services continues to be an issue with no public transportation and limited van service. In addition, consumers are hesitant to visit the local ER on the weekends due to a general fear of commitment. Consumers enjoy a service level, however, gaps do exist with step-down services including Partial Hospitalization and Day Treatment programs.

Financial Overview

Rockingham's financial team is limited in its ability to identify additional funds necessary to expand MH and SA services for Rockingham County residents. Overall the staff is knowledgeable of the current challenges facing Area Programs throughout the State but struggles to find funding to finance new program initiatives as Medicaid and other State funds decrease on a per capita basis. Rockingham has projected a 44% increase in Medicaid revenue for FY 00 to offset projected liabilities, a challenging obstacle considering the corresponding expansion in services is not likely. Although the Area Program has experienced a slight increase in clients served over the past three years, a 43% increase in total clients served would be necessary to achieve projected Medicaid revenue.

Clients Served



* Estimated client requirement to achieve Medicaid revenue target.

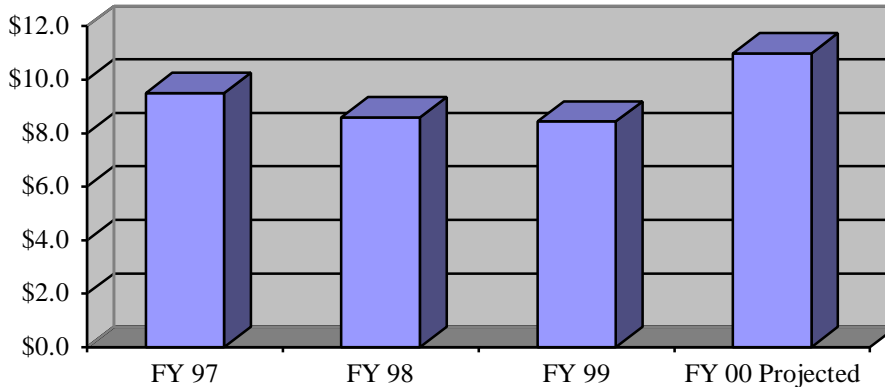
Chief Financial Officer

Linda McMahan serves as Chief Financial Officer and is considered second in command at the Area Program. She has been employed by Rockingham in various capacities for over 30 years.

FY 1999 Operating Budget

Rockingham operated with a \$8.6M budget in FY 99, with projected growth exceeding \$11.0M in FY 00. Rockingham Area Program has seen a variable operating budget for the past three years, consistently budgeting for expanded service offerings. In FY 00 they budgeted a \$11M operating budget (a 30% increase); however, they have been unable to achieve this budget growth to date. In fact, Rockingham has experienced a 35% decrease in revenue from FY 98 to FY 99, partly attributable in the changes to CAP/MRDD billing. All other programs have remained steady, with the exception of the Willie M. program, growing by \$200K.

AP Expenditures (In millions)

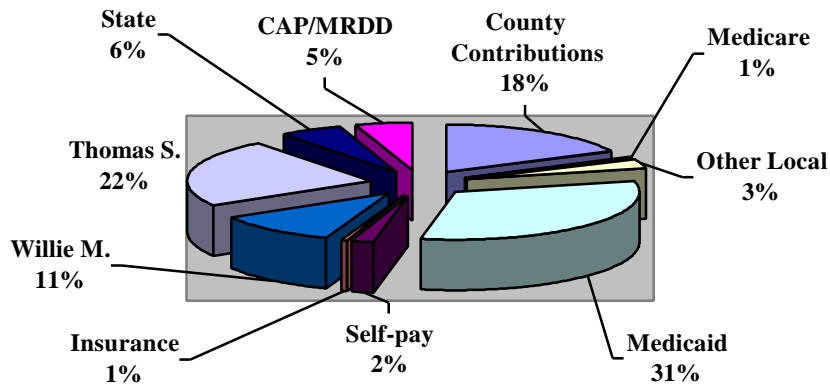


Rockingham relies heavily on State funding and Medicaid, representing approximately 54% of its operating budget in FY 99, to support the clinical service programs. Projecting a \$1.3M revenue increase for FY 00, Rockingham has budgeted significant across payor sources with a 44% increase in self-pay and as previously mentioned, a 44% increase in Medicaid revenue. Additionally, the Area Program is also dependent on a 7% increase from the County and a 52% increase in Other Local funds.

2.9 Area Program Site Visits

Revenue Summary - by Payor Source	FY 98	FY 99	FY 00 Projected
Self-pay	\$121,692	\$111,449	\$160,047
Private Insurance	\$66,440	\$40,348	NA
Medicaid	\$2,300,461	\$1,926,791	\$2,783,626
County Contributions	\$989,635	\$1,077,055	\$1,149,776
State Funds	\$3,188,427	\$3,347,504	\$3,676,054
Medicare	\$9,026	\$41,205	\$112,975
Thomas S.	\$1,241,719	\$1,404,427	\$1,476,445
Willie M.	\$548,173	\$654,598	\$562,914
Other Local	\$812,463	\$170,825	\$258,445
CAP/MRDD	\$811,471	\$362,510	\$534,922
Fund Balance	\$58,551	\$561,922	\$267,863
Total Revenue	\$10,148,058	\$9,698,634	\$10,983,067

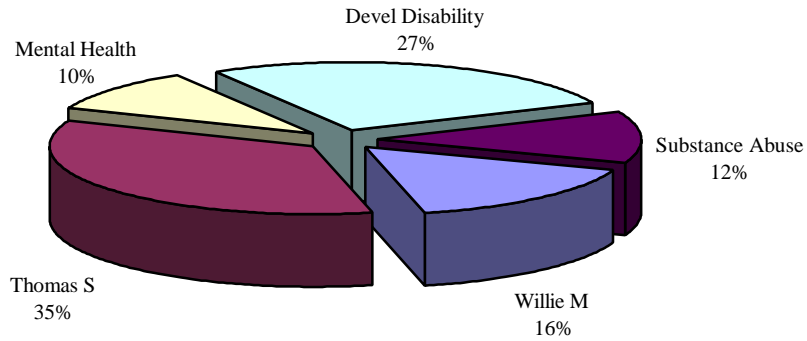
Breakdown by Revenue Source (FY 99)



Further analysis of Rockingham's State Funding for FY 99 illustrates the disparity in funding across the disability groups of substance abuse, mental health and developmental disabilities, including additional funding for Thomas S. and Willie M. consumers. Restricted funds account for 51% of the total state funding with Thomas S. at 36% and Willie M. at 15%, limiting the opportunity for Rockingham to expand service delivery for the unclassified population.

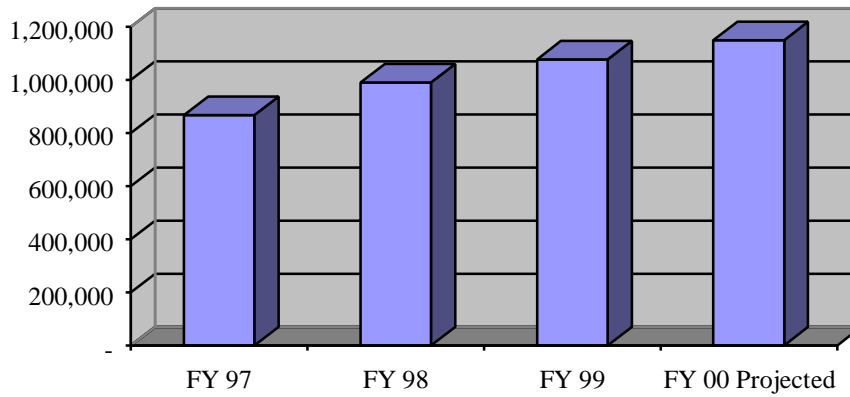
2.9 Area Program Site Visits

State Funding Distribution for FY 99



County Funding

The County contribution towards the Area Program is the shortfall between revenue and expenses. The County Finance Officer has voiced concerns over this method of funding and would prefer a fixed or per capita contribution. Rockingham's per capita contribution is relatively low in comparison to average county contributions across the state.



Per Capita Financing

FY 99	Population	Operating Expenditures	Per Capita Expenditures	County Funding	Per Capita Funding
Rockingham	89,651	8,438,039	94.12	1,077,055	12.01

Division Funding

The overall state funding of the Area Program ranked Rockingham seventeenth among the forty-one programs that existed in FY 97. There was however, a large disparity in the funding of individual programs. Rockingham ranked thirty-ninth in Mental Health funding, with per capita funds averaging only \$7.42. This is in contrast to the funding of Developmental Disabilities, where Rockingham ranks fifth, at \$17.94 per capita. Rockingham ranked fifteenth in the state funding for substance abuse, with per capita funding of \$6.36.

Cash Flow Analysis

Rockingham does not complete a cash flow analysis. The Area Program appears to be solvent but has relied on the County Finance Office to float expenses in the past when cash flow has become an issue. Rockingham's ability to generate significant revenues over expenses has been a key contributing factor to their ability to generate cash.

Accounts Receivable Balance

As of 6/30/99, Rockingham had approximately \$6 million in their accounts receivables, with a reserve of \$4 million. The Area Program maintains a consistent annual write-off procedure by purging accounts without activity for three years.

Fund Balance

Rockingham maintains a separate fund within the budget of the County, but does not maintain a specific fund balance, as would a multi-county program. The separate fund was established to allow the County Finance Officer more information regarding the Area Program funds that remain in the County fund balance until settlements are completed by DMH. According to Rockingham's Finance Officer, the settlements are not completed until the spring of the following fiscal year, thus prohibiting the county from knowing how much money is available to be reappropriated.

Front End Management/Client Registration

Client entry into the Area Program is well documented and roles and responsibilities are appropriately assigned. Rockingham does not strictly enforce income or residency verification of their clients. Even though clinical staff gets involved in reimbursement issues, self-pay collections are low and the process to identify and track potential Medicaid eligible clients is not clearly defined.

Cost Allocation Plan

The Area Program does not have the resources to complete a cost allocation plan, yet recognizes the need to develop a plan that adequately identifies costs of each of the internal programs. Rockingham relies heavily on the cost finding prepared and submitted to the Division each year to monitor costs.

Clinician Productivity Tracking

A plan was developed to track the clinical productivity of clinical staff several years ago but languished upon the departure of the MIS director. The new MIS director has simplified the data collection and processes and expects to resurrect the tracking system in FY 2000.

2.9 Area Program Site Visits

MIS

The Area Program uses the AS4000 owned by the county MIS department. This represents the only MIS support received by the Area Program. The MIS staff of three manages the billing software, the internal network and processes client event tickets. According to staff, the system is Y2K compliant.

AREA PROGRAM PROFILE: SANDHILLS CENTER

Administration

Operating Structure

Sandhills Center is a multi-county program with five counties: Moore, Richmond, Anson, Hoke, and Montgomery. The first two are relatively larger than the rest, but do not play an overly dominant role. The Center is a local political subdivision of the state, and operates independently of the counties. It is the smallest multi-county program among the 8 surveyed, both by population and budget.

The Center has a professional and well-managed corporate structure. The central office is located in Moore County, but the Center operates offices and services in each of the five counties. Each county has dedicated staff for all outpatient services, and each mental health center has a full array of outpatient, case management and psychiatric services, both child and adult. Other services, including Thomas S. and Willie M. services, are run centrally out of the West End office.

Employees: 380

Budget: \$25M (the smallest multi-county Area Program surveyed)

Area Program Statistics: Sandhills Center receives only 2% of its budget from member county contributions, a small amount, but not unlike other Area Programs surveyed. In addition, an inequitable correlation exists among the member county populations and the respective county with larger counties not necessarily contributing greater amounts. See the table below:

	Population			Clients		County Contribution		Board Membership	
	#	% of Total	% Medicaid Eligible	#	% of Total	\$	% of Total County \$	# Members	% of Total
Moore	71,394	36%	9%	2,363	30%	\$380K	63%	6	29%
Richmond	46,221	24%	18%	1,980	25%	\$114K	19%	5	24%
Anson	24,354	12%	20%	1,130	15%	\$39K	6%	4	19%
Hoke	30,424	15%	15%	1,193	15%	\$25K	4%	3	14%
Montgomery	24,080	12%	14%	1,124	14%	\$45K	7%	3	14%
Total	196,473			7,790		\$604K		21	

Governance

The Sandhills Center is an example of an independent Area Program, with an active board and a clear reporting relationship between the Area Program and Board. Five County Commissioners on the Area Board exercise significant management influence despite their limited county general funding commitment.

Role of the Counties

The counties do not play a significant role in the governance of the Center, and do not view the Center as their responsibility, which may correlate to the size of the financial contribution. The Center Director reports to the Board, not the counties; however, the Moore County Finance Officer is a member of the Board's Finance Committee. The Center is independent of county personnel and budget processes allowing them flexibility when making hiring decisions and planning for future program expansion

The Center Director does not view the counties as a payor of last resort. Neither he nor the Board Member interviewed believe that the counties are interested or willing to increase their current contribution. The Director believes that the county's preference would be to provide more services, including inpatient beds, locally.

Role of the Area Board

The Area Board is comprised of 21 members, including one county commissioner from each of the five counties. The Board meets monthly. As the table on the previous page illustrates, seats are roughly proportional to the respective counties' populations.

There is a direct reporting relationship between the Center Director and the Board. Although a certain level of parochialism exists, the board members generally do not vote in county blocks.

Capacity to Manage Change & Meet Future Demands

The Center appears to have an aggressive and forward-thinking management staff who actively pursues new revenue sources in order to facilitate service expansion. The Area Director, with 15 years experience, reports that the Center "takes on change constantly," and would be willing to bring additional area programs under their umbrella.

The autonomous multi-county structure allows the Center operational flexibility to manage change, yet limits the financial responsibility felt by member counties. In times of financial instability, this arrangement may cause a detrimental effect on the Center's services due, in part , to the member counties' limited obligation to subsidize underachieved budget targets.

The involvement of five counties on the Area Board may create problems that limit the Center's adaptability to change. Commissioners in different counties may have divergent opinions and philosophies on the expansion of services; however, this has historically not been an issue.

Service System: Continuum of Care

Sandhills Center serves five counties over a relatively large geographic area in the southcentral portion of the state. The service system is well developed and innovative in some places and much more limited in others. Sandhills operates under a clinical management structure that provides consistent clinical direction across all program areas. Services are provided by a mixture of county-based and area-wide staff, depending on the nature and demands of the service. For example, Sex offenders treatment is an area-level service, while general outpatient services are county-based. This structure is seen as necessary because of the distances involved and lack of public transportation in the region. Predictably, Moore and Richmond Counties have the largest population and budget and a greater range of services available to its constituents than its smaller and more rural partners, Anson, Montgomery, and Hoke Counties.

2.9 Area Program Site Visits

Due to budget reductions the availability of inpatient services at Hamlet Hospital was significantly reduced in July, 1999. According to the Medical Director and others, the reduction in this service is a major setback in the Area's attempts to provide community-based care for its population. The Hamlet Unit served as the Area Program's primary acute care resource and provided services to a large number of uninsured and Medicaid covered individuals who will now be referred primarily to Dorothea Dix Hospital in Raleigh for services (Sandhills has traditionally functioned below its state hospital bed day allocation). Financial problems associated with recent Medicaid decisions were cited as the reason for budget reductions. Sandhills is similarly dependent on state hospital resources for acute care for children although they also access services at private hospitals outside the area when possible.

Sandhills provides a central emergency phone line. Incoming calls are referred to the appropriate county-based emergency service team for disposition. Emergency services are available in four of the five counties serviced by the program. Emergency cases originating in Hoke County, which does not have emergency services, are treated in Moore County. Crisis stabilization and respite care are provided by contracted vendors and are also difficult to access and not available in every county. Cooperation with the hospital emergency rooms used as night/weekend service locations is uniformly excellent. The availability of emergency services in the Sandhills area exceeds State requirements.

A range of outpatient, case management, rehabilitation, and substance abuse services are available in each of the counties. Much attention has been paid to community linkages with the criminal justice system and social services.

Child Mental Health

Development of services for children has proceeded at a rapid pace over the last five years due to energetic leadership and creative financing. Partnerships with other agencies (juvenile justice, social services, school systems) have been successful in securing funding for numerous community initiatives in which the Area Program plays a major role. The range of community-based services throughout the Sandhills region is impressive and would be a statewide model if all programs were available in all counties. As currently configured, the continuum of care in Richmond, Moore, and Montgomery though not identical to each other are relatively rich compared to Anson and Hoke.

Each county has the capacity to directly provide case management and outpatient care to children and families, and provides residential care through network providers. Some preventative and intensive services are also available throughout the Sandhills region. This group includes a specialized program for treatment of "sexually aggressive" youth and a school-based initiative to provide substance abuse education and assessment. Four of five counties also participate in MAJORS, a collaboration with juvenile justice that provides intensive in-home and wrap around services to adjudicated youth coming out of training schools or at risk for placement there. All of the counties also have access to the Bethesda Link program, a structured, therapeutic residential facility for adolescents with substance abuse/dependence diagnoses

Other intensive services are provided at specific locations in the area. Richmond county has several types and intensities of in-home services and is a participant in the FACES project, a community collaboration and federal grant program that emphasizes local governance and responsibility for the development and maintenance of a system of care. Moore County is also a participant in FACES, has some in-home services and has developed in partnership with the local school system a day treatment program, MASTERY, for children in grades 5 through 8. Montgomery County has a similar array of services and a day treatment collaborative in the schools but for younger children, ages three to six.

Adult Mental Health

The Sandhills Center has a long-standing commitment to providing comprehensive mental health services to adults in their community. The Center strives to make outpatient treatment services readily available and accessible across a wide geographic area. The organization has an organized management structure that promotes this concept and allows for the development of integrated services across counties. Sandhills operates a number of programs designed to service the needs of adults with acute mental health problems (e.g., crisis beds, housing, high-risk teams and clubhouses, etc.). There is an unmet demand for local inpatient care, particularly indigent care.

There are gaps in the continuum of mental health services in the area of acute mental health treatment. Community inpatient beds are limited. Clients are primarily referred to the state hospital for acute psychiatric treatment and transitioned back to the mental health center for outpatient care. The strengths of the Center that create the possibility for an expansion in their scope of service delivery include:

- A centralized dispatch number for the coordination of community-based emergency services across counties. The availability of face-to-face evaluations by a psychiatrist on a 24 hour emergency basis. Access to 23- hour observation beds for diversion from hospitalization for both mental health and substance abuse clients.
- Outpatient clinics located in each county that provide the full range of outpatient services including the availability of mental health and substance abuse clinicians.
- Quality outpatient programs that address identified specialty needs: an intensive outpatient program for dual diagnosis treatment (MI/SA), a Sexual Offenders Treatment Program, nursing home consultation services for geriatric clients and staff training in Dialectical Behavioral Therapy for crisis clinicians.
- Case Management services across counties to coordinate treatment options and facilitate access to care.

Due to the large retirement community, geriatric services are reasonably well developed and accessible. The community has available rest homes, skilled nursing facilities and immediate care facilities that are willing to accept psychiatric clients. There are 2 community-based psychiatrists that specialize in geriatrics and the Center provides psychiatric consultation to nursing homes. There is also a specialized Alzheimer's unit. This is an expanding population in the 5 counties.

Due to the rural nature of the area, there is limited transportation available for clients. This is often a barrier to treatment and places a burden on the county Sheriff to provide transportation for clients requiring inpatient treatment.

Substance Abuse

The Center provides access to a continuum of substance abuse services. A significant number of services are provided through contractual arrangements including medical and social setting detoxification, 23-hour observation beds for hospital diversion and substance abuse day treatment programs. Clients that are involuntary or require long-term rehabilitation are referred to the ADATC at Butner. There is a strong agency effort to train staff in dual diagnosis treatment (MH/SA). Currently dual diagnosis groups are available in all 5 counties and there is a well-developed, dual diagnosis intensive outpatient program in Richmond County. Substance abuse clinicians are available in each county location. There is a strong emphasis on family treatment. An intensive case management system exists for the priority client group of women and children.

Gaps in substance abuse services include limited access to safe and sober housing. There are limited residential beds for women and a need for increased halfway houses and long-term transitional beds for men and women. The ability to expand programs is an issue as the outpatient treatment sites operate at full capacity within the existing space.

Management Infrastructure

Contract Monitoring

While non-service contracts are managed through staff in the Finance area, service contracts are entered into by the Program Managers representing the major disability areas (Adult Mental Health, Child Mental Health, Developmental Disability, etc.). Contracts are monitored by the Program Managers and the case managers who are responsible for tracking clients when they are referred out for services provided by contracted agencies. Service contracts come up for renewal on an annual basis

Quality Management

Sandhills Center has an established Quality Improvement Plan that dictates a philosophy of Quality Assurance and Quality Enhancement. There is also a distinct Quality Improvement Plan for Thomas S. services. The Quality Improvement Committee, which reports to the Area Board on a quarterly basis, has the following subcommittees: 1) Credentialing, Privileging and Supervision, 2) Utilization Management. Program Evaluation/Outcome Studies, 3) Staff Growth and Development, 4) Incident Report Review and 5) Task Forces/ Quick-Success Teams, which are appointed as necessary. Quick Success teams, made up of Assistant Directors and other staff, are convened for special projects expected to last fewer than three months.

The Medical Director initiated a process wherein staff anonymously submitted ideas for needed areas for personal and organizational growth. These ideas were reviewed and prioritized and sent to the Area Directors, who then worked with their Assistant Directors to incorporate the prioritized ideas as goals for Quality Improvement.

Utilization Management

In each of the 5 counties served by the Area Program, there are High Risk Teams that meet on a weekly or bi-weekly basis. The High Risk Teams are charged with reviewing high risk/ high cost cases, including coordination and management of care, crisis planning, service authorization, and monitoring of multiple/ expensive services. Providers from contract agencies are actively involved in this process on a regular basis.

Currently, the documentation of cases reviewed through this process occurs in a largely non-automated fashion. However, prospectively, Sandhills anticipates utilizing a new automated system that will facilitate more centralized tracking.

Privileging and Credentialing

The personnel office grants temporary privileges to newly hired staff and it becomes the supervisor's responsibility to review the employee's performance. It is the Credentialing, Privileging and Supervision subcommittee of the Quality Improvement committee that is responsible for: designating staff member privileging status, assuring that clinical supervision is provided by fully qualified staff to professionals who are not (as yet) fully qualified, and ensuring that there are written plans for supervision of non-qualified staff.

2.9 Area Program Site Visits

While the subcommittee is currently involved in granting privileges for individual external providers, Sandhills, at the time of our site visit, was in the process of deciding whether or not to utilize the State's ASO for the credentialing of contract providers.

Outcome Evaluation

The Outcome Studies subcommittee of the Quality Improvement committee is responsible for monitoring, review and evaluation activity related to client outcomes. This activity, which takes place throughout the year results in the generation of goals for the following year.

Sandhills Center has been using the Client Outcomes Inventory (COI), a Division tool, since May 1999. This tool involves an extensive collection and analysis of medical record data on approximately 20% of all clients. The review sample is based on the last digit of the client's medical record number and also includes all Willie M. and Thomas S. clients. Data for the review is collected at three months, six months, annually and at discharge. Additionally, Sandhills performs a random audit of all in-house and contract records on a monthly basis.

COI activity, including data collection, is said to require as much as 5 full days of work for a senior staff person per month. There is much duplication in data elements required for collection in this process and data routinely collected through existing systems.

Accreditation

Sandhills was accredited by the State in August of 1998 for a three-year period, and will begin the Council on Accreditation (COA) process with an application due in February, 2000 and an on-site review in October, 2000. Sandhills requires that the providers with whom they contract be accredited prior to providing services to their clients; this accreditation is managed by an external ASO.

Sandhills Center staff feels that they are subject to a high degree of scrutiny through multiple external reviews, which often include extensive chart reviews and documentation preparation. Because Sandhills Center serves five counties, this activity requires a substantial dedication of staff time and resources. Reviews include, in addition to the accreditation process, those for Willie M. services, Thomas S. services, annual Medicaid reviews and reviews associated with special funding.

Consumer Rights and Input

The Sandhills Center has established policy related to client rights, which is maintained as part of its Clinical Policy Manual. The manual includes provisions regarding consumer grievance, informed consent and procedures through which staff and consumers are to be informed about consumer rights.

Sandhills has a Client Rights Committee, which is a subcommittee of the Area Board. The subcommittee membership consists of a majority of non-Area Board members. An effort is made to have representation from all disability groups: mental health, developmental disability and substance abuse, and to include consumers and family members.

During the site visit, PCG met with several consumers. At Samaritan Colony, a residential substance abuse treatment program in Rockingham, a man in his mid-forties described having been a bus driver and endangering his passengers as a result of his substance abuse problem. He was very thankful for the staff of Samaritan Colony who helped him through several relapses. In addition, he explained that his addiction caused there to be strained relationships in his family and that the Samaritan Colony staff played a role in reaching out to his family, as well.

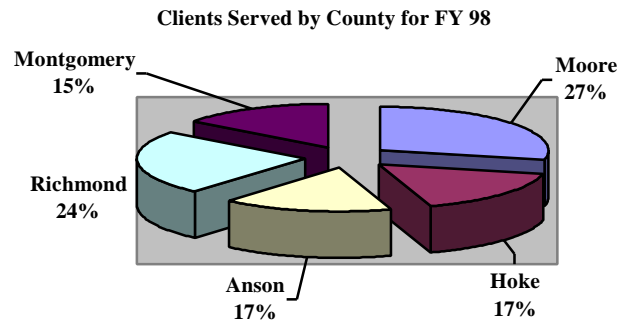
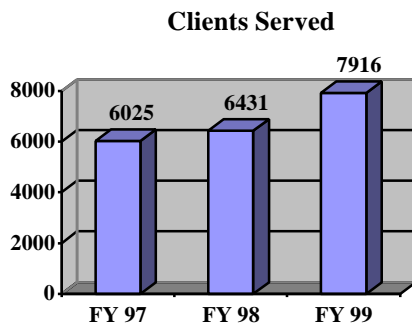
2.9 Area Program Site Visits

At the psychosocial rehabilitation program, PCG met with four consumers, one female and three males, each with long histories of serious and persistent mental illness. They described their experiences of stopping their medications and dropping in and out of treatment. One highlighted transportation and access to medications as areas that would otherwise be problematic if it were not for the treatment he was receiving through the psychosocial rehabilitation program.

PCG also met with a fourteen-year-old girl in the day treatment program. She spoke very highly of the staff and explained that through the Rewards program, she earned enough funds to purchase a basketball net illustrating the motivating characteristics of this program. Having graduated from the program, she was heading back to school and expressed concerns about this transition.

Financial Overview

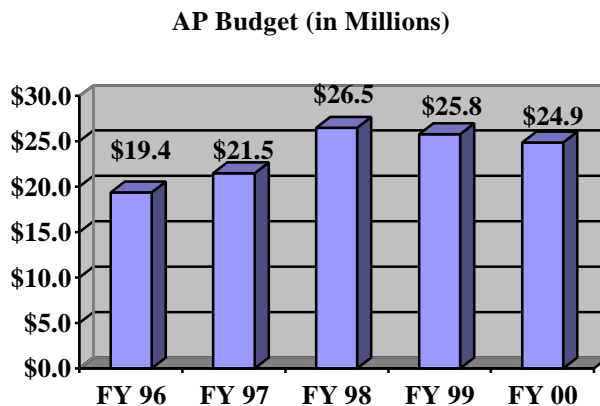
The financial services team at Sandhills is faced with many of the common day-to-day problems of most area programs: limited county appropriations, the introduction of new computer systems and applications with limited resources and the management of costs while providing as many services as possible to the clients of this five county area program



Chief Financial Officer

Tommy Scott is the Chief Financial Officer. He has been in with the Center for 13 years.

FY 1999 Operating Budget



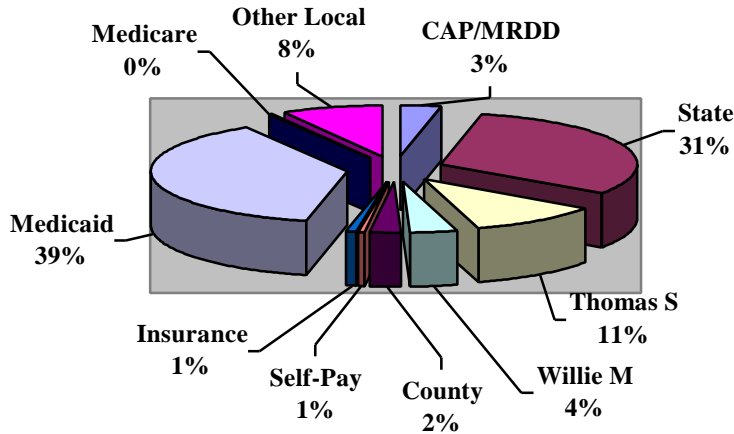
2.9 Area Program Site Visits

Sandhills' FY 99 Operating Budget was \$25.8M, a 3% decrease from the FY 98 budget (\$26.5M) due in primarily to changes in the State Medicaid policy (e.g., rate reductions and a required “hard match” contribution from Area Programs). Additionally, a reduction in CAP MR/DD revenues was associated with a State policy change that allowed for direct billing by the Center’s CAP providers, resulting in a significant reduction in the CAP revenues flowing through Sandhills. Currently, 40% of Sandhills' revenue is generated through Medicaid representing a significant funding source for the Area Program. Over the last three years, Medicaid reimbursement has increased by 53%, while other State funds have remained relatively constant resulting in a greater reliance on a single funding source, which in turn increases the risk to the Area Program. With the combination of Medicare, commercial insurance and self-pay receivables constituting less than 2% of the FY 99 actual revenue, obtaining significant increases in these funding sources present a notable challenge for the Area Program. The FY 99 Budget includes a minimal increase in unrestricted Medicaid revenue and a decrease in Other State Funds limiting the Area Program’s ability to expand the service continuum.

	FY 98	FY 99	* FY 00 Projected
Self-Pay	\$179,109	\$150,136	\$162,376
Medicaid	\$9,668,890	\$9,768,884	\$10,064,967
CAP/MRDD	\$1,923,638	\$864,575	\$611,049
Medicare	\$53,246	\$27,034	\$60,000
Insurance	\$190,970	\$196,414	\$194,553
Other Local	\$1,753,883	\$2,166,792	\$2,268,235
Fund Balance	\$161,797	\$233,398	\$0
County Contributions	\$570,244	\$604,184	\$604,184
Thomas S.	\$1,826,315	\$2,793,689	\$2,284,010
Willie M.	\$1,559,525	\$1,038,165	\$1,188,415
Other State Funds	\$8,593,017	\$7,991,993	\$7,463,234
Total	\$26,480,634	\$25,835,264	\$24,901,023

2.9 Area Program Site Visits

Breakdown by Revenue Source (FY 99)

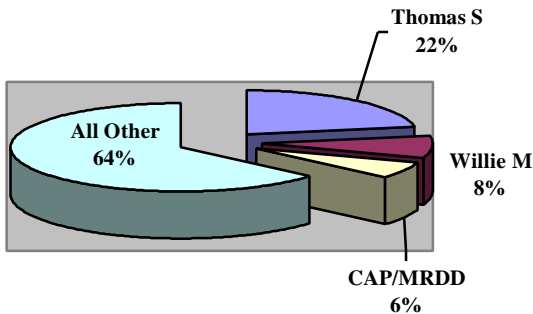


Further analysis of State funding illustrates the increasing predominance of restricted funds in the overall total of the State fund allocation. Funds received from Thomas S., Willie M., and CAP/MRDD comprised 37% of the total State allocation and represented 18% of the total revenue generated in FY 99. The restricted funds limit Sandhills' ability to expand services beyond these designated populations, thus placing the burden on an increase in unrestricted Medicaid reimbursement to facilitate service expansion.

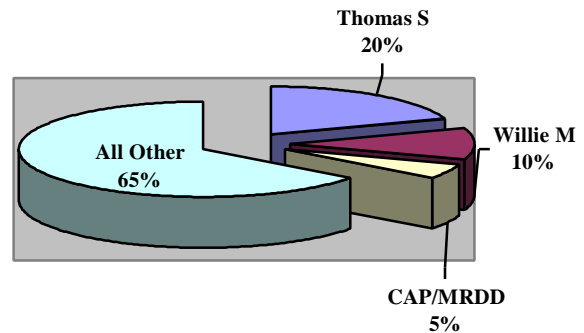
Revenue Summary by Service Category

	FY 98	FY 99	FY 00 (Projected)
Thomas S.	\$ 1.8 M	\$ 2.8 M	\$ 2.3 M
Willie M.	\$ 1.6 M	\$ 1.0 M	\$ 1.2 M
CAP/MRDD	\$ 1.9 M	\$ 0.8 M	\$ 0.6 M
Other State	\$ 8.6 M	\$ 8.0 M	\$ 7.5 M
Total	\$13.9 M	\$12.6 M	\$11.6 M

Revenues by Service Category (FY 99)



Revenues by Service Category (FY 00)

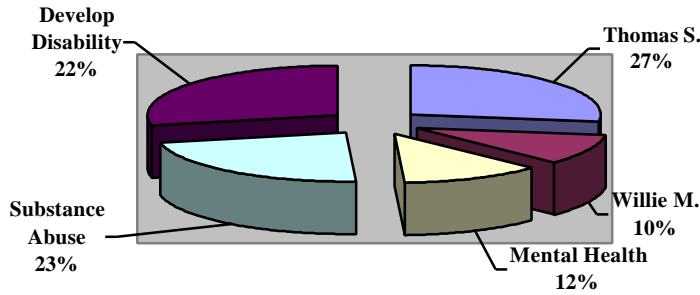


* FY 00 projected

The breakdown of Sandhills' State funding for FY 99 demonstrates the inequity of total State dollars for each of the disability groups of Developmental Disabilities, Substance Abuse and Mental Health with additional funding for Willie M. and Thomas S. consumers. Further analysis of the State funding distribution reveals an even greater disparity between SA and MH as compared to DD, when Thomas S. funds and Willie M. funds are incorporated into DD and MH respectively.

2.9 Area Program Site Visits

State Funding Distribution
(FY 99)



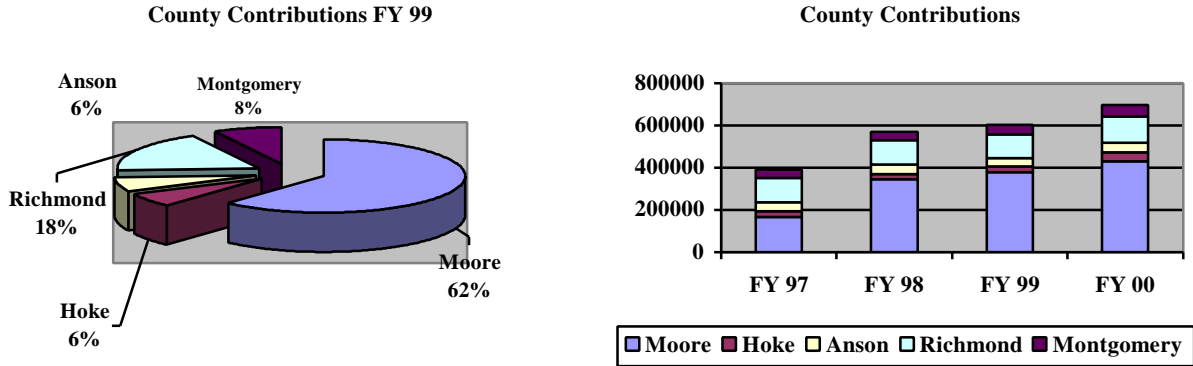
County Funding

	FY 97	FY 98	FY 99	FY 00 (Projected)
Moore	\$167,580	\$346,060	\$380,000	\$430,000
Hoke	\$25,000	\$25,000	\$25,000	\$42,250
Anson	\$44,933	\$44,933	\$44,933	\$45,135
Richmond	\$114,451	\$114,451	\$114,451	\$124,451
Montgomery	\$39,800	\$39,800	\$39,800	\$54,750
Total	\$391,764	\$570,244	\$604,184	\$604,184

The County contribution is based on historical data of contributions made by the five counties. This area program ranks 38th statewide in the amount of county funding received. When asked about this dubious distinction, County Finance Officer Mike Griffin commented that counties are content with the amount of services delivered for the dollars spent. He continued by saying that some counties would like to contribute even less in response to fiscal demands of other projects in the counties.

Comprising about 2% of the total budget, Sandhills' County Contribution does not significantly impact program's ability to provide services. The county funding per capita varies greatly among the five counties with Moore at \$5.36 per capita, Hoke at \$.83, Anson at \$1.87, Richmond at \$2.52 and Montgomery at \$1.61 per capita. Over the last three years, Moore's contribution to the Area Program has increased by 127%, while the contribution from Hoke, Anson, Richmond and Montgomery has remained static. Montgomery's contribution does not include \$25K in rent and utilities that are donated by the county to Sandhills Center.

2.9 Area Program Site Visits



Capita Financing

FY 99	Population	Operating Expenditures	Per Capita Expenditures	County Funding	Per Capita Funding
Sandhills	196,473	\$25,835,264	\$131.49	\$604,184	\$3.07

Division Funding

The overall division funding of the Area Program ranked Sandhills eleventh among the forty-one Area Programs in FY 97. Sandhills ranked sixth in Mental Health funding with per capita funds averaging \$14.27, in comparison to a state average of \$10.56. Similarly, Sandhills ranked thirteenth in Developmental Disability funding with per capita funds averaging \$13.71, as compared to a state average of \$11.51. In contrast to MH and DD funding, Sandhills ranked twenty-second in Substance Abuse funding with a per capita of \$5.75 and a state average of \$6.03.

A/R Balance

As of 6/30/98, the A/R Balance was approximately \$1.6M. The agency makes a good effort at collecting past due balances and involves the clinical staff when appropriate. The Division has noted that this Area Program has the highest Medicaid reimbursement per visit than any other Area Program in the State.

Fund Balance

Sandhills currently maintains a 5% fund balance. The management team is concerned and uncertain about the State's response to the Program's 5% fund balance vis-à-vis the State's Performance Contract which requires an 8% balance. The fund balance allowed for the upgrades in software and hardware in June 1999.

Front End Management/Client Registration

Client entry into the Area Program is well documented and roles are appropriated assigned. Reimbursement staff does not have responsibility over registration staff. The Area Program does not strictly enforce income or residency verification. While clinical staff does get involved in reimbursement issues, self-pay collections are low and the process to identify and track potential Medicaid eligible client is not clearly defined.

Cost Allocation Plan

The Area Program has identified the need for a comprehensive cost allocation plan but does not have the resources to complete this analysis. They rely heavily on the cost finding prepared and submitted to the Division each year to monitor costs.

Clinician Productivity Tracking

A well-designed clinician productivity-tracking plan is in place and has been accepted by the clinical staff. Data downloads from the MIS system and is manipulated to produce a comprehensive productivity report by department and by clinician. Individual productivity is monitored and effects each clinician's annual performance evaluation. Sandhills has enjoyed flexibility with salary administration as annual raises have been awarded for the past 15 years. Due to the Center's financial situation a 3% bonus was given to most staff members in FY 99, in lieu of an across the board pay raise.

MIS

Sandhills is in the midst of a systems transition from a UNIX based A/R systems to the newest Windows based version of CSM. Sandhills is fortunate to have recruited an enthusiastic and seasoned MIS manager from the private sector to spearhead this initiative. The Center has been a prudent purchaser of MIS hardware and software and plays a dominant role in the user group across the state, consisting of representatives from the other 12 area programs using CSM. One identified concern is the shortage of resources for support and training once staff expands access to systems.

WAKE COUNTY HUMAN SERVICES: MH/DD/SAS PROGRAM PROFILE

Administration

Operating Structure

Wake County Human Services, a comprehensive agency combining health, mental health, and social services, provides MHDDSA services to county residents. The Wake County Human Services Board serves as a policy, advocacy and advisory board to the agency director, county manager and county commission. The Program Director reports to the Wake County Manager. Services are provided centrally and regionally, in county owned and operated facilities in several locations in Raleigh, as well as regional sites in Cary, Fuquay Varina, Wake Forest and Zebulon. The human services agency was created by state legislation in Dec. 1996, and reports annually to the legislature on its activities.

The MH/DD/SAS services are currently undergoing a period of change as it attempts to more fully integrate its MH/DD/SAS, public health and social services together into a unified delivery system. In addition to those previously independent departments, the Human Services Agency also includes Child Support Enforcement, Job Training Services, and Housing and Community Revitalization.

Employees: 385 employees can be traced directly to MH/DD/SAS services, though other employees in Human Services do MH/DD/SAS work that is funded by other sources

Budget: Wake Human Services Budget \$121M (FY98) of which \$39M is categorically received to serve MHDDSA populations; however, as noted above, 'other' staff and 'other' dollars also serve these populations (the second largest of the 8 Area Programs surveyed)

2.9 Area Program Site Visits

Area Program Statistics: Wake county contributes 21% of monies directly budgeted for MHDDSA services, and 7% of the total agency operating budget, among the highest of the programs surveyed. County moneys are blended to provide comprehensive human services, as opposed to categorical services. See the table below:

	Population		Clients	County Contribution	Board Membership
	#	% Medicaid Eligible	#	\$	# Members
Wake	574,828	5.80%	10,391	\$8,365,547	25

Governance

Wake County Human Services serves a single county area and is a fully integrated agency of county government. The Human Services Board has wide representation with slots set by legislative mandate, and serves in a policy, advocacy and advisory capacity.

Role of the County

The Human Services Agency is a department of county government. All of its employees are county staff, operating under all personnel and budget processes established in the County. The Agency Director is under the direct authority of the county commissioners, and reports on a daily basis to the County Manager. This direct line of authority is valued by the commissioners, and is the primary reason the MH/DD/SAS program was integrated into county government. Since the County contributes 21% of the MH/DD/SAS budget, its close relationship makes it fiscally responsible for the Agency.

Role of the Human Services Board

The Human Services Board is the successor board to separate health, mental health and social services boards and, as such, contains 25 members filling both categorically determined slots (e.g., physician, social worker, nurse, pharmacist, parent of child with developmental disability, consumer of MHDDSA services, consumer of services other than MHDDSA, etc.) and at large slots. Many members of the previous boards accepted appointments to the new Human Services Board and provide valuable continuity and experience. The Board serves in a policy, advocacy and advisory capacity, without a direct role in agency operations. It recommends a budget and policies, serves in an advocacy role and participates in the hiring decision of the HSB director. The Board itself nominates members to the county commissioners for appointment, with the exception of the one commissioner seat. The Human Services Agency Director interacts regularly with the Board, but reports to the County Manager.

Capacity to Manage Change & Meet Future Demands

The MH/DD/SAS services are becoming more fully integrated with Public Health and Social Services. The agency is in a period of change, restructuring services around twelve agency-determined outcomes directed at general and targeted population groups rather than to service categories (e.g., MHDDSA, social service or public health). The goal is to integrate services not only at the administrative or agency level, but also at the client level, in recognition of the major overlap of services required by many clients. These efforts have been time consuming, but have not precluded the agency developing new services addressing identified needs for specific populations.

2.9 Area Program Site Visits

The agency staff and county managers value local control and autonomy, and would not be amenable to micromanagement from the state level. They wish to be given the latitude to meet state goals within their own management framework. The agency wishes to balance accountability for state funds with flexibility to blend federal, state and local funds to better serve locally identified populations and needs. Additionally, the agency seeks to measure not outputs or processes, but outcomes and indicators, as better measures of success in meeting community needs.

Service System: Continuum of Care

Wake County Human Services serves a single county area including rapidly growing metropolitan and urban areas in Raleigh and Cary, and increasing development of previously rural areas. Services are provided centrally in Raleigh, and regionally in Cary, Fuquay Varina, Wake Forest, and Zebulon. It is a unique program for North Carolina in that it operates public health, mental health, social services, and child welfare through a single administrative structure. There appear to be numerous benefits inherent in this model including the potential for integration across program and departmental lines. Wake County has focused a great deal of energy on developing operating principles and specific program-wide outcome expectations that are intended to drive the development and performance of the service system and seems to have been successful in communicating the philosophy to staff at all levels of the organization. Although many of the treatment programs strongly resemble programs in other parts of the state, there is some evidence of successful integration within the clinical service system that might otherwise not be possible. One good example of this is the creation of a position for an adult substance abuse counselor in “Reflections,” a child protective program. Child welfare programs readily identify substance use issues but are typically ill equipped to deal with treatment issues.

In general, the Wake County service system appears to be well organized and aware of the needs of its residents. Recruitment of trained staff is not difficult in this area of the state and turnover is reported to be quite low especially at the senior clinical management level. Clinical leadership is shared among a number of highly trained and experienced individuals including the Medical Director, the Adult Services Director, and the Child Services Director. There is significant concern among this group and others of not having adequate capacity to service the needs of the population as it grows. Timely access to care has already become an issue for some services. Despite the operation of a full service psychiatric emergency room, the program is having trouble meeting the demand for acute care and relies heavily on Dix Hospital for all inpatient services. Though the agency operates 24 hour, 7 day a week emergency services efficient entry into the system results in a back log of clients requiring outpatient services. There is no county operated psychiatric hospital in Wake County and, despite a long history of study and negotiation with area hospitals, no prospect in sight to readily meet acute hospitalization needs for adults, the dually diagnosed, and the elderly (acute children and adolescent services had been developed through the now defunct Carolina Alternatives waiver). Wake County is, then, heavily dependent on Dix Hospital for inpatient services, outposts staff to the Dix campus for discharge planning and service coordination, and meets regularly with Dix clinical staff for service planning. Wake County acknowledges its need for a local inpatient facility, but also believes market forces and economics argue against creating new inpatient resources at this time.

Administrative systems to support clinical operations are generally available though some areas are clearly further along than others. Wake County was a participant in Carolina Alternatives and had developed a utilization management team and structure. Wake County intends to share lessons learned and expertise gained throughout the organization, utilizing former Carolina Alternatives staff with Performance Improvement and Operations staff to manage existing and create new contract relationships with community providers. There has been progress in utilization review and quality management within agency operated programs and services and all contracts with community providers have been revised to reflect more attention in these areas. Inadequate reimbursement rates, changing state mandates and funding streams, and the changing medical market place limit the agency’s ability to contract for services

2.9 Area Program Site Visits

from community providers. Contract monitoring has increased in importance, as several important contract providers have been unstable this past year. The agency accepts responsibility for its clients as a provider of last resort when contract agencies are unable to effectively serve client needs.

Child Mental Health

Child Mental Health is a major component of the Child and Family Services Unit that also includes child protective services and child health services. By creating an integrated structure, Wake County intends to deliver services that are comprehensive and aligned with the five prioritized agency outcomes addressing child and youth services. While many of the mental health treatment programs have been developed along traditional lines, there are numerous examples of integration across program boundaries. Innovations have been accomplished through cross-training, consultation, cross-staffing and creative hiring where individuals with clinical mental health skills are recruited for traditional child welfare staff positions, as with the adoption, foster care and family reunification teams, and an individual with child welfare skills assigned to the Intensive Intervention Program (previously Willie M.).

Wake County has a relatively well-developed continuum of behavioral health care for children and adolescents. Wake County was a Carolina Alternatives site and had expanded community based options and alternatives during the waiver through contracting externally and building internal case management and utilization management capacities. These contracts have been mostly maintained since the demise of the waiver, though some contracts go begging due to unfavorable rates, particularly for higher levels of residential treatment. Existing contracts have been reviewed to maintain a more narrow continuum of care with a winnowing of network providers largely based on affordability of services. Children may be cared for out of county, where contractors will accept existing rates. There is a centralized phone screening and intake and 24 hour emergency response through the regional offices and school based clinics during normal business hours and the psychiatric emergency service after hours, weekends and holidays. The after hours emergency system would be much improved by some physical alterations that would permit separation of children from adults and the availability of clinical consultation from a child specialist even if just by phone. There are a number of alternatives for crisis intervention and crisis stabilization including two therapeutic foster care homes, an acute partial hospital program operated by a private vendor, and an intensive home-based treatment service. Many diversion services were funded by Carolina Alternatives dollars, and the breadth of service availability has contracted without more flexible funds.

Wake County utilizes Holly Hill for most Medicaid funded hospitalizations; Bryn Marr for locked residential treatment; John Umpstead and UNC Hospitals for latency aged children; and Dorothea Dix for the uninsured population requiring hospitalization. Without Carolina Alternatives and the resources that were developed with that funding, admissions to the state hospital may rise. An intensive, level 4 residential service had been in development prior to the loss of the waiver.

Wake County has an extensive network of affiliated private providers and tends to refer its Medicaid eligible residents to that network. Youth who have limited insurance or who require multiple services generally receive outpatient treatment and case management through the three internal treatment units. The network also provides most of the intermediate care services including a mix of residential services (group home, therapeutic foster care), in-home services, and substance abuse treatment. Specialized services are operated by the county for youth "at risk" for sexually inappropriate behavior. Services for Willie M. designees are primarily purchased through a private vendor (Intensive Intervention Program).

Substance abuse counselors are assigned to each of the two regional teams and the school-based teams. All new admissions are screened for substance use at intake. Intensive services for this group are purchased from the network (Pathways is the major contractor). There is a shortage of residential

2.9 Area Program Site Visits

placements for youth with substance abuse issues and a stated need for preventative services in the health clinics and schools. Further planning and development in this area is anticipated during this fiscal year.

Adult Mental Health

Wake County offers a continuum of adult mental health services that are comprehensive and accessible to area consumers. The services provided are well organized and the organizational culture supports the growth and development of creative programs that are responsive to community needs. The county provides services to an increasing number of clients who are local to the area and to individuals who are transient and homeless who upon discharge from the state hospital migrate to the area. This increasing population has challenged the ability of the organization to provide timely services to clients. Programs operate at capacity with lengthy waiting lists for some services. Priority clients that are unknown to the agency are able to access immediate services through a bridge system created with the evaluation and emergency service team [EES], mobile support team and the outpatient staff that provides interim treatment while the client is awaiting an appointment. Clients requiring acute services are referred to EES for evaluation and treatment or referral to the state hospital. There are a limited number of acute psychiatric beds within the county. Clients that require inpatient treatment are primarily referred to the state hospital due to the lack of alternative inpatient resources and the proximity of the state hospital. There is strong interagency support between the state hospital and Wake County Human Services.

Wake County has a geriatric team that provides community based services to geriatric clients. There currently exists a group of multi-need individuals who reside at the state hospital that are unable to be placed in the community due to their complicated medical and psychiatric needs. There are many rest home and private nursing home beds available but these homes are not equipped to manage the mentally ill/medically complicated client. It is often difficult to recruit and retain trained staff to service this population. There is a gap in the availability of specialized programs for the treatment of dementia/Alzheimer's disease.

Two additional services are offered to adults with mental illness under the auspices of economic services (formerly social services): supportive employment, and clubhouse model services. Supportive employment offers a broad range of services including a job coach for Work First participants with mental illness, and combines vocational rehabilitation services and job placement services in a one stop JobLink Career Center. Clubhouse programs provide psychosocial rehabilitation services to individuals with severe and persistent mental illness.

Substance Abuse

Wake County provides an extensive substance abuse services program, which includes a full range of services from acute inpatient detoxification through outpatient treatment. The Wake County Human Services operates The Alcoholism Treatment Center, which provides services annually to approximately 1500 Wake County residents. These valuable but costly services are generally un- or under-reimbursed and represent a substantial outlay of county dollars. This Center has the capacity to provide 8 inpatient detoxification beds and 26 inpatient hospital based treatment beds onsite that are community based and easily accessed through the walk-in evaluation service which is available 24 hours per day. There is a strong well-focussed treatment program that is tailored to meet the needs of the individual client and is capable of providing specialized treatment for the dually diagnosed and for priority pregnant substance abusers. The Evaluation and Emergency Service program operates adjacent to the inpatient program. This service offers a unique outpatient detoxification program that combines initial medical monitoring followed by daily outpatient medical detox.

The community has joined together to address the need for additional treatment services for the homeless, indigent, substance dependent males by creating The Healing Place. This award-winning program is

2.9 Area Program Site Visits

modeled after the original Healing Place of Louisville, Kentucky and will be built on the campus of Dorothea Dix Hospital by primarily private donations. This program will provide 165 additional beds to the service delivery system for substance abuse treatment and will help to resolve the missing link in residential care for this population. Gaps remain in the availability of community based substance use services for adolescents, Hispanics, and women with children, some of who are reluctant to participate in inpatient treatment without being accompanied by their infants. The agency has developed an Alcohol, Tobacco and Other Drugs (ATOD) community prevention plan which address the range of preventive opportunities in the community, particularly for youth and families.

Management Infrastructure

Contract Monitoring

Contracts are entered into by the Program Managers for the different major disability areas (i.e. Adult Mental Health, Child Mental Health, Developmental Disability etc.). Monitoring is coordinated between program leaders, case managers, and contracts management staff, the latter devoted to contracts development and management who visit contract providers annually. Staff from the contract monitoring team visit all contract providers at least once a year, often with Program Managers.

The contract management team uses GIZMO, a database through which contract information is entered, maintained and updated. Certain contract information data fields can be entered and amended only by designated staff, while other information, such as lists of contract providers for different services, is available for viewing by a wider audience, including Program Managers who may be seeking to refer a patient. GIZMO also maintains an auditing/monitoring plan for each contract provider.

Quality Management

Wake County Human Services has an established Continuous Quality Improvement Plan for mental health services, including substance abuse and developmental disability services. The purpose of the plan is to involve clients, line staff and management in the ongoing evaluation and improvement of services. An updated plan reflecting the incorporation of the former DSS, PH and MH/DD/SAS is under discussion.

Wake has an active Continuous Quality Improvement Committee, which is overseen by the QI Director. The QI Director participates in monthly case conferences with Dorothea Dix Hospital to discuss the management of Wake County clients who have been hospitalized.

The CQI Committee is supported by the activities of six subcommittees, as follows: 1) Peer Review, 2) Privileging and Credentialing, 3) UR, 4) Risk Management, 5) Research, and 6) Medical Records. Notably, the CQI committee has no formal reporting relationship to the Area Board.

Wake County Human Services Performance Improvement staff provide consultation with all program staff to better link program activities and outcomes with agency wide outcomes and indicators, providing support not only for the five priority agency outcomes, but all twelve human services outcomes.

Utilization Management

Wake County has established a Utilization Review Committee as a standing committee of the Continuous Quality Improvement Committee. The UR Committee meets at least 10 times per year and performs a number of functions, including monitoring to ensure compliance with HCFA UR standards, assuring proper allocation of resources through analysis of instances of over- or under- utilization and recommending plans of action.

The UR process incorporates multiple approaches to identifying areas requiring intervention. These include concurrent review of a patient's clinical record documentation to monitor progress toward identified goals and patient involvement in the treatment process, as well as reviews of the appropriateness of ancillary service utilization.

Privileging and Credentialing

Wake's Privileging and Credentialing process assures adequate training, experience and competence among staff to provide services to consumers. Personnel representatives are responsible for verifying the credentials at the time of employment for internal staff and for keeping updated records of licensure for clinical personnel. Contract agencies maintain responsibility for documenting and verifying credentials for their personnel. Contract agencies may adopt Wake's Privileging and Credentialing procedures, or may submit their own procedures for review and approval as part of their CQI plan.

Privileging is based on verification of provider credentials and competence. Providers may be granted Full Privileges, Privileges with Supervision or No Privileges. Copies of privileges, and, if applicable, supervision contracts, specifying the supervisor, frequency duration and scope of supervision, and specific activities, are maintained in personnel files, unless otherwise agreed upon and maintained by the Program Manager.

Outcome Evaluation

Wake County Human Services has developed a list of 12 outcomes that are actively publicized as points of focus for the agency. For each of these outcomes, the County has developed a target population, strategies, partners, a timeline and indicators of achievement. According to the *Human Services Road Map*, a report developed by the Human Services Director and the Leadership Team, five of these outcomes are prioritized for the next two-year period.

Outcome management is a component of the Performance Improvement Group, which also includes client rights and medical records. Wake has recently hired a Director for Outcomes-Focused Management whose philosophy for his initial work includes less of a focus on measurement, and a greater focus on business models and how staff organize themselves to be self aware of what they do. As a demonstration, the Director is working closely with a small group of programs showing particular interest in looking at outcomes issues.

Accreditation

Wake County Human Services describes four levels of accreditation activity:

- 1) focused on internal services;
- 2) contracted services;
- 3) Council on Accreditation, for which Wake will be applying for one year of self study beginning in April, 2000; and
- 4) CARF accreditation for rehabilitation and employment services for mental health and some developmental disability.

Wake reports that Durham, Chapel Hill and Wake are considering funding a joint staff to handle all accreditation and contract monitoring functions to streamline what's currently viewed as duplicative processes. Wake Human Services recently contracted with the statewide ASO for assistance in accreditation.

Consumer Rights and Input

Wake has designated a highly visible individual as Director of Consumer Rights, a full-time position with a direct access relationship to the Human Services Director. Formerly, the focus of this role was to receive and respond to complaints posed by mental health consumers. However, as the County has restructured its organization to form Wake County Human Services, charged with serving all human service clients, the Human Services Director's focus now includes all human service clients, as well. The Director for the Consumer Rights Program is staff to the Human Rights Committee of the Board. The chair of the Human Rights Committee is a member of the Human Service Board.

On average, the Director of Human Rights receives approximately 12 – 15 complaints per week. Complaints are tracked through an Access database through which the Director performs trend analysis to monitor the nature, source and focus of complaints over time.

The Human Rights Committee of the Human Services Board includes representation from all three major disability groups: mental health, developmental disability and substance abuse. For complaints of a very serious nature, consumers and involved staff have the opportunity to present their case to the Human Rights Committee who then make a recommendation to the Human Services Board and Human Services Director for resolution of the matter.

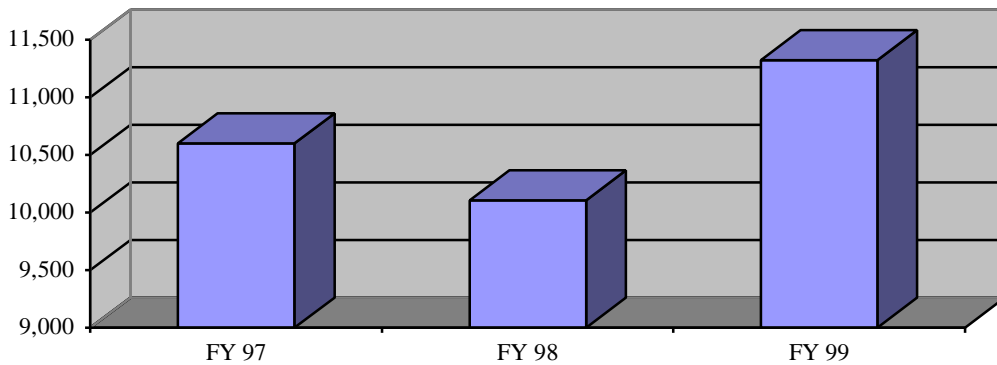
Two consumers offered input through individual discussions with PCG. The first, a fifty-year-old woman with cerebral palsy, has served as a member of the Human Rights Committee, which meets monthly, for five years. She is also an active member of the Developmental Disability Council. She has moved into subsidized housing with assistance from the County and this has enabled her to become more independent.

A second consumer, a thirty-four year old man who has been diagnosed with manic depression, is an active member of the local NAMI chapter. He shared his concern that consumer input is lacking, and stated that he would like to see North Carolina have an Office of Consumer Affairs as they do in other states. In addition, he stated that he felt positive about how things were working in Wake, but expressed concern about access to care in more remote parts of the State. Specifically, he would like to see a dedicated effort to improving transportation, ensuring affordable housing and promoting education so that consumers in need of services are aware of what's available.

Financial Overview

Wake County has a robust and dynamic management team in place in the fiscal services area. Mental Health has been a department of the human services division of county government since 1996. As a result, Wake is unique in its experiences and the way in which business is conducted.

Clients Served

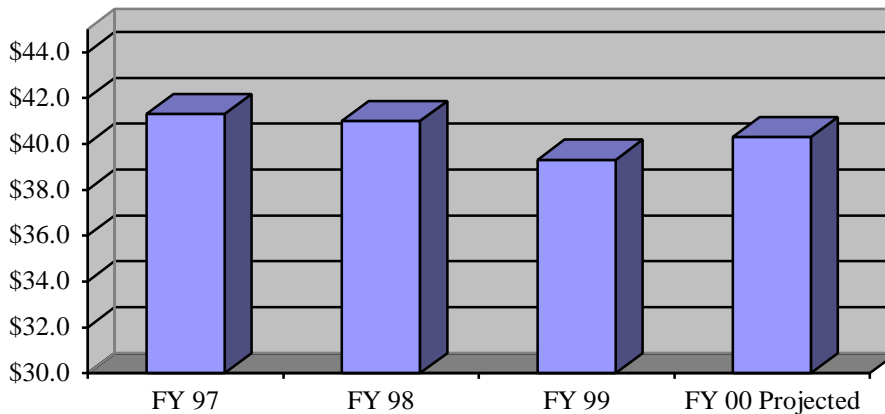


Chief Financial Officer

Camille Schaffer is the Chief Financial Officer. She has been in that role for over 13 years.

FY 1999 Operating Budget

Wake operated with a \$39.4M budget in FY 99, with a minimal projected growth to \$40.3M in FY 00. Wake has seen a fluctuating operating budget for the past three years, both increasing and decreasing. The 4% decrease from FY 98 to FY 99 was partly attributable to changes in the CAP/MRDD billing, in which Wake's revenue decreased by \$2.3M. Other funds and programs within the Human Services



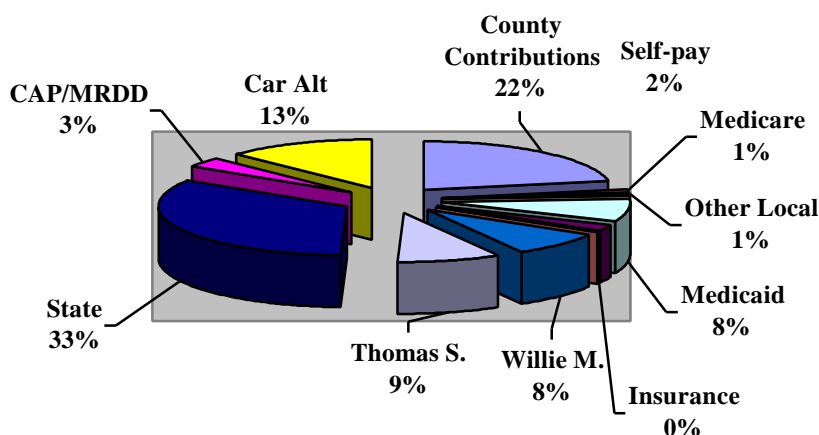
Agency also provide services that directly serve, or might be considered, MHDDSA services. These funds are not factored in to this analysis.

Wake relies heavily on State funding and Medicaid, representing approximately 40% of its operating budget in FY 99, to support the clinical service programs. With the disbandment of Carolina Alternatives, Wake has proposed an increase in FY 00 revenue sources, namely Medicaid, to subsidize the loss of revenue associated with end of the Carolina Alternatives waiver. Compared to the other Area Programs visited, Wake has a relatively low reliance on Regular Fee-For-Service Medicaid, representing 7% of FY 99 revenue budget.

2.9 Area Program Site Visits

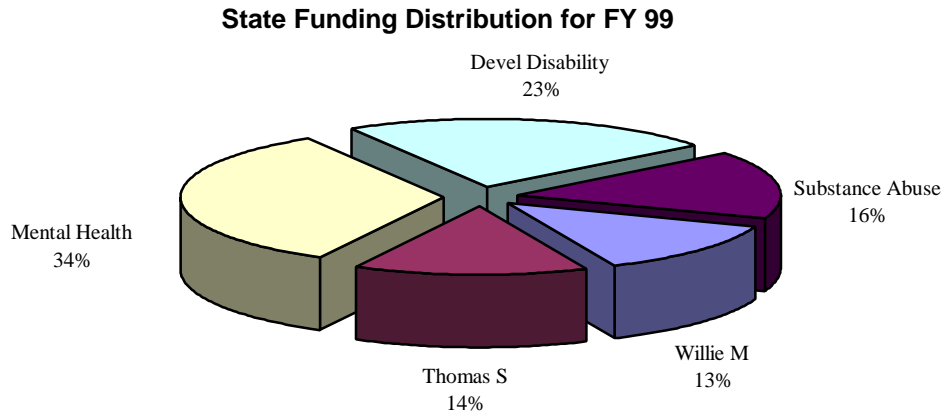
Revenue Summary - by Payor Source	FY 98	FY 99	FY 00 Projected
Self-pay	\$460,547	\$710,866	\$773,294
Private Insurance	\$112,612	\$111,693	\$117,970
Medicaid	\$1,842,105	\$2,904,198	\$3,873,064
Carolina Alternatives	\$5,452,555	\$4,935,997	\$0
County Contributions	\$7,978,306	\$8,365,547	\$8,502,278
State Funds	\$14,539,688	\$12,749,457	\$14,716,323
Medicare	\$511,656	\$421,253	\$369,512
Thomas S.	\$2,904,453	\$3,420,516	\$4,062,281
Willie M.	\$2,713,938	\$3,083,000	\$3,718,355
Other Local	\$331,895	\$344,630	\$390,062
CAP/MRDD	\$3,572,617	\$1,232,124	\$2,325,805
Fund Balance	\$655,390	\$1,092,176	\$1,500,000
Total Revenue	\$41,075,762	\$39,371,457	\$40,348,944

Breakdown by Revenue Source (FY 99)

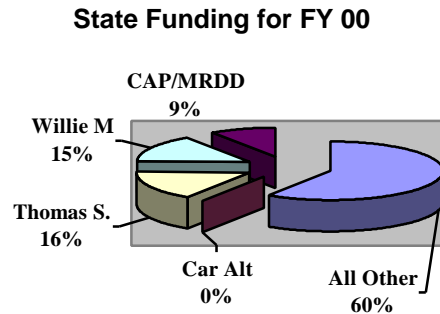
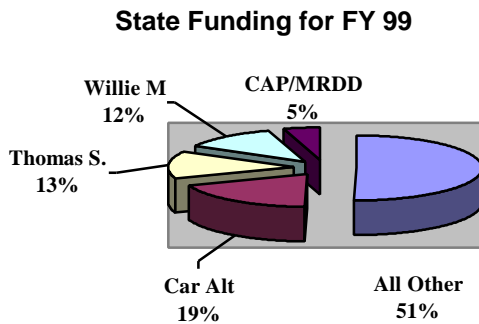


The breakdown of Wake's State Funding for FY 99 illustrates the disparity in funding across the disability groups of substance abuse, mental health and developmental disabilities, including additional funding for Thomas S. and Willie M. consumers. Further analysis of the State funding distribution reveals a different view when Thomas S. funds and Willie M. funds are incorporated into DD and MH respectively ; thereby demonstrating an even greater disparity between DD and MH as compared to SA.

2.9 Area Program Site Visits



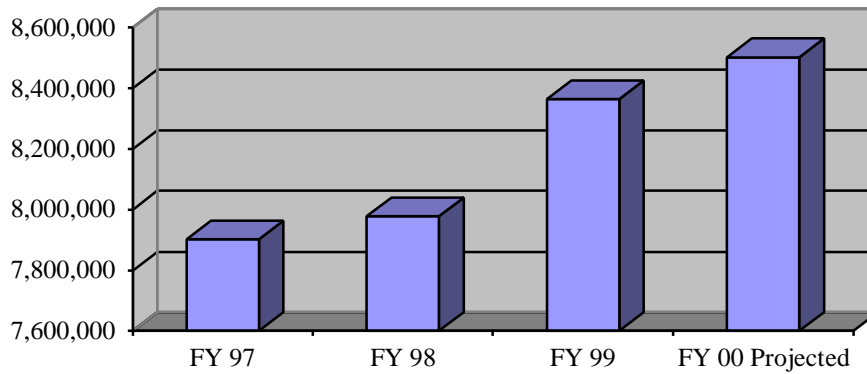
Restricted funds account for 30% of the total state funding with Thomas S. at 13%, Willie M. at 12% and CAP/MRDD at 5%, limiting the opportunity for Wake to expand service delivery for the unclassified populations. With the elimination of Carolina Alternatives' funding, the reliance on restricted State Funds increases to 40% of projected revenues for FY 00.



County Funding

Wake County contributed \$8.3M in FY 99, an increase of 5% from FY 98. Additional services provided include “soft” areas such as management and oversight from county staff as well as benefiting from county services such as legal services, housekeeping, buildings and grounds and facilities management, etc. In-kind contributions are valued at \$2.8M for FY98, \$3.5M for FY99 and \$4.1M projected for FY00. A strong, collaborative relationship exists between Wake County management and the County Finance Officer.

County Contribution



Per Capita Financing

FY 99	Population	Operating Expenditures	Per Capita Expenditures	County Funding	Per Capita Funding
Wake	574,828	\$39,371,457	\$68.49	\$8,365,547	\$14.55

Division Funding

The overall state funding of the Area Program ranked Wake forty-first among the forty-one programs that existed in FY 97. Wake ranked thirty-sixth in Mental Health funding, with per capita funds averaging only \$8.28. Similarly in the funding of Developmental Disabilities, Wake ranks fortieth at \$6.63 per capita. In addition, Wake ranked thirtieth in the state funding for substance abuse, with per capita funding of \$5.11.

Cash Flow Analysis

Wake benefits from county oversight for cash management and thus cash flow is not a day-to-day issue for management; however, Wake managers are held accountable for close management of the their respective budgets. This stems in part from financial difficulties the County experienced in the early 1990's, which resulted in a broad reduction in force. In addition, Wake voluntarily reviewed its documentation and volunteered a payback for inadequately documented services.

Accounts Receivable Balance

As of 6/30/99, the A/R Balance is approximately \$ 4M net of reserves. The agency makes a focused effort at collecting past due balances and involves the clinical staff when appropriate. Wake takes a balanced, but aggressive, approach at managing the A/R. Patients are given every opportunity to seek assistance for payment of services. For the non-compliant clients with the ability to pay, aggressive collection activity may occur including possible discharge from non-emergent Wake County services.

Fund Balance

Wake County Human Services maintains a single fund reserve identifying funds by source. MHDDSA funds can be identified separately from health fund reserves.

Front End Management/Client Registration

Wake aggressively verifies client income and county residency at the time of initial registration. This stems from the financial difficulties of the 1990's along with issues surrounding non-Wake residents crossing county lines seeking services at Wake facilities.

Cost Allocation Plan

Wake County has a federally approved cost allocation plan that identifies costs to all service areas.

Clinician Productivity Tracking

A well-designed clinician productivity-tracking plan is in place and has been accepted by the clinical staff. Data downloads from the MIS system and is manipulated to produce a comprehensive productivity report by department and by clinician.

MIS

Wake enjoys the benefits of the IS staff serving Wake County government. Unicare is the clinical/A/R software used by the agency. The IS staff is in the early stages of linking all three human services departments (Mental Health, Social Services and Public Health) into a shared file to promote complete and comprehensive care of the citizens of Wake County.

AREA PROGRAM PROFILE: WAYNE COUNTY MENTAL HEALTH CENTER
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Administration

Wayne is a small single county program that is a local political subdivision of the State and not part of the County. The County Manager does, however, exercise significant control over the Center. The Program Director reports to the County Manager rather than the Area Board on most management issues.

Employees: 117

Budget: \$9M

Area Program Statistics: Wayne received 10% of its budget from the County in FY 99, an average level compared to other programs surveyed. See the table on the following page.

2.9 Area Program Site Visits

	Population		Clients	County Contribution	Board Membership
	#	% Medicaid Eligible	#	\$	# Members
Wayne	113,300	14%	5,723	\$887K	15

*Much of this has been reverted to the County during the past several years.

Governance

Wayne is an example of a single county area program that is legally independent of the County, but in effect operates as a department of County government. It is extremely similar in its set up and relationship with the County to Rockingham Area Program. The Program director effectively reports to the county manager rather than the Board. This contradicts the independent legal status of the Program, but appears to be favored by all parties, who believe that the Program benefits from its close relationship with the County.

Role of the Counties

The Program operates as if it is a department of County government:

- Even though the Director has an ad hoc reporting relationship with the County Manager, he also reports regularly to the Area Board. The County Manager has the prerogative of recommending merit raises for department managers independent of the Area Board’s request. Final decisions regarding merit raises remain in the control of the County Commissioners.
- The County reverts its original contribution if it is not spent at the end of the year
- The Area Program is housed in County offices
- The budget is overseen and controlled by the County Manager and Commissioners

There do not appear to have been incidences in recent memory to challenge these de facto governance structures, for example, there have been no clashes between the Board members and the County Manager on the Area Program’s operations.

There has not been a strong call for increased County funding in recent years. In fact, the County appears to have reverted money routinely over the past several years.

Role of the Area Board

There are 15 board members, all of whom are appointed by the County Commissioners. From the County’s perspective (according to a County Commissioner), the Board has responsibility for hiring and firing the director, but day-to-day operations are overseen by the Manager. It is also the Director’s understanding that it is the Board’s role to set policy, but not to be involved with management.

Capacity to Manage Change & Meet Future Demands

Wayne County has an on-going collaboration effort in process with Duplin-Sampson and Lenoir Area Programs. They are currently in the process of merging some administrative functions, including MIS, human resources, quality improvement and network management. The Area Programs acknowledge the difficulty of potentially merging governance structures, and for the time being, are concentrating on operations only. It may be difficult to maintain consensus among the various boards of County Commissioners, whether through informal or formal structures, as this collaboration progresses.

2.9 Area Program Site Visits

The close relationship and high degree of accountability between the Area Program and the County may be beneficial to change in that the County may be relatively more willing to increase its financial contribution than those that are associated with multi-County programs. However, as it is currently constructed, there is an inherent weakness in the de facto (County authority) and the legal (board authority) governance structures. In an atmosphere of new demands, this could create conflict if the board chooses to take a more active role. The fact that the board is appointed by the commissioners may alleviate this potentiality, however.

Service System: Continuum of Care

This is a small single County program that is two to three years into a re-organization plan that will merge some functions with two other neighboring counties. There are significantly different views about the advisability of the multi-County cooperation plan within the clinical group and between clinical and administrative areas.

Development of the continuum of care is affected by limited financial resources, difficulty in recruiting adequately trained clinicians, high staff turn-over and a lack of private providers. The program relies heavily on Cherry Hospital for acute and long-term inpatient care and employs a roster of consulting psychiatrists who spend most of their work time at Cherry Hospital. Clinical leadership is provided by a small group of senior clinicians, primarily doctoral level psychologists, who all continue to provide some direct care. There is no medical director.

There have been recent attempts to improve service delivery through a new “Access” department that is responsible for phone triage, crisis intervention and routine intake functions. There is general agreement that the change has been good for clients and staff resulting in faster response to service needs. First appointments for individuals requesting non-urgent evaluation and treatment are occurring within approximately five days while urgent care requests are seen within 24 hours. Attempts to staff the telephone function with volunteers is creative but questionable. After hours emergencies are handled by an on-call system that is staffed primarily by the senior management group who are privileged at the local acute care hospital and work closely with the emergency room physicians.

Case management and outpatient treatment are the core services provided. Individuals requiring more intensive care generally must access these services outside of the County. There are several group homes in the County for individuals stepping down from Cherry Hospital. Staff report that a large number of individuals who are referred to Cherry Hospital from other counties stay in Wayne County after discharge and become their responsibility.

Child Mental Health

Services for children and families are primarily provided through four programs: Children’s Services, the outpatient clinic; “ASAP”, specialized substance abuse services; Willie M.; and “WISH”, school-based collaboration with the County health department.

The outpatient clinic provides a range of services including case management, evaluation and outpatient care. Service providers are encouraged to do home visits and consultation in the schools, but difficulty in recruiting and filling positions often make it impossible for clinicians to get out of the office. The Wayne Initiative for School Health, WISH, is a joint effort with the health department. Essentially satellites of the outpatient clinic, this program provides services on-site to three middle schools in the County. There are plans to expand this program as it has been well received by the community.

2.9 Area Program Site Visits

“ASAP” is the Area Program’s resource for substance abuse treatment for children and adolescents. An after school and evening group therapy program is the primary treatment vehicle although individual and family treatment is also offered. There is a desire to expand the family treatment component. Similar to other counties, the Willie M. program provides intensive treatment through a broad spectrum of services for youth designated by the State. This continuum includes in-home services, multiple levels of residential care, school-based services, and a consulting psychiatrist who has been with the program for many years. The program has seen a large increase of application for services in the past year including referral of many more girls. Changes in Medicaid reimbursement and difficulty accessing intensive services in the County are seen as the primary reasons for the increase.

There are very few private providers in the County and no day treatment, partial hospital, crisis stabilization or respite care resources. A few providers such as Methodist Home provide therapeutic foster care placements for non-Willie M. youth. Inpatient services are provided by private providers in Winston-Salem or Fayetteville or by the units at Cherry Hospital. Case managers work closely with the State hospital when children are sent there but have a much more difficult time when children are placed elsewhere.

Adult Mental Health

Wayne County adult mental health services is in the process of developing a more centralized system of care that will bolster the already existing programs and expand services across the continuum. Currently, traditional outpatient mental health services are available which include individual psychotherapy, group therapy and medication administration. The Center is considering the addition of an intensive outpatient program component and evaluating the need for an acute partial hospitalization program. Acute inpatient services are currently primarily provided at the State hospital, which is located within the County. Community based inpatient services are limited to those clients who are voluntary and have access to Medicaid. Case Managers function as the liaison to the State hospital for current clients. Recruitment and retention of trained clinicians is a major concern of the organization. There are currently multiple vacant clinical positions across disciplines. The mental health center has not had a Medical Director for 6 years.

Crisis services are directed through the information and referral hotline that is available 24 hours per day 7 days a week to screen emergency calls and coordinate outpatient referrals. Volunteers man the hotline with back up from clinical staff. Face to face assessments are conducted in the emergency room of the local hospital. The Crisis Services Director has developed a training program for volunteers to ensure that quality crisis services are provided. Referrals for intake screening are routinely completed within 5 days. Clients who require an urgent appointment are seen within 24 hours.

Access to specialized geriatric services is minimal. There is an active Council on Aging that offers groups, activities, meals and nutritional services. Residential services include family care facilities, rest homes and nursing homes. Clients requiring medical psychiatric treatment are referred to Dorothea Dix Hospital.

Substance Abuse Services

The substance abuse services continuum includes community based access to a variety of detoxification programs. There is a 6 bed social setting detox and a MISA unit at the State hospital that accepts clients who are one day sober. The Center operates a 5-day per week outpatient detox program that then refers the clients to ongoing treatment when the detox is complete. This program offers daily monitoring and is utilized for holding clients awaiting outpatient services. Clients who require an extended rehabilitation program are referred to programs outside the County or to the State hospital. The Center offers an active intensive outpatient treatment program that is frequently at capacity. Outpatient clinician staffing at the

mental health center is a serious concern. Turnover of staff is high and access to trained substance abuse clinicians is limited. Services are somewhat disjointed and might be accessed more easily if they were co-located in the same building.

Service System: Management Infrastructure

Wayne County Mental Health Center is a small, single County program with an adequate continuum of care that includes a wide array of services for Adult MH, Child MH, DD and Substance Abuse services. The infrastructure to support these services is currently operating at near full capacity with limited support available to expand services under the current management arrangement. The recent collaboration efforts between Wayne and Lenoir counties is an effort to avoid additional cost by duplication and expand the continuum of care offering within the designated populations.

Contract Monitoring

Wayne County has enhanced its ability to expand its service offerings by contracting with external providers to deliver services that would otherwise not be available. The contract administrator's challenge with the increased number of providers is to monitor the compliance with the Area Program's contract. Wayne County currently contracts with approximately 60 providers consisting of nearly 120 service contracts. An internal software package is utilized to manage the contractor process to ensure expenses remain within designated budgets. About \$4.5M of a total \$10.5M dollar budget (43%) is paid to contract providers with more than 95% of the external provider budget allocated to DD and Willie M. providers leaving less than 5% allocated to Child MH/SA and Adult MH/SA. Due to the limited staff and resources available to support the contract monitoring function, Wayne County is exploring collaborative opportunities with surrounding counties to enhance the monitoring process.

Quality Management

To ensure the quality of services provided to its clients, Wayne County utilizes a formal Quality Improvement Committee led by a designated Director and consisting of representatives from all departments throughout the organization. This group addresses issues of consumer complaints, additional service needs, current service enhancements, and other issues that affect the overall delivery system of Wayne Mental Health Center. To verify the integrity of the Center's Medicaid billing, Wayne County relies on its Case Managers to review 100% of the notes and other necessary documentation requirements.

Utilization Management

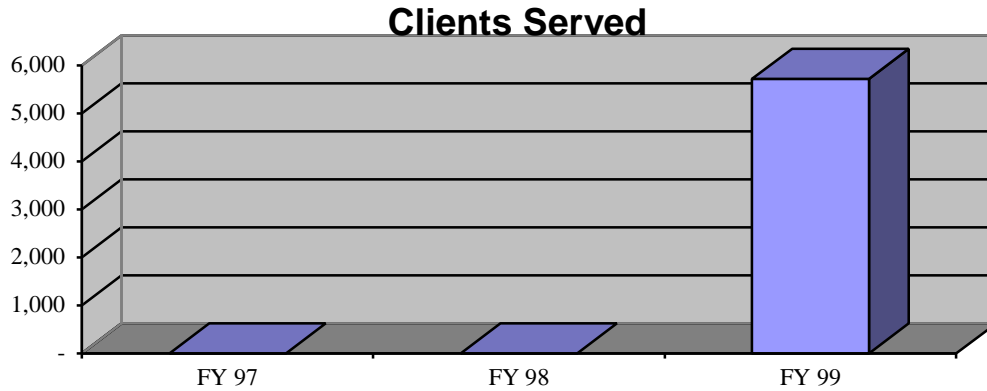
Currently, Wayne County does not support a formal utilization management function. The State's proposal to implement a statewide Utilization Management process, if implemented, would constitute Wayne County's only utilization review procedure.

Privileging and Credentialing

Wayne County currently privileges and credentials each of its contract providers through the utilization of a formal privileging and credentialing process. The Area Program does not rely on its vendors to perform this function and instead has chosen to substantiate the competencies of all providers of all services. The proposed collaboration efforts with the surrounding counties may provide an opportunity to reduce duplication of the credentialing and privileging process for those providers jointly utilized by each program.

Financial Overview

Wayne County operates the mental health authority as if it were a department of County government resulting in the County’s involvement with the Area Program’s financial issues. The financial team at Wayne County is struggling with the changing landscape of mental health delivery in North Carolina. Overall, the staff is educated and knowledgeable and is dedicated to improving the Area Program’s financial position using the collaboration with Duplin-Sampson and Lenoir as the tool for this task. Cash flow issues, a growing client base and an increased demand to monitor compliance fueled by an increased contract provider volume are the top concerns of the financial team.



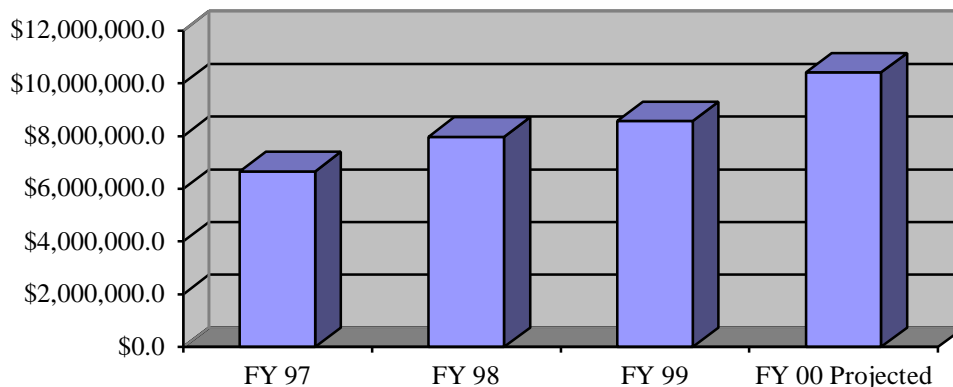
Chief Financial Officer

Cathy Redmon serves as Chief Financial Officer for Wayne Area Program. She has been in this capacity for approximately four years.

FY 1999 Operating Budget

Wayne operated with a \$8.6M budget in FY 99, with projected growth exceeding \$10.4M in FY 00. The Area Program has seen an increasing operating budget for the past three years, consistently budgeting for expanded service offerings. From FY 97 to FY 99, operating expenditures have increased by 28% and

Wayne County Operating Budget



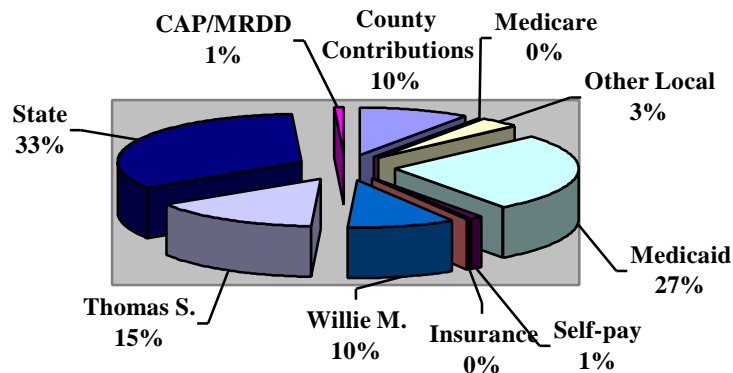
2.9 Area Program Site Visits

are expected to increase another 21% for FY 00. The most significant expenditure increase is projected for the Willie M. and Thomas S. clients totaling more than \$250K and \$800K respectively.

Wayne relies heavily on State funding and Medicaid, representing 33% and 28% of its operating budget, respectively in FY 99 to support the clinical service programs. Projecting a \$1.3M revenue increase for FY 00, Wayne has budgeted significant increases across payor sources with a 340% increase in CAP/MRDD, an increase in County Funds by 108% and Willie M. revenue increasing by 44%. Between FY98 through FY00 (projected) there has been a significant increase in County contributions from \$623,140 to \$1,850,393.

Revenue Summary - by Payor Source	FY 98	FY 99	FY 00 Projected
Self-pay	\$142,362	\$105,760	\$145,719
Private Insurance	\$99,910	\$20,074	\$120,000
Medicaid	\$1,985,008	\$2,419,946	\$2,236,083
County Contributions	\$623,140	\$887,073	\$1,850,393
State Funds	\$3,848,879	\$3,019,246	\$3,018,243
Medicare	\$29,381	\$0	\$25,000
Thomas S.	\$922,041	\$1,344,432	\$1,101,895
Willie M.	\$754,638	\$862,864	\$1,245,475
Other Local	\$348,444	\$315,336	\$328,075
CAP/MRDD	\$334,952	\$75,227	\$337,656
Fund Balance	\$0	\$0	\$0
Total Revenue	\$9,088,755	\$9,049,958	\$10,408,539

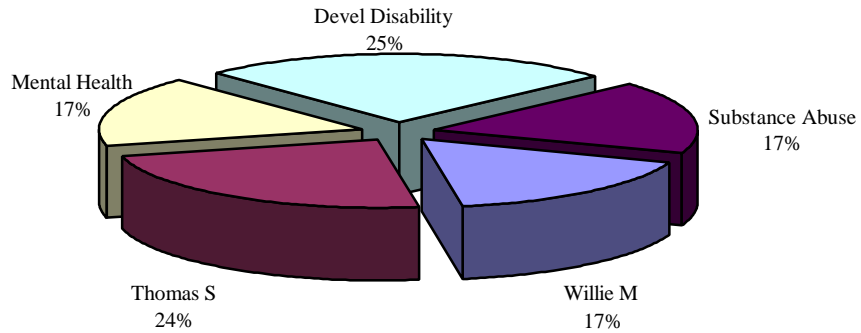
Breakdown by Revenue Source (FY 99)



Further analysis of Wayne's State Funding for FY 99 illustrates the disparity in funding across the disability groups of substance abuse, mental health and developmental disabilities, including additional funding for Thomas S. and Willie M. consumers. When Thomas S. and Willie M. are included with DD and MH respectively, a chasm exists between the three disabilities with DD at 49%, MH at 34% and SA at 17%. Restricted funds account for 41% of the total State funding with Thomas S. at 24% and Willie M. at 17%, limiting the opportunity for Wayne to expand service delivery for the unclassified population without collaboration with other area programs

2.9 Area Program Site Visits

State Funding Distribution for FY 99

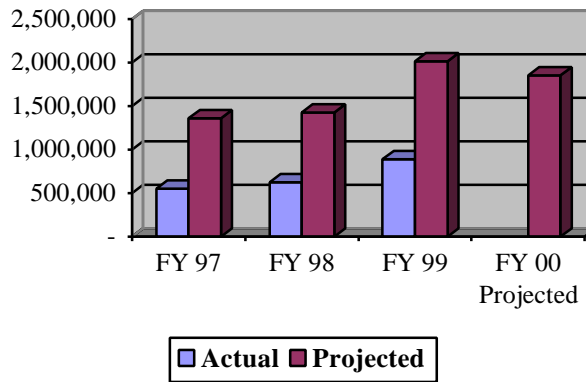


County Funding

County funding in FY 99 was approximately \$887K. The County allocates \$370K to the Area Program that is paid directly back to the County for indirect costs, building, maintenance, etc. An estimated additional \$49K in in-king contributions for other services and facilities provided. Mental health does not take a high priority in County government and expectations of increased funding for mental health services are low. As a result, Wayne County is in the early stages of negotiation with two other area programs to share services or explore the possibility of merging clinical programs.

County contribution comprised about 10% of FY 99 revenues and is projected to increase to 18% of the FY 00 budget.

County Contribution



Per Capita Financing

FY 99

	Population	Operating Expenditures	Per Capita Expenditures	County Funding	Per Capita Funding
Wayne	113,300	8,568,022	75.62	887,073	7.83

Division Funding

The overall State funding of the Area Program ranked Wayne thirty-first among the forty-one programs that existed in FY 97. There was however, a disparity in the funding of individual programs. Wayne ranked thirty-third in Mental Health funding, with per capita funds averaging only \$8.91. Similarly, Wayne ranked twenty-seventh for Developmental Disabilities with \$10.78 per capita. This is in contrast to the funding of Substance Abuse, where Wayne ranked fourteenth, with per capita funding of \$6.46.

Cash Flow Analysis

Wayne benefits from County oversight for cash management; therefore it is not a day-to-day issue for management. Wayne relies on the County accounting system and fiscal staff to manage all cash and accounts payable.

Accounts Receivable Balance

As of 6/30/98, the A/R Balance is approximately \$ 2.4 net of reserves.

Fund Balance

Wayne Mental Health does not maintain a separate fund balance. Because of the relationship to County government, this Area Program does not make a distinction between County and Area Program funds. To date, the Division has not made an issue of this practice.

Front End Management/Client Registration

Wayne makes a reasonable effort to verify demographics and eligibility at the time of patient registration and attempts to collect outstanding patient balances on a regular basis.

Cost Allocation Plan

The Area Program has identified the need for a comprehensive cost allocation plan but does not have the resources to complete this analysis. They rely heavily on the cost finding prepared and submitted to the Division each year to monitor costs as well as the County-developed cost allocation plan.

Clinician Productivity Tracking

Wayne County has implemented a staff productivity tracking system developed and updated by the MIS department. A monthly report is produced that shows the number of reimbursable units for each clinician with an expectation that 50% of their time is spent providing direct to clients.

MIS

Wayne operates its own data processing division, employing two full-time staff. The County provides support and installation of the financial package utilized by the Center. Client information, billing and reporting are covered under programs licensed to the Center by an independent vendor (CSM). The lack of adequate office space combined with double-entry in the Area Program and County systems hinders the efficiency of the MIS function.

OVERVIEW

PURPOSE OF THE ANALYSIS

The purpose of this portion of the overall study of State Psychiatric Hospitals and Area Mental Health Programs is focused on the state administrative structure for North Carolina's developmental disabilities system. Specifically the study's objectives were:

- To document the challenges and issues facing North Carolina's public developmental disabilities system,
- To analyze ways to address them through changes in the management structure. The DD study looked specifically at two options:
 - 1) Creating an independent Division of Developmental Disabilities, or
 - 2) Initiating a restructuring of the management of the current Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS).

In order to analyze the pros and cons of these options, criteria have been developed – based on the initial data collection phase — that spell out the prerequisites for change. Additionally, the costs of both options were considered. It should be noted that, given the challenges facing the developmental disabilities system in North Carolina, the current structural arrangement was not an option in the analysis.

The scope of work did not include an analysis of separating developmental disabilities services and supports at the local level. As such, this report assumes that developmental disabilities services would be included in the proposed county programs. However, PCG recommends that North Carolina conduct further study of the means by which DD programs would be integrated into the County Programs.

Methodology

There were several activities undertaken to weigh the two options for State organization of developmental disabilities services in North Carolina:

- Interviews with key State developmental disabilities, mental health, Medicaid, and other human services officials;
- Interviews with self-advocates and family members, and providers;
- Site visits to six area programs, Catawba, Mecklenburg, Tideland, Smoky Mountain, V-G-F-W, and Wake, including interviews with program administrators, providers, and case managers;
- Site visits to four regional MR/DD centers, and interviews with all five directors;
- Review of previous plans and proposals for DD systems reform; analysis of DD administrative structure and expenditure data;
- Conduct of a DD Experts Panel highlighting organizational configurations in Oregon, Missouri, South Carolina, and Pennsylvania;
- Presentation of preliminary findings and solicitation of feedback at four regional meetings.

3. Developmental Disabilities Structure

This scope of work was completed under a subcontract by Human Services Research Institute (HSRI), under the direction of PCG.

National Context

Before analyzing the specific context in North Carolina, it is important to assess the national context within which developmental disabilities services are delivered and the assumptions and policies that govern such services and supports. It is also important to distinguish between the fundamental principles that underpin developmental disabilities services compared to those for people with mental illness and related disabilities. According to a recent report, excerpted below, by the National Conference of State Legislators (Davis, Fox-Grage, & Gehshan, 2000), there are fundamental differences in the premises and intervention philosophies between the two fields.

More than 3.6 million non-institutionalized Americans have either mental retardation or developmental disabilities. Roughly one out of 10 of them lived in a residential setting in 1998 (348,394), not including natural or adoptive families or psychiatric facilities. The high number of non-institutionalized people with developmental disabilities highlights the need to develop a service delivery system that does not depend upon public institutions to provide care.

Deinstitutionalization of people with mental retardation and related developmental disabilities has been far less problematic than for the mentally ill population because: a) the population of persons with mental retardation and developmental disabilities is a more stable, easily identifiable and definable population than the population of those with mental illness; and b) the nature of admissions to psychiatric facilities tends to be episodic and transitory, because people with mental illness may use psychotropic drugs or therapy to substantially improve their conditions. Consequently, psychiatric facilities often have incidents of reinstitutionalization of those with mental illness, whereas facilities serving the MR/DD population do not. (p. 6-7)

Before the late 1960s, people with developmental disabilities were largely ignored or segregated from the mainstream of their communities. But over the past 25-30 years, these patterns of neglect have gradually given way to approaches that stress the provision of services and supports in communities. Backed by state and federal legislation, community and educational services for children and adults have expanded dramatically over the past 20 years making placement in an institution an exception rather than the rule. And while remnants of past service practices remain, there is much to be optimistic about as the momentum for a community and person-centered response to disabilities has grown across the country.

This evolving set of assumptions acknowledges that people with developmental disabilities are capable of making choices about their own lives, respects their right to do so, and focuses on individualized supports and empowerment. Bradley and Knoll (1995) identify four major attributes of this new approach : emphasis on community, importance of relationships, person-centered supports, and choice and control. The adoption of these revised priorities has created significant changes in how services are provided:

- *Emphasis on community* -- A fundamental belief that people with developmental disabilities can and should live in communities as full participating members. The role of service providers is to identify and remove barriers to full community participation.
- *Importance of relationships* -- People with developmental disabilities have the same needs for social connectedness as do any other persons living in communities. A fundamental task of service providers is to ensure that people make social connections and become fully integrated into the life of the community. These social relationships make it possible for people with disabilities to make use of natural supports in their communities.

3. Developmental Disabilities Structure

- *Person centered supports* --This view of services for people with developmental disabilities eschews the notion of fitting people into available program “slots.” Rather , supports should be designed to respond to the unique situation of each individual in his or her community. People with disabilities should live in homes, not in programs and they should work in jobs, not in simulated job activities. Program planning should be an activity that includes the individual participant and those close to him or her.
- *Choice and control* -- The emerging approach recognizes the right of consumers to make choices about where and with whom they live, how they spend their time, and how they want their supports configured. The task for the public developmental disabilities system is to assist consumers in making informed choices and to ensure that meaningful choices are available.

Until recently, the beneficiaries of the rapid expansion of services in the 70s and 80s were those individuals who were moved out of institutions, and the aspirations of thousands of people with intellectual disabilities who had never been institutionalized were put on hold. Further, it is becoming increasingly obvious that the highly specialized and costly models of residential and day services developed during the 1970s and 1980s are too expensive to meet the needs of increasing numbers of individuals on waiting lists. Gettings (1992) has estimated that to meet the residential demand in the United States, states would have to increase their residential budgets by a full 20%. In reflecting on the fiscal realities at the federal and state level, Gettings makes the following observation:

The resources are simply not available -- and not likely to be available in the foreseeable future - to sustain the growth rate in spending which the field experienced during the past decade. Further expansions and improvements in services to people with developmental disabilities, therefore will be largely dependent on the capacity of advocates, providers and state officials to join hands in charting a new course that emphasizes more efficient utilization of available human and fiscal resources. (p. 16)

Future Challenges

Over the next few years, five basic trends will come together to prompt significant reform within developmental disabilities service systems:

- 1) *Creation of systems that maximize self-determination* – In order to create more responsive systems built on customer choice and preference, reforms, such as those embodied in the “self-determination” movement should be undertaken. Agosta (1998) has defined this approach as follows:

...[in self-determination], systems are structured so that service recipients influence policy, and individuals have the freedom and authority to determine the substance and texture of their own lives, including control over the resources allocated for personal services or support.

- 2) *Growing waiting lists and pressures from aging parents* – This is an issue that is facing North Carolina as well as the rest of the nation. As the baby boom ages, so do their families. The vulnerability of these aging families and the potential instability it may create will pose serious problems for service agencies. Additional pressure will be felt from those young people emerging from school systems with no productive job or leisure activities.

Prouty and Lakin (1999) estimate that in June 1998 there were 61,373 individuals who were on waiting lists for residential services. They conclude that:

States would need to expand their current residential services capacity by 17.6% to create residential services for all the people presently on waiting lists for them. This does not include

3. *Developmental Disabilities Structure*

growth in specific types of services needed to serve persons wishing to move from one type of residential setting to another (e.g., a large facility to a community residence) (p. 78).

In addition, these estimates do not address the thousands of others who may be waiting for daytime vocational services (e.g., supported employment).

Echoing such research, a National Arc study (1997) concludes that the nationwide shortfall of community support services has reached crisis proportions for people with mental retardation and their families. The Arc's report examines state-by-state data regarding the status of requests for critical residential, day/vocational and other community support services. According to the report, more than 218,000 requests for support remain unanswered for people with mental retardation and their families.

- 3) *Development of capacity to monitor performance through outcome assessment* -- Performance measurement has evolved as the system of supports has evolved. Quality assurance systems based predominately on input approaches were needed when the major goal of public policy was to provide for people's basic needs; process measures were needed when the goal was to expand and embed emerging technologies and interventions; and outcome measures are needed now to ensure that those technologies are in fact resulting in an improved quality of life for those being served and supported.

As supports become more individualized, strict input and process measures become problematic. Many argue that such prescriptive standards constrain the flexibility and creativity needed to individually tailor supports to peoples' unique capabilities and preferences.

- 4) *Direct support staff recruitment, retention and competence in a full employment economy* – Changes in the configuration of services and supports have put new pressures on direct support workers (e.g., isolation, increased responsibility, etc.), at a time when turnover rates are skyrocketing and the ability to attract staff in a full employment economy is severely compromised.
- 5) *Understanding and planning for the implications of the Olmstead (Supreme Court) decision*-- On June 22, 1999, the U.S. Supreme Court, in *Olmstead v. L. C.*, 119 S.Ct. 2176 (1999), ruled that, although states generally support the idea of a community-based delivery system and provide community services, many of them continue to rely heavily on their public institutions to provide services to those with developmental disabilities who are capable of living independently. As a result, many states, including Georgia, continue to maintain waiting lists of people with developmental disabilities who are hoping to receive care in less restrictive settings.

In the case, two women with mental retardation, L.C. and E.W. (also diagnosed with schizophrenia and personality disorder, respectively) were voluntarily admitted to a psychiatric unit of a Georgia state hospital. Their treatment professionals eventually determined that the women were qualified to receive care in an appropriate community-based program, but the women were placed on a waiting list for the services and remained institutionalized. The women filed suit against Georgia officials, alleging a violation of the Americans with Disabilities Act for the state's failure to place them in a community-based program.

3. Developmental Disabilities Structure

The Court ruled that states are required to provide community-based services for people with mental disabilities if treatment professionals determine that it is appropriate and the affected individuals do not object to such placement. However, the Court concluded that states are responsible for community-based placement if they have the available resources to provide community-based services. The Court also requires that states demonstrate that they have a comprehensive, effective working plan, including timetables and progress reports, for placing qualified people in less restrictive settings. States that maintain waiting lists must make a good faith effort to move people on the list to community programs at a reasonable pace.

In a recent letter from the Health Care Financing Administration and the Office of Civil Rights (January 14, 2000) the following principles for state responses were suggested:

- *Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings :*
- *Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up. When effectively carrying out this principle:*
- *Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities. When effectively carrying out this principle:*
- *Ensure the availability of community-integrated services.*
- *Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.*
- *Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.*

Summary

The pressure for reform that these challenges -- alone or in combination -- will place on developmental disabilities systems cannot be underestimated. To develop creative and cost efficient responses will require knowledgeable and committed leadership. They should be in the forefront of any decision regarding the ultimate configuration of the North Carolina's systems of support for people with developmental disabilities.

FINDINGS

Allocation of Resources to Supports and Services for People with Developmental Disabilities

The following section discusses trends in the allocation of resources in North Carolina's publicly funded services for people with developmental disabilities compared to the rest of the country. The analysis is included here in order to show those areas where the State has progressed as well as those areas where there is still work to be done to move the system more in line with national norms of best practice. The analysis was prepared, and updated for PCG/HSRI, by Gary Smith, National Association Directors of Developmental Disabilities Services.¹ The main issues raised by this analysis include:

3. *Developmental Disabilities Structure*

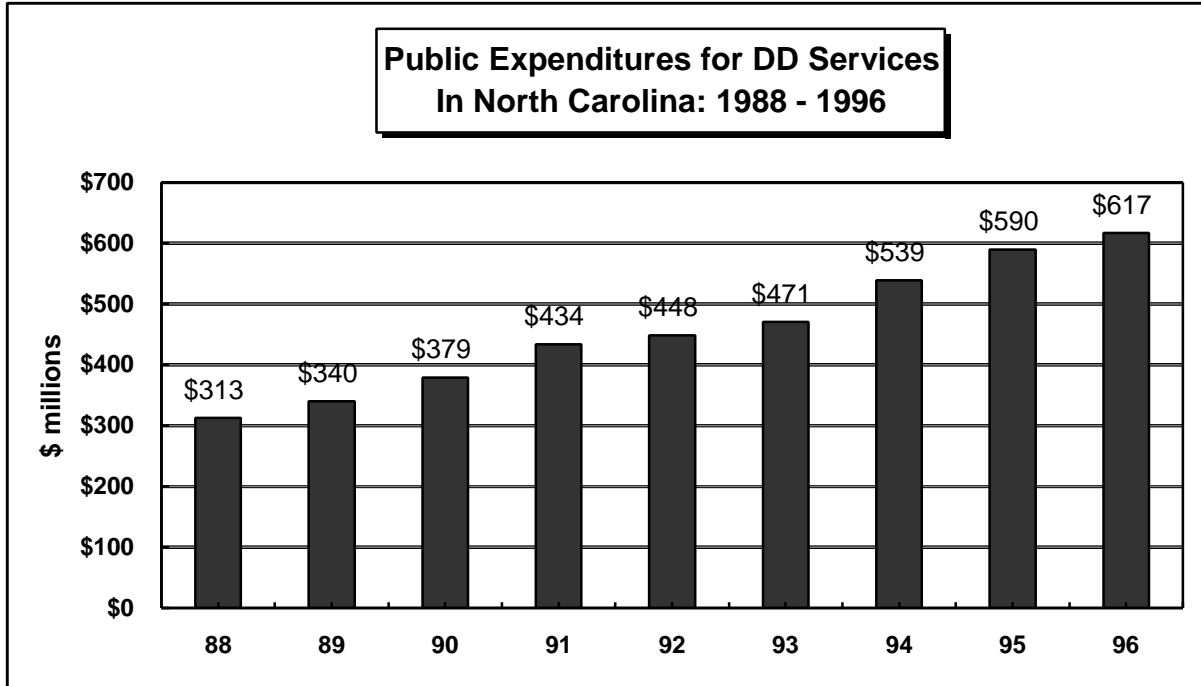
- North Carolina's financial investment in services and supports for its citizens with developmental disabilities increased at a more rapid rate between 1988 and 1996 than the nationwide rate. By 1996, the total dollars available for developmental disabilities services in North Carolina – when measured on a per capita basis – were only slightly less than elsewhere.
- In 1998, residential services overall were markedly less available in North Carolina than nationwide. In North Carolina, there was an especially large shortfall in residential service capacity and the scope of services needed to meet consumer demand. This gap was about twice as large in North Carolina than in other states.
- Relative to population, North Carolina served more people with developmental disabilities in its large state-operated Centers than the nationwide norm. While the number of individuals served in the Centers has steadily decreased, the rate of decline was less rapid than the nationwide rate.
- In 1998, North Carolina furnished residential services in settings that were larger than was typical elsewhere in the country. Relatively fewer people receive supported living services in North Carolina compared to nationwide and the number of families receiving family support services was markedly smaller than as in other states.
- In 1998, a greater proportion of North Carolina's residential services for people with developmental disabilities were provided in ICFs/MR than was the norm nationwide. While the CAP/MR-DD program has expanded considerably, North Carolina is not employing the Medicaid Home and Community Based (HCG) waiver program as extensively as other states to underwrite for community services on behalf of its citizens with developmental disabilities and their families.
- Overall, relative to population, fewer North Carolinians with developmental disabilities received Medicaid-funded long-term services (via the ICF/MR and HCB waiver programs in combination) than nationwide. However, in 1998, the total Medicaid dollars available for these services (measured on a per citizen basis) was greater than in other states. Since a greater proportion of Medicaid recipients in North Carolina were served in ICFs/MR, the state's per recipient expenditures for these services were well above nationwide levels.

The statistics contained in this report are drawn from nationwide data that are compiled by various organizations². At the start of each section, the source of the information is noted. If another source also was used, it is indicated in the text. The figures cited for North Carolina were furnished by state officials to the organizations that compiled the data that appear in this analysis.

Overall Spending for Developmental Disabilities Services (Source: DHD/UIC)

In 1996, public spending for services and supports for North Carolina's citizens with developmental disabilities totaled \$617.3 million. The chart at the left shows the trend in expenditures for these services from 1988 through 1996. These figures have been adjusted for inflation so that a direct comparison may be made among years. Spending in 1996 was about twice the 1988 level. Between 1988 and 1996, inflation-adjusted spending in North Carolina for developmental disabilities services grew at an annual rate of 8.9%. Nationwide, the rate of growth in spending for developmental disabilities services was significantly lower (5.3% annually). It is clear that over this period North Carolina considerably increased its financial support for such services.

3. Developmental Disabilities Structure

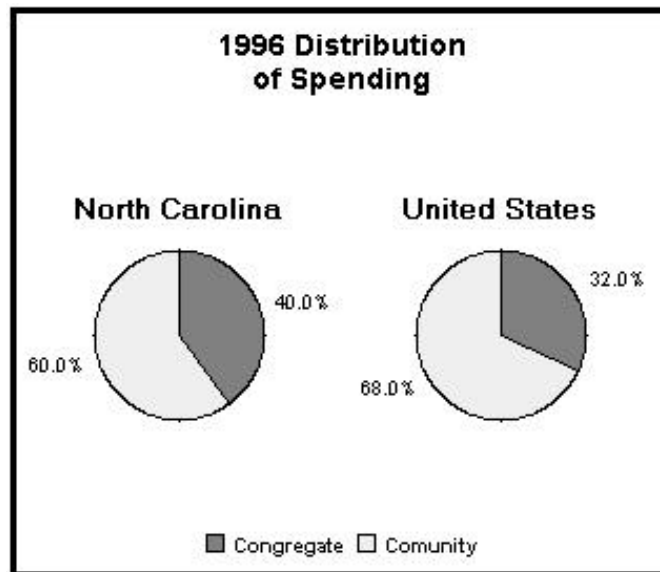


How did spending for developmental disabilities services in North Carolina compare to levels nationwide? One way to answer this question is to calculate “per citizen spending” (i.e., total spending for services divided by total state population). In 1996, per citizen spending for developmental disabilities services nationwide was \$86.30/citizen; in North Carolina, the comparable figure was a little lower -- \$85.17/citizen. The dollars available to underwrite developmental disabilities services in North Carolina were about on a par with other states. Measured another way³, North Carolina ranked 21st among the states in its citizens’ willingness to financially support developmental disabilities services. In 1988, the state ranked 25th.

What do these dollars buy? One way to break down state spending for developmental disabilities services is to look at the distribution of expenditures between “congregate” and “community” services.

Congregate services are provided in larger facilities (i.e., where 16 or more individuals are served at a single site). include smaller homes or other of daytime services, supports. In 1977, in every \$4 was services.

Since then, states availability of considerably while the use of larger The pie charts distribution of congregate and North Carolina to



Community services residences (e.g., group settings), various types family and in-home nationwide roughly \$3 spent on congregate

have expanded the community services concurrently reducing congregate facilities. compare the 1996 spending for community services in the nation as a whole.

3. Developmental Disabilities Structure

Compared to other states, in 1996 North Carolina earmarked a greater share of its dollars for congregate services and a smaller proportion for community services. Still, from 1988 forward, there were major changes in the services that North Carolina purchased on behalf of its citizens with developmental disabilities. In 1988, congregate services accounted for nearly 71% of all North Carolina spending for developmental disabilities services. Spending for community services in North Carolina first surpassed outlays for congregate services in 1993. Between 1988 and 1996, the share of dollars spent on community services in North Carolina increased from 29% to 60%.

Residential Services(Source: RCCTL)

Providing and purchasing residential services claim the majority of state expenditures for developmental disabilities services. Nationwide, in 1998 states provided residential services to approximately 348,000 individuals. As recently as 1982, the majority of residential services were furnished in large, state-operated residential facilities.⁴ Since then, states have been shifting residential services away from larger congregate settings to smaller living arrangements in the community. More recently, many states have fostered the provision of services in living arrangements that are owned or rented by people with developmental disabilities rather than in facilities or sites that are controlled by provider agencies. Such services often are referred to as “supported living”.

Here, information is provided concerning residential services for people with developmental disabilities in North Carolina. This information includes: (a) services furnished in large state-operated facilities; (b) all types of residential services; and, (c) other related services and supports.

Large State-Operated Residential Facilities

While the number of individuals served in large, state-operated facilities has been declining for more than 30 years, in many states these services continue to be important. Typically, these services are the most costly that a state provides. Table A shows the number of individuals served in North Carolina’s Centers over the period 1987 – 1998 and comparable nationwide figures.

**Table A:
Persons Served in Large, State-Operated Facilities:
North Carolina and United States (1987 – 1998)**

Year	North Carolina	Percent Change	United States	Percent Change
1987	2,720	N/A	95,022	N/A
1988	2,845	+4.6%	91,703	-3.5%
1989	2,715	-4.6%	87,071	-5.1%
1990	2,567	-5.4%	83,041	-4.4%
1991	2,528	-1.5%	78,407	-5.6%
1992	2,606	+3.1%	74,775	-4.6%
1993	2,469	-5.3%	70,760	-5.4%
1994	2,378	-3.7%	66,235	-6.4%
1995	2,229	-6.3%	62,499	-5.6%
1996	2,227	-0.1%	58,320	-6.7%
1997	2,141	-3.9%	55,017	-5.7%
1998	2,084	-2.7%	51,469	-6.4%
1990-1998	-483	-18.8%	-31,572	-38.0%

3. Developmental Disabilities Structure

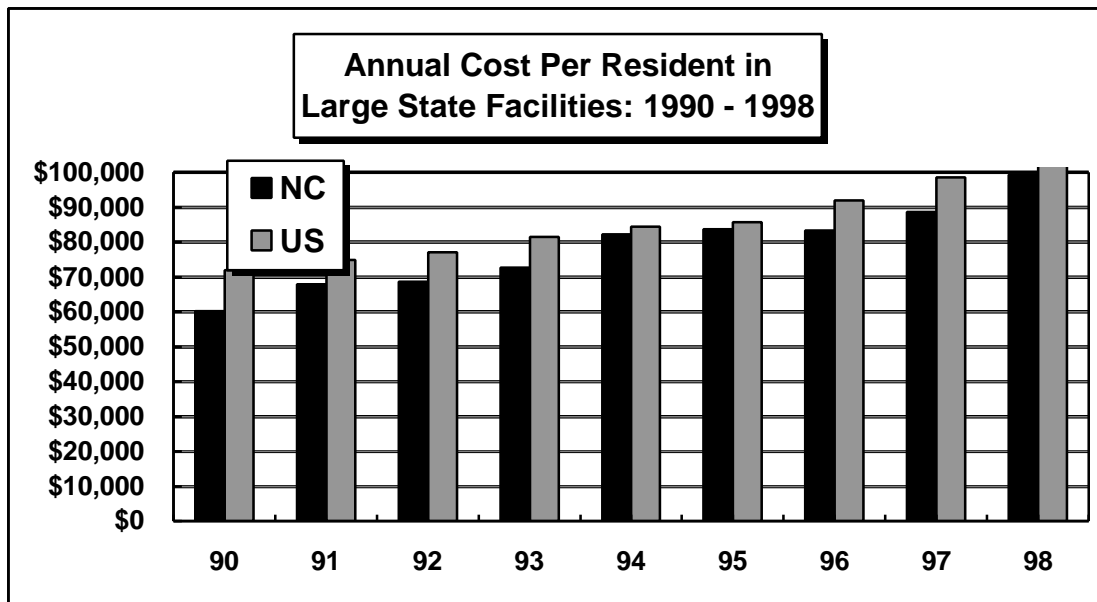
The number of individuals served in North Carolina's Centers declined steadily between 1987 and 1998. Nationwide, between 1990 and 1998, the number of individuals served in large state-operated facilities dropped by nearly 40%. Indeed, by the end of 1999, nine states (AK, DC, HI, ME, NH, NM, RI, VT, WV) had completely closed down the operation of such facilities. In North Carolina during the same period, the rate of decline in the number of individuals served in large state facilities was roughly one-half the nationwide rate.

How does North Carolina compare to other states in terms of the number of individuals served in large state-operated facilities? The best way to make this comparison is to divide the number of facility residents by total general population (expressed in 100,000s). This calculation yields an "index" that is not distorted by differences in overall population. In terms of people served in large state-operated facilities, Table B below shows this index for North Carolina and nationwide in both 1990 and 1998:

**Table B:
Persons Served in Large, State-Operated
Facilities per 100,000 Population**

Year	North Carolina	United States	North Carolina As Percent of US
1990	38.6	33.3	115.7%
1998	27.6	19.0	145.3%

The table also compares North Carolina's utilization rate for such facilities to the national rate. In both 1990 and 1998, North Carolina served more individuals relative to population in its Centers than was the case nationwide. Post-1990, North Carolina's use of these facilities declined significantly but less rapidly than elsewhere. Relative to population, in 1998 North Carolina served 45% more individuals in large state-operated facilities than the nationwide average. If North Carolina's use of large public facilities had been the same as the rest of the nation, there would have been roughly 650 fewer individuals served in the state's five Centers in 1998.



With respect to the cost of large state-operated facility services, the chart at the right shows the annual cost of serving an individual in North Carolina's Centers compared to the nationwide average for the period 1990-1998. By 1998, North Carolina's annual cost per resident for these services had climbed to \$99,280 (\$272 per day). The nationwide average was 5% higher (\$104,025/year or \$285/day). Between

3. Developmental Disabilities Structure

1990 and 1998, the costs of these services in North Carolina increased at the compound rate of 6.5% per year, a more rapid rate of increase than the 4.7% per annum nationwide rate of increase.

In 1996 spending for services provided in North Carolina's Centers claimed a little over one-third of all state spending for all types of developmental disabilities services (in 1988, the Center spending accounted for 63% of all dollars expended) (DHD/UIC). Nationwide in 1996, a significantly lower proportion of available dollars (about 25%) was earmarked for services in large state-operated facilities than was the case in North Carolina.

Residential Services of All Types

Residential services include not only large state-operated facilities but also other Medicaid-funded ICFs/MR (discussed in more detail below), other group-living arrangements, family care homes, and supports furnished to an individual who lives in his or her own home. Table C (next page) shows the number of North Carolinians with developmental disabilities who received publicly funded specialized residential services (including the Centers) on June 30 of each year during the period 1990 – 1998 and comparable figures for the nation as a whole.

The figures show that the number of individuals who received residential services in North Carolina grew considerably over this period and at a brisker rate than the nation as a whole. The table also indexes these services to population (i.e., the number of persons receiving these services per 100,000 general population). In 1990, North Carolina – relative to its population -- furnished residential services to 27% fewer individuals than was the case in other states. Since 1990, North Carolina has expanded the availability of residential services at a faster pace than the nation as a whole. By 1998, relative to population, the availability of residential services in North Carolina was 22% greater than in 1990.

**Table C:
Persons Receiving All Types of Residential Services:
North Carolina and United States (1990 – 1997)**

Year	North Carolina	Per 100,000 Population	United States	Per 100,000 Population
1990	5,467	81	277,188	111
1991	6,028	89	287,294	114
1992	6,322	92	294,026	116
1993	6,820	98	308,984	114
1994	6,893	99	310,177	121
1995	7,045	99	314,503	119
1996	7,183	99	324,567	122
1997	7,566	102	342,244	126
1998	7,485	99	348,280	129
% Change 1990-1998	+36.9%	+22.2%	+25.6%	+16.2%

Despite growth in the absolute number of people with developmental disabilities receiving residential services, the difference in the availability of such services in North Carolina compared to other states was unchanged between 1990 and 1998. In 1990, the difference between North Carolina's population-indexed "service rate" and the nationwide rate was 30 persons/100,000 population. In 1998, the difference was the same. During the 1990s, North Carolina experienced a relatively high rate of state population growth. Between 1993 and 1998, the expansion of residential services in North Carolina matched the rate of state population growth. North Carolina held its own with respect to the availability of residential services

3. Developmental Disabilities Structure

relative to state population. Elsewhere, states achieved a net increase in the availability of these services relative to population and, hence, were able to make progress in reducing their waiting lists for these services.

If specialized residential services had been available to the same proportion as elsewhere in the U.S., almost 2,270 more individuals would have been served in 1998 than actually were.

In 1998, North Carolina officials reported that 2,450 persons with developmental disabilities had been identified as needing residential services but had been “wait-listed” because such services were not available. This meant that North Carolina fell short by about 33% of being able to serve all individuals identified as needing or wanting these services. Nationwide, the shortfall in residential service capacity was much lower (17.0%). Had residential services and supports been as available in North Carolina as nationwide, the state would have been able to serve nearly all individuals waiting for such services.

There are North Carolinians with developmental disabilities waiting for other types of services as well. According to the North Carolina Waiting List Project:

- As of January 1999, a total of 6,126 individuals with developmental disabilities and their families in North Carolina were waiting for services.
- From 1997 to 1998, there was a 23% increase in the number of people on the waiting list for services.
- North Carolina had the sixth largest waiting list per capita in the United States according to a 1997 report issued by The Arc of the United States.
- 2,000 people had been waiting for services for more than two years.

Hence, North Carolina’s relatively large gap between the supply of and demand for residential services is paralleled by similar gaps in system capacity for other types of services. In recognition of this shortfall, the North Carolina Legislature has earmarked extra dollars to address the needs of individuals and their families waiting for services.

There is a particularly wide disparity between North Carolina and the rest of the nation in terms of the availability of community residential services outside large state-operated facilities. Nationwide in 1998, residential services outside large state-operated facilities were furnished at the rate of 110 individuals per 100,000 population; in North Carolina the rate was 71.4 persons per 100,000 population or roughly 35% less.

Over the past two decades, there has been a major shift in the provision of residential services away from larger congregate settings to smaller living arrangements. In 1977 nationwide, the average residential setting served 22.5 individuals; by 1998, the average had dropped to 3.3 individuals per site. Table D on the next page shows the distribution in North Carolina and nationwide of individuals receiving residential services by size of the facility or living arrangement in 1990 and 1998:

3. Developmental Disabilities Structure

Table D: Distribution of Individuals Receiving Residential Services by Size of Living Arrangement (1990 & 1998)

Year/ Setting	North Carolina	Percent of Total	United States	Percent of Total
1990				
1-6 Beds	2,029	37.1%	99,306	35.5%
7-15 Beds	265	4.8%	51,504	18.4%
16+ Beds	3,173	58.1%	128,914	46.1%
1998				
1-6 Beds	4,393	58.7%	204,571	58.7%
7-15 Beds	484	6.4%	54,474	15.6%
16+ Beds	2,608	34.9%	89,234	25.6%
% Change 90-98				
1-6 Beds	+116.5%		+109.0%	
7-15 Beds	+82.6%		+5.8%	
16+ Beds	-17.8%		-30.8%	
Average Number of Persons Per Setting –1998	6.7		3.3	

In 1990, the proportion of individuals receiving residential services in smaller (1-6 person living arrangements) was about the same in North Carolina as the nation as a whole. However, North Carolina served a considerably larger proportion of individuals in large congregate (16 person or more) facilities, principally the Centers. Like most other states, from 1990 forward, growth in residential services in North Carolina mainly took the form of expanding smaller living arrangements. The percentage of individuals served in large facilities fell in North Carolina, albeit at a slower rate than in other states. Overall, North Carolina followed the general national trend of shifting residential services to smaller, community living arrangements. However, in 1998, the average number of persons served at residential sites in North Carolina was twice as high as the nationwide average. In 1998, it was more common for North Carolinians with developmental disabilities to be served in larger living arrangements than their counterparts in other states.

One reason for this difference is that nationwide there has been a growing emphasis on furnishing residential services to individuals in homes of their own. In 1998, nationwide about 18% of all individuals who received residential services lived in a home of their own or one they shared with another individual. The number of individuals being supported in their own home nationwide has been growing rapidly, increasing by roughly 60% nationwide between 1993 and 1998. In North Carolina, a far smaller percentage of individuals are reported as receiving residential services in homes of their own. In 1996, for example, it was one-third less common in North Carolina for individuals to receive supported living services than was the case nationwide (DHD/UIC).

Other Related Services and Supports

To round out the picture, the following information also is provided:

- The foregoing statistics do not include people with developmental disabilities who reside in general-purpose nursing facilities. In 1998, 860 people with developmental disabilities were served in nursing facilities in North Carolina. Taking into account the size of North Carolina's population, it was somewhat more likely that a person with a developmental disability will be served in a nursing facility in North Carolina than in other states. When nursing facility and developmental disabilities residential services are combined, a greater percentage (about 10%) of North Carolinians with

3. Developmental Disabilities Structure

developmental disabilities who receive a residential service of any type are served in nursing facilities than nationwide, where the percentage is 6.5%.

- Nationwide, states furnish in-home services and supports to about as many individuals who live with their families as are provided in specialized, “out-of-the-family-home” residential facilities. In 1998 (RTCCL), North Carolina officials reported that these in-the-family-home services were furnished to about 3,100 individuals with their families. More than two times as many individuals received residential services outside the family home in North Carolina as in the family home. Nationwide, about 121 persons per 100,000 population received in-home supports in 1998. In North Carolina, the figure was far lower – about 41 persons per 100,000 population. Consequently, not only are residential services less available in North Carolina than nationwide but also “in-the-family-home services” were furnished at a rate that was one-third the nationwide average.

Medicaid Funded Services (Source: RTCCL & NASDDDS)

Nationwide, the single most important source of federal funding for the specialized services and supports that states furnish or purchase on behalf of people with developmental disabilities is the Medicaid program. Through the Medicaid program, the federal government financially shares in the meeting the costs of various types of services. In the case of North Carolina, the current federal financial participation rate in Medicaid-reimbursable services is 62.5%. In other words, for each \$1 spent on a Medicaid qualified service, about 63¢ is paid by federal Medicaid funds and 37¢ by the State of North Carolina.

In 1996, state-federal Medicaid payments accounted for roughly 75% of all dollars spent nationwide on developmental disabilities services (DHD/UIC). In North Carolina, the proportion was lower – about 69% -- but still quite large.

The two main Medicaid program categories used by North Carolina (and other states) to secure Medicaid funding for specialized developmental disabilities services are the ICF/MR and home and community-based waiver programs. In 1998, North Carolina’s spending for these two programs in combination totaled \$514.4 million; federal payments to the state for these services came to \$324.5 million. Clearly, the Medicaid program plays a critical role in underwriting developmental disabilities services in North Carolina. In the following sections, information is furnished concerning each of these programs individually and in combination.

3. Developmental Disabilities Structure

ICF/MR Services (RTCCL)

One avenue for securing federal Medicaid funding of specialized residences for people with developmental disabilities is to certify such facilities as Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).⁵ Table E below shows the number of individuals who received ICF/MR services in North Carolina and nationwide during the period 1990 – 1998 as well as utilization indexed to population.

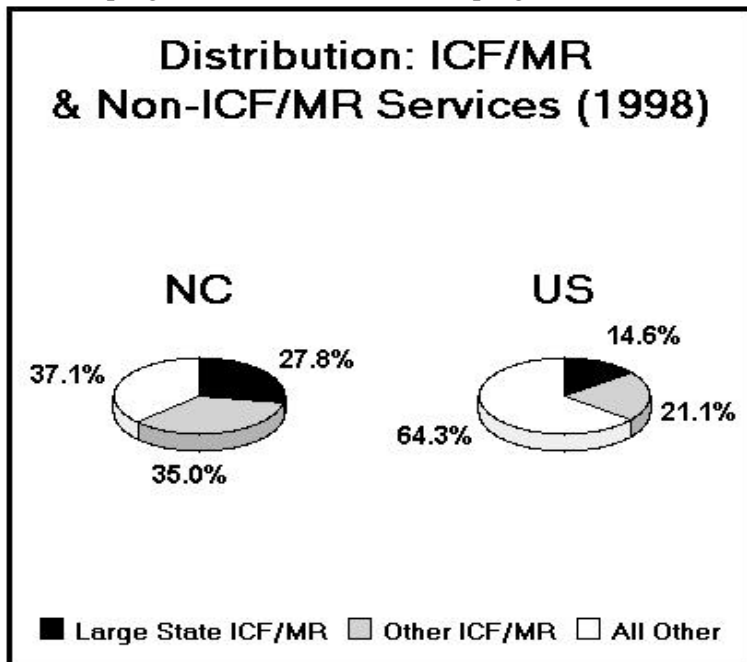
Table E

**Persons Receiving ICF/MR Services:
North Carolina & United States (1990 – 1998)**

Year	North Carolina	Per 100,000 Population	United States	Per 100,000 Population
1990	3,799	57.1	144,286	57.9
1991	4,378	64.8	146,657	58.2
1992	4,502	65.8	146,460	57.4
1993	4,662	67.0	147,729	57.3
1994	4,732	66.8	142,118	54.6
1995	4,595	63.8	134,384	51.1
1996	4,593	62.7	129,449	48.7
1997	4,777	64.3	126,697	46.7
1998	4,705	62.4	124,258	45.9
% Change 1990 - 1998	+23.8%	+9.3%	-13.9%	-20.7%

Between 1990 and 1998, the number of persons served in ICFs/MR in North Carolina grew by almost 24% overall and nearly 14% with respect to State population. In 1990, the utilization of ICF/MR services in North Carolina was the same as the nation as a whole when indexed to population. Starting in 1993, the utilization of ICF/MR services nationwide began to decline. This decline reflected both the ongoing downsizing and closure of large state-operated facilities (most of which are certified as ICFs/MR) and more recently the conversion of a growing number of private ICF/MR facilities to funding under the HCB waiver program. Due to both cost and programmatic considerations, most states have been reducing the

role that ICFs/MR play in their service systems. The growth in ICF/MR services in North Carolina stands in contrast to the trend nationwide of declining ICF/MR utilization. In 1998, about 36% more individuals were served in ICFs/MR in North Carolina relative to population than nationwide.



There are two ICF/MR “sectors” in North Carolina. The five large State-operated Centers are certified as ICFs/MR. Center residents accounted for approximately 44% of all individuals who received ICF/MR services in 1998. The remaining individuals were served in 336 non-State privately operated facilities. About 92% of these facilities served six individuals per site. Between 1990 and

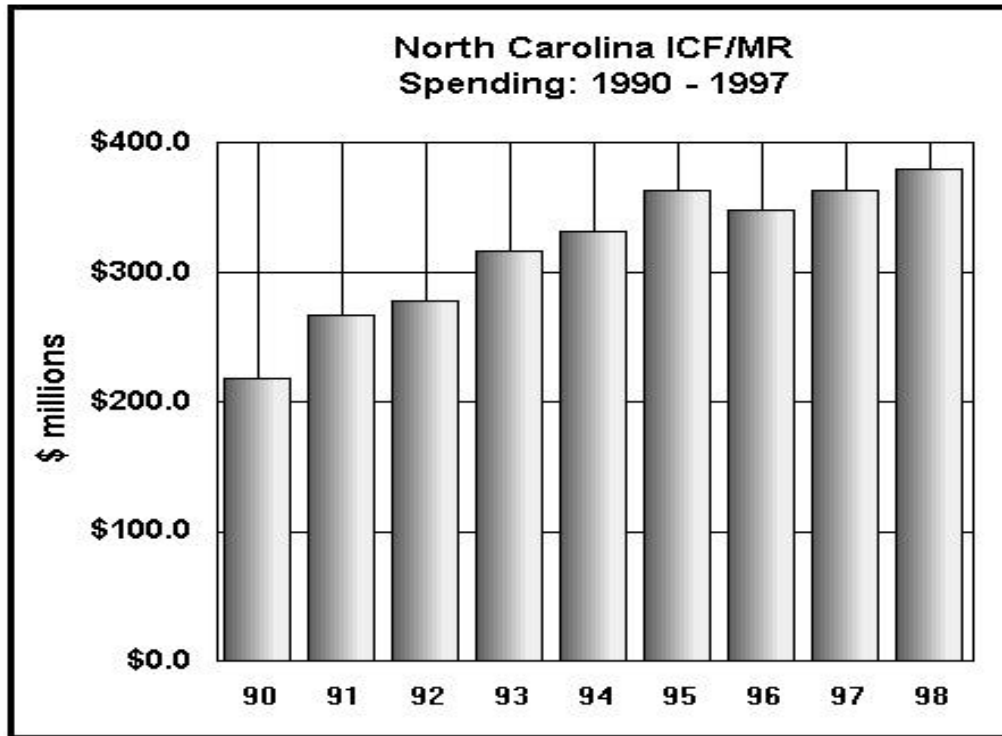
1998, the number of persons who received ICF/MR services in North Carolina’s Centers declined by approximately 480. During the same period, the number of persons served in non-State operated facilities

3. Developmental Disabilities Structure

more than doubled from 1,232 to 2,621. Growth in privately operated ICFs/MR was substantially greater in North Carolina than the country as a whole.

The pie charts above show the distribution of residential services in North Carolina and nationwide across three sectors: (a) ICF/MR services provided in large State-operated facilities; (b) ICF/MR services provided in other types of facilities; and, (c) all other non-ICF/MR residential services (including those funded through the HCB waiver program and state general revenue dollars). These charts reveal that roughly 63% of all North Carolinians with developmental disabilities who received residential services in 1998 were served in ICFs/MR. Nationwide, the proportion was substantially lower – 37%. North Carolina’s relatively high rate of utilization of ICFs/MR set the state apart from most others.

The next chart displays total state-federal Medicaid spending for ICF/MR services in North Carolina for the period 1990-1998. In 1998, spending for ICF/MR services totaled \$380.2 million. This was approximately 75% greater than in 1990 (not adjusted for inflation) and 40% higher after adjusting for inflation. The rate of growth in ICF/MR spending in North Carolina was about *two-and-one-half times as* great as the nation as a whole during this period. In large part, this difference stemmed from the fact that the number of people receiving ICF/MR services in North Carolina increased during this period while elsewhere there was an overall decline in ICF/MR utilization. From 1995 onward, there has been little overall real-dollar change in total ICF/MR spending in North Carolina because ICF/MR utilization held relatively steady.



In 1998, the annual cost of serving an individual in an ICF/MR in North Carolina was \$80,185 (\$221/day) or about 2.3% greater than the nationwide average of \$78,411/year (\$215/day). When the large state-operated Centers are factored out, payments to non-state operated ICFs/MR in North Carolina averaged roughly \$181/day per resident or about \$66,200/year.

3. Developmental Disabilities Structure

HCB Waiver Services (RTC/NASDDDS)

The second major avenue available to states to secure federal Medicaid funding for specialized developmental services is the home and community-based (HCB) waiver program. Individuals who are eligible for ICF/MR services may instead be offered HCB waiver alternative services. These services may be provided to individuals who are served in licensed residences, live in their own or with their families. North Carolina first gained federal approval in 1983 to operate an HCB waiver program (the CAP/MR-DD program) for people with developmental disabilities. The CAP/MR-DD program offers a wide array of services⁶

Table F shows the number of individuals with developmental disabilities who participated in the CAP/MR-DD program each year between 1990 and 1998 as well as the nationwide total number of participants. In each case, the table also shows the number of participants indexed relative to population.

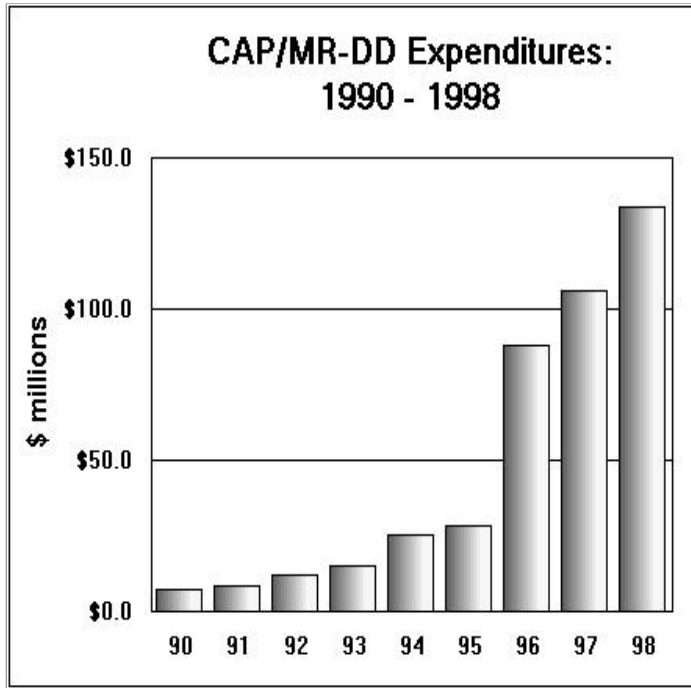
Table F:
HCB Waiver Participants
North Carolina and United States (1990 – 1998)

Year	North Carolina	Per 100,000 Population	United States	Per 100,000 Population
1990	731	11.0	45,220	18.1
1991	837	12.6	52,745	21.1
1992	996	14.7	73,534	29.0
1993	1,117	16.5	101,725	40.1
1994	1,318	18.8	136,665	52.8
1995	1,902	26.7	168,287	64.4
1996	3,201	44.2	194,317	73.6
1997	3,726	50.6	222,120	83.8
1998	3,986	52.8	239,077	88.5
% Change 1990 - 1998	+442.9%	+380.0%	+426.7%	+389.0%

As can be seen from the table, between 1990 and 1998 there was more than a five-fold increase in the number of individuals with developmental disabilities receiving HCB waiver services in both North Carolina and nationwide. The rate of growth in the number of persons served through the CAP/MR-DD program has been slightly greater than the rate of growth in HCB waiver programs nationwide. Post 1994, there was a substantial expansion of the CAP/MR-DD program.

Relative to population, however, North Carolina provided HCB waiver services to 40% fewer individuals than was the case nationwide in 1998. If North Carolina had furnished HCB waiver services at the same rate as other states, the CAP/MR-DD program would have served 6,680 individuals in 1998. In 1998, *HCB waiver services were markedly less available in North Carolina than elsewhere in the nation.*

3. Developmental Disabilities Structure



The chart to the left shows North Carolina's expenditures for HCB waiver services for the period 1990 – 1998. The increase in the number of individuals participating in the program post-1994 translated into a major increase in expenditures for CAP/MR-DD services beginning in 1996. In 1998, CAP/MR-DD HCB waiver outlays totaled \$134.2 million. In 1998, the average annual expenditure per CAP/MR-DD participant was \$34,794 (\$95.33/day) or 13.1% above the nationwide average of \$30,756 (\$84.26/day). Adjusting for differences between the two programs⁷, the annualized per person cost of HCB waiver services in North Carolina during 1997 was approximately 46% of the comparable costs of serving an individual in an ICF/MR of any type. Nationwide, this ratio was about the same.

ICF/MR and HCB Waiver Services in Combination

The same eligibility criteria apply in determining the eligibility of an individual for either ICF/MR or HCB waiver services. In other words, both programs are intended to serve the same population. Therefore, in examining how Medicaid dollars are used in support of individuals with developmental disabilities, it is useful to examine both programs in combination.

Table G pulls together information concerning HCB waiver and ICF/MR services in North Carolina and nationwide in 1990 and 1998:

Table G:

ICF/MR & HCB Waiver Services

	North Carolina	% of Total	United States	% of Total
Recipients - 1990	4,668		189,506	
ICF/MR	3,799	81.0%	144,286	76.1%
HCB Waiver	731	19.0%	45,220	23.9%
Recipients - 1998	8,691		363,335	
ICF/MR	4,705	54.1%	124,258	34.2%
HCB Waiver	3,986	44.9%	239,077	65.8%
Spending - 1990	\$225.0 million		\$8.5 billion	
ICF/MR	\$217.7 million	96.8%	\$7.6 billion	89.4%
HCB Waiver	\$7.3 million	3.2%	\$0.9 billion	10.6%
Spending - 1998	\$514.4 million		\$16.9 billion	
ICF/MR	\$380.2 million	77.4%	\$9.8 billion	58.0%
HCB Waiver	\$134.2 million	22.6%	\$7.1 billion	42.0%

3. Developmental Disabilities Structure

Between 1990 and 1998, North Carolina's spending for Medicaid services for people with developmental disabilities more than doubled and increased at a rate greater than the nation as a whole. The number of individuals who received either ICF/MR or CAP/MR-DD services grew by 86% during this period. Nationwide, the increase was greater – 92%. In 1998, nationwide, nearly 66% of individuals who received Medicaid funded services were served through the HCB waiver program. In North Carolina, the proportion was significantly lower – about 45%.

As was the case nationwide, North Carolina directed a significantly greater percentage of its Medicaid dollars to purchase home and community-based waiver services in 1998 than it did in 1990. However, the proportion of dollars earmarked for HCB waiver services was substantially lower in North Carolina than was the case nationwide. Both in North Carolina and nationwide, the percentage of Medicaid dollars spent on ICF/MR services was disproportionate to the proportion that ICF/MR residents represent of the total of all individuals who received Medicaid funded services (e.g., nationwide, 34% of Medicaid recipients were served in ICFs/MR in 1998, but spending for these services accounted for nearly 58% of the total).

Table H furnishes additional 1998 comparisons between North Carolina and the nation as a whole with regard to Medicaid-funded services for people with developmental disabilities.

**Table H:
Additional Indicators of
Medicaid Utilization and Spending (1998)**

	North Carolina	United States
Total ICF/MR & HCB Waiver Recipients	8,691	363,355
Recipients Per 100,000 Population	115.2	134.33
Total Outlays	\$514.4 million	\$16.9 billion
Outlays Per Citizen	\$68.16	\$62.60
Average Annual Expenditure Per Recipient	\$59,826	\$47,539

Relative to population, North Carolina provided Medicaid-funded services to approximately 14% fewer individuals than was the case nationwide. When Medicaid spending is expressed on a per citizen basis (i.e., by dividing total spending by total population), North Carolina's Medicaid spending for developmental disabilities services was approximately 9% higher than nationwide level. There also was a relatively large difference in the annual expenditures per Medicaid recipient in North Carolina compared to the remainder of the nation. North Carolina's average cost per recipient was about 26% greater than the nationwide average. This difference stemmed in large part from North Carolina's relatively heavier use of more costly ICF/MR services to meet the needs of individuals.

State Key Informant Interviews

In general, responses from the various key constituencies suggested a system at odds with itself, buffeted by a variety of challenges and changes, and lacking in consensus regarding both a vision for the future as well as a means to get there. In spite of these differences and stresses, there appeared to be general agreement that changes are necessary at the State level to sharpen the focus on developmental disabilities, to support continued growth of community supports, and to ensure a responsive system at the local level.

3. *Developmental Disabilities Structure*

Observations made by advocates, providers, and other stakeholders

- Area programs are in a period of significant transition and their role as a manager versus a provider is in question. They are changing from direct service providers to service brokerage, monitoring and purchase of services. There is resistance among some providers to a stronger role for Programs especially as it relates to “single point of entry” and the implied control over admissions to particular classes of programs. Further, there is tension between attempts on the part of the State to tighten controls, and the interests of counties to become more autonomous.
- DD stakeholders are split regarding the optimal service configuration of the system. Views range from those who support a strong public institutional system as a viable option, to those who would strengthen facility based services through the expansion of ICF/MRs in the community, to those who would “deconstruct” the system and base it on individual supports. North Carolina, as noted in the previous section, has one of the highest ratios of institutional to community outlays in the country and continues to allow institutional admissions (65 last year). As a result of this disproportionate distribution of resources, it is difficult to support innovative agencies and to encourage emerging best practice at the community level.
- There was concern expressed among some advocates regarding the influence of major providers (some of which are multi-state) in the legislature compared to the power of the voice of consumers and families. Further, while the North Carolina Arc is an advocacy organization, it is also one of the state’s major providers of services to people with developmental disabilities.
- Though recent legislative appropriations have made some inroads into reduction of the waiting list in North Carolina, there is a consensus regarding the immediacy of the need of those still on the waiting list for services and supports. Some area programs had problems gearing up to spend the funds and had to turn back dollars. However, there are varying opinions about how these needs should be met (facility-based versus individual supports).
- Without a concerted effort to alleviate the problems of those on the waiting list as well as those who are inadequately supported, some advocates are concerned that the rest home industry (domiciliary care) will move to fill the void, and many individuals with DD will be left with little more than custodial care.
- Some stakeholders maintain that the state has not taken sufficient advantage of the Title XIX Home and Community-Based Waiver. (Given the national comparisons discussed above, this perception appears to be true). North Carolina’s program, while it has grown recently, has been slow to develop. As a result, North Carolina spends a substantial amount of pure state funding on services such as community group homes – money that could be used to leverage additional federal dollars.
- Concern was expressed among advocates and others that the current quality assurance system is fragmented and uneven given the reliance on Area Programs to carry out much of the oversight. As one advocate put it, “you could run a bad group home badly, and no one would check up.”
- There is also a suspicion among some constituencies that the problems experienced by the local mental health system have drained energy and resources from DD programs at the area level.
- The movement of the early intervention (0 to 2) out of the Division was seen by advocates as a further fragmentation of services to families and children with developmental disabilities.
- Area Programs vary dramatically in their ability to provide timely payments .

3. Developmental Disabilities Structure

- There is anxiety regarding current funding levels and concern that some providers may discontinue services.
- There is concern regarding the “disproportionate” allocation of funds between institutional (public and private) and individual community supports .
- Integrated MH/DD/SA funding streams make it difficult to track the ultimate destination of funds allocated for people with developmental disabilities and their families .

Observations raised by DHHS and DMHDDSAS staff

It should be noted that the interviews with State level staff occurred prior to the most recent reorganization. On September 13, the Director of MHDSSAS announced a reorganization of the division. The major changes for developmental disabilities services were: movement of a portion of the Thomas S. program into the DD Section’s MR/MI unit, but dispersing resources; transfer of the early intervention program out of the DD Section to new Early Intervention and Education Division; movement of staff from crisis services and CAP/MR to the DD Section, but dilution of DD Section policy-making authority over waiver implementation; rate setting for ICF/MR remains in DMA.

- There is little agreement within the Department regarding a vision of the future configuration of the DD system. This includes disagreements regarding the place of institutional and other large long-term care facilities in the long-term future of the DD system.
- Among senior level staff, there is disagreement regarding the importance and/or advisability of a “non-categorical” approach to the provision of services and supports to people with substance abuse, mental health and developmental disabilities . Some maintain that a more holistic, non-categorical approach is more efficient and responsive. These individuals support unified outcome and performance measures, and the integration of various operational responsibilities (such as management of the HCB waiver). Others maintain that such an approach ignores the obvious differences among the populations, dilutes expectations for DD services, and diminishes the programmatic integrity. Further, there is concern that a non-categorical approach leaves the center of gravity with the mental health/substance abuse program and that those involved in DD would not be fully included in policy discussions and decisions.
- There is a concern that funding streams dictate policy and program direction (e.g., ICF/MR, waiver, etc.). Given the centrality of federal funding in particular for individuals with developmental disabilities, the management of the Title XIX as well as the ICF/MR program is particularly important. Based on State-level interviews, it would appear that such management issues have significantly affected organizational decisions. In order to ensure the cooperation and support of DMA, steps were taken two years ago to move the waiver out of the DD section to a separate section. Some maintain that the move has significantly improved the management of the waiver. Conversely, others feel that it has diminished the ability of the DD section to influence the system of services. In any event, it appears that at least a part of the rationale had to do with personalities and other intra-agency concerns.

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- The integration of Thomas S into the other services systems is a major issue, including decisions regarding the level of on-going funding that will be available to class members now that they are no longer a legally protected class. There is a fear on the one hand that if Thomas S. services are reintegrated into the Division's budget, they will be siphoned off to other priorities leaving the multiply challenged class members with inadequate support. On the other hand, there is a sense that the Thomas S. decree has created a "two class system" in which non-class members receive less than their fair share of public support. Virtually everyone interviewed recognized the need for some organizational change once the court relinquished jurisdiction. The challenge seems to be how to take advantage of the expertise developed in Thomas S. in the enhancement of best practice in mental health, as well as developmental disabilities.
- The very reasons that brought about the Thomas S. litigation in the first place (a group of class members whose needs spanned categorical programs) now make it difficult to determine how to reintegrate the program into the Division. The class members have both mental health and developmental disabilities – a combination that poses challenges to categorical systems.
- Three separate entities within the Department have contact with DD providers in the field, resulting in confusion among consumers, families and providers at the local level. The entities are Thomas S, CAP-MR (Title XIX waiver) and the DD section. These overlapping jurisdictions create confusion regarding rate structures, quality assurance standards, priority populations, and programmatic expectations.
- There is an inconsistent policy regarding Area Programs' ability to provide direct services – they cannot for CAP-MR slots, but can for other services. Senior staff have different opinions about the appropriate role of Area Programs. As a general matter, there was a consensus at the State level that the separation of case management from direct support provision at the Area Programs is a worthy goal.
- There is an expectation among some of those interviewed that the implementation of the NC/SNAP (a new assessment tool) will assist the State to control the flow of individuals into facility-based services, and to develop supports tailored to levels of functioning. It is hoped that NC/SNAP in conjunction with an evolving "single point of entry" will create a more rational system and one more responsive to State and local public priorities.
- Even with improvements over the last two years, the enrollment of individuals in the CAP-MR waiver is still not as timely as many would hope.
- It appears that the current quality assurance system for services to people with developmental disabilities is spread among a variety of entities in the State. CAP/MR has some responsibility to ensure that providers are qualified, the DD section carries out accreditation of Area Programs, Area Programs monitor local services, a portion of the licensing is handled at the county social services level, Thomas S. staff monitor class member plans, and DMA is responsible for the quality of ICFs/MR. Current QA initiatives in the Division are focused on Council on Accreditation indicators that were primarily developed for individuals in the behavioral health arena.

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- All of those interviewed noted that there were multiple efforts in progress directed at the potential reorganization of MH/DD/SA services including the work being done by the Moss Group (study of purchase of service issues), Robin Cooper, NASDDDS, (review of Medicaid waiver and state plan services for DD services), Peat Marwick (analysis of reorganization of targeted disabilities services), and Public Consulting Group (study of structural, financing, facility and other issues affecting behavioral health care system), etc. It is not clear to what extent these efforts are or should be coordinated.

Summary

As noted above, these comments reflect a system in flux and one in which lines have been drawn and contentious relationships exist among many individuals and groups who administer and as well as rely on DD services and supports. This lack of cohesion is both the cause and the result of a lack of vision and direction in the system. Michael Smull (2000), in a recent report to the State of Oregon regarding the implementation of person-centered planning, made an observation that applies to the system in North Carolina:

Crisis and blame cultures are pervasive in the disability system and are a major barrier to change. In a crisis culture there is no reflection, learning is curtailed by the perceived need to have a quick fix and move on. In a blame culture the goal is to avoid responsibility. There is no creativity as creativity involves risk. Even if managers learn better problem solving skills they will not apply those skills in a blame culture. In order to have change managers have to also be leaders. A crisis culture's focus on the quick fix doesn't support developing leaders and a blame culture punishes anyone too far "out in front".

Area Program/Regional Center Key Informant Interview

A clear understanding of the operating issues and service needs at the local level is key in analyzing structural changes at the State level. State level structure must be designed to support the local service networks. To gain this important perspective, HSRI and PCG staff conducted six site visits to Area Programs: Catawba, Mecklenburg, Tideland, Smoky Mountain, V-G-F-W, and Wake. At each site, staff conducted interviews, where possible, with Area Program directors, developmental disabilities staff, providers, board members, people with disabilities, and family members. Sites were selected to ensure geographic, size, and population diversity. An inquiry guide was prepared to govern the interviews.

Responses to questions in a structured interview guide suggested summary conclusions:

- Quality assurance systems and contract oversight mechanisms are geared to input and process measures, and have little relevance to the outcomes of interventions for people with developmental disabilities;
- The Developmental Disabilities Section has very little direct contact with Area Program administrators or local providers insofar as the provision of training, direction, or technical assistance;
- As a general matter, the array of supports offered to people with developmental disabilities and their families is limited and the ability of the system to meet individually tailored needs and preferences is constrained;
- Staff turnover both in the direct support as well as case management area is having a negative impact on service quality;

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- Administration of the CAP-MR waiver is improving but is still not providing a catalyst for the development of more flexible supports;
- There does not appear to be a consensus throughout stakeholder groups regarding the future delivery of supports to people with developmental disabilities;
- Regional centers increasingly see themselves as providers of specialized services and training to local programs and providers;
- There is anxiety among Area Program directors about the administrative burden at the local level regarding the development of a separate developmental disabilities division,
- The overall administrative structure and oversight of the Area Programs more closely resembles a behavioral health program with a developmental disabilities component added on.

Quality Assurance and Enhancement of Best Practice

There are multiple quality assurance expectations at the Area Program level but no overriding vision of quality across the system. For example, Thomas S. services have been monitored under The Council on Leadership and Quality, and the Area Programs under Council On Accreditation. Further the Division of Medical Assistance requires Area Programs to accredit private vendors. This process includes privileging and credentialing of provider agency staff, client outcome inventory, and customer satisfaction. According to many advocates interviewed, the customer satisfaction tool, required for accrediting the Area Program, has little relevance for many participants with developmental disabilities.

“Privileging” and credentialing of staff yields minimum value-added to the quality of services and may consume scarce human and fiscal resources in aid of a largely paper compliance activity. This process illuminates the system’s orientation to the medical model through the State Medicaid plan that governs human services in the State. Further, administrators do not routinely use information from QA system to extract and interpret important information about system quality (e.g. flags, deaths, critical incidents, etc).

There is little communication from DMHDDSAS to the field about the vision or components of quality service systems. Area Programs are left to define quality in the developmental disabilities system as best they can. The overall administrative structure and oversight of the Area Programs more closely resembles a behavioral health program with a developmental disabilities component added on. This phenomenon plus the heavy clinical monitoring mandated by the state means that “hours of services delivered” predominates administrative approaches to quality monitoring and enhancement. Few Area Programs appeared to be positioned to ask questions about core issues in the field such as value, quality, choice and control.

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The Area Programs vary in their ability and capacity to monitor services. This is a function of their relative autonomy in setting their own rules and related processes, the resources available to the Area Programs, the views of the leadership about what is important to monitor and the competency of the case managers employed by the Area Program. This issue is further compounded by high case manager turnover in some areas. High turnover, according to administrators interviewed, is attributable to the demands placed on case managers as well as their salary levels.

The development of the NC-SNAP suggests a movement toward individualized supports. It appears valid and has undergone rigorous psychometric testing. Generally well received by stakeholders, it holds promise given its ability to match individual levels of need with supports provided true choices and options can be developed.

Finally, the HCB Waiver is structured in a way that constrains choice and control. With limited slots and overly medical/clinical definitions of support, the waiver depersonalizes service designs and does not allow for system flexibility to meet new or individual needs.

Managing Vendors

With some exceptions, Area Programs do not employ a competitive bidding process. While they speak about consumer and family choice, limited efforts to foster competition have left consumers and families with forced choices from conventional menus of services. Five of six programs visited continue to rely on a “service continuum” rather than on individual supports, an approach more in keeping with national best practice. There was little discussion during the interviews regarding the benefits of customizing or individualizing services based on individual or family needs. A major obstacle to building such a capacity is the lack of information about the true cost of services – a necessary first step in creating a flexible menu of supports.

Oversight in the current system is heavily weighted to cost/billing monitoring. While larger providers can develop accounting systems necessary to respond to Area Program data requirements, smaller providers are at a distinct disadvantage. The situation is further exacerbated by the fact that no additional reimbursement has been made available for software or staff despite increased demands for cost information. Because of the complex Medicaid rules and regulations, cost monitoring is complex.

According to interviewees, the State does not provide resources for Area Programs to monitor services though they are expected to perform this function. While some area programs indicated that they do specify certain outcome-oriented standards in their provider contracts, this was not a consistent requirement across Area Programs. One program shared its information about preferred outcomes, few of which could be characterized as focused on individuals with developmental disabilities.

In general, the system does not appear to be oriented toward outcomes; the exception is services and programs previously under the Thomas S. Services Section. Prior to its integration into the Developmental Disabilities Section, the Thomas S. administrators required all providers to use Council for Leadership accreditation standards. Adherence to this outcome-oriented perspective along with availability of resources in Thomas S. fostered, according to some of those interviewed, a higher level of service quality.

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Rate setting rules provide little capacity for individualizing contracts and creating person centered budgets and services. Further, there is no institutionalized method for measuring actual costs and to set rates accordingly. Little attention is paid to the impact of such approaches on individuals and their families. For example, in one Area Program the implementation of cost controls allowed the Program to terminate services with four private providers, giving 30 days notice. These terminations included two residential support providers, and represent an extreme disruption to the customers. There was little evidence that the Area Program had examined or analyzed these important and secondary effects of contract termination.

In sum, with the primary focus on fiscal monitoring, private providers are free to set their own rules about models of care and support, populations they serve, and the extent to which customers are collaborators or subjects of service intervention.

Extent of Consumer/Family Focus

While Area Programs assess customer satisfaction through surveys, the results are not frequently analyzed or integrated into strategic or other planning efforts. Primarily, respondents felt that the information gathered in these surveys was not especially relevant or useful.

Case manager turnover presents a barrier for many individuals. Structured as the link between the individual or family and the Area Program and private services, frequent disruption of this relationship can have serious effects. Additionally, caseload sizes vary by funding stream (rather than individual need), thus making for inconsistent quality and frequency of this support.

The presence of families and consumers as leaders varies according to the leadership of the local system. Despite a well-organized and recognized self-advocacy movement in the State, there is little to no connection (formal or informal) between self-advocacy and the Area Program governance or administration.

Families identify transportation, social and leisure opportunities and meaningful career and day activities as priority concerns. Area Programs' ability and willingness to respond to these concerns varies for a variety of reasons, including no clear connection between advocacy and service systems, absence of clear policy directions, and extreme limitations on the flexibility and use of service dollars for innovative purposes.

Likewise, individuals, administrators, private providers and families are involved in a variety of self-determination initiatives throughout the State. Yet this movement has had no discernable effect on the operations or vision of the Area Programs responsible for local service and support delivery for people with developmental disabilities.

Throughout the site visits, the team encountered a multitude of administrators and managers. Surprisingly, few of those representing the Area Programs were people of color, though the State is racially diverse. That Area Programs and other administrative systems do not reflect the local population begs the questions of cultural competence within the service structure, and whether these systems are examining issues of access for under-represented populations.

State Technical Assistance and Support to Area Programs

Area Program administrators noted that there was little support insofar as training and technical assistance from DMHDDSAS. There was evidence, however, that the State centers for developmental disabilities provide some basic training for direct support staff in the regions surrounding the center. The State centers also provide technical assistance to providers and sometimes Area Programs for specialty services and supports, such as site adaptations, occupational and physical therapy consultations, behavior management techniques, etc. A review of one urban region's training calendar showed a schedule of over 60 disability related training events, of these 24 were related to developmental disabilities. Topics were primarily focused on required trainings such as medication administration and the Essential Lifestyle Planning process required of Thomas S. case managers.

Thus, while some areas would welcome efforts at capacity building, little is available from the State to assist in developing innovative practice. Thomas S. services were the only place where project staff observed consistent evidence of training and utilization of progressive interventions such as "person-centered planning" and constructs of self-determination, but there were few systematic efforts to replicate these practices in other parts of the system. On a pragmatic level, without the resources associated with Thomas S., it would be difficult to bring such practices to scale in an environment where case managers not assigned to CAP or Thomas S., may be covering as many as 40 to 80 people.

There are pockets of excellence in other locations primarily funded by the Developmental Disabilities Council or by more progressive private providers, but Division leaders have not placed a high priority on disseminating these practices throughout the State or fostering new ideas and models through training or other capacity building activities (e.g., technical assistance, challenge grants).

Aside from the lack of information on innovative support models, there are high levels of turnover among case managers and direct support staff in many areas of the State. Among direct support, the rate of turnover averages 79.4%. Given this instability, it is increasingly important to provide sufficient training to prepare incoming staff and to build the capacity to retain incumbent workers. Recent research in North Carolina indicates that two thirds of new direct support staff working in developmental disabilities received less than one week of training before starting their jobs, with 25% of new direct service employees receiving less than eight hours of training (Test, 1999).

Finally, there is little coordination of training on a statewide basis or even within regions. This results in a topic-based approach to training which fails to build expertise or knowledge among direct support workers in a planned manner. While there are some certificates and licenses available to direct support professionals, through agencies and workshops (CPR, First Aid, Supported Employment, Blood Borne Pathogens, Certified Nursing Assistant (C.N.A.)), there are no certificates or higher education programs specific to the broad functions of the direct support staff. This presents a barrier to retaining direct support staff (in a direct support role) that are career oriented. An employee at a State center indicated that the career track chosen most often by direct support staff was the nursing track, starting off as a C.N.A. Given the labor shortages predicted for the next decade and longer and the current difficulties within the direct support role, the ability to serve more people will be foreclosed and quality will certainly suffer if changes are not made.

Medicaid Waiver and System Flexibility

Most respondents felt that Medicaid funding streams were not flexible enough to meet individual or programmatic needs. The highly clinical waiver and day habilitation models created more documentation and accounting systems than they did outcomes for individuals using services. Although the Single Portal is intended to streamline access to appropriate supports, many reported that families can bypass this system if they opt for their family member to be placed in an ICF/MR. There is little to no real integration of the private ICF/MR system and the Area Program system. Contracting directly with Medicaid and monitored outside the Area Programs, private ICFs/MR and their residents were not on the radar screen for strategic local planning or waiver maximization. Further, there appears to be no incentive for local Area Programs to address the bifurcation of the service system (there is no central vision of what the service system should look like and therefore, no communication of strategy or priority). By and large, Area Programs presented their mission as purchaser of cost effective services for individuals.

Many respondents, including a consultant to the Division,⁸ felt that aggregate funding through the HCBS Waiver would help to reduce waiting lists and would make the service system more flexible for current and future consumers. However, we saw little movement toward flexible supports and individualized budgeting of any sort.

Some policy makers interviewed in Raleigh suggested that the Regional Office of HCFA is uncomfortable with support model waivers. In order to get the waiver application accepted, it was necessary to adopt a carefully cost controlled medical model of service delivery. However, this assertion begs the question of whether a demonstration of the ability to provide and monitor supports rather than medical services, would make HCFA feel more comfortable with a restructured waiver.

State Structural Issues

DD Services have a distinct function within the Area Programs. Area Programs have developed positions to administer the differing mental health and developmental disability population demands (e.g. there is a DD Director and other staff.) However, we found that typically DD services were viewed as one of the varied, behavioral health services an Area Program might administer. While advocates, some state center personnel and some central administration staff view the development of a distinct DD division as a means to creating equitable attention and resources within the Department of Health and Human Services, stakeholders at the Area Programs are not as supportive. In addition to concerns about increased overhead costs, they felt that the distinction was not necessary. They point to integration of services for unique populations as a rationale for retaining the current structure. For example, they report that individuals with mental retardation and mental illness can access services at the Area Program for their mental health needs and case managers can find needed resources quickly with both programs housed together. While this assertion is true, it also supports the perception that developmental disabilities services are treated as a subset of mental health services provided by Area Programs.

Review of Previous Studies and Committee Reports

There were many collaborative efforts working parallel to the PCG/HSRI evaluation during the course of the analysis. These activities were variously stimulated by the spate of external reviews of the MH/DD/SA system, the prospect of significant change emanating from the PCG study, and general concerns regarding service delivery issues in DD. These activities primarily revolved around the work of the DD Policy Work Group (including input from the DD Consortium). Subcommittees reviewed quality assurance, service arrays, system organization and improvement, and increased accountability. There were several themes in the documents available to the evaluators that bear on the State organizational structure:

- The importance of ensuring the availability of a core of services and supports in each Area Program in the State for people on the waiting list as well as those who remain in substandard circumstances (e.g., large rest homes);
- The desirability of exploring a regional state structure to deliver training and technical assistance, to enhance capacity, to provide advocacy for individuals and families, and to support quality assurance activities;
- The necessity of developing uniform eligibility requirements;
- The importance of expanding data collection and improving the accuracy of information about service quality;
- The desirability of separating service brokerage from service delivery;
- The immediate need to ensure adequate resources in the system to ensure provider stability;
- The benefits of including consumer satisfaction/outcome assessments to evaluate service quality;
- The crucial nature of improving the “business” aspects of managing the system at the Area Program level including timely payments and more accurate costing protocols.
- The importance of developing a distinct policy line of authority between the state DD leadership and the implementation of local programs.

Staff also reviewed the proposed Utilization Management Contract Proposal and written responses to the proposed RFP. With respect to DD services, these responses raised the following issues:

- The proposal does not take into account the potential impact of changes in the authorization of Medicaid “Y” code services on services to people with developmental disabilities who rely on some of these services for long-term supports;
- It does not address the “interface” of the Y Code services and the CAP waiver;
- It fails to address the potential loss of case management services to people with DD that may flow from a revised medical necessity definition; and
- The interjection of a private entity to make decisions about the authorization of services removes the important input of DD stakeholders throughout the system.

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Disagreements regarding the Utilization Management proposals underscore the unintended consequences of restructuring and system change activities that do not take into account the interests of long-term populations – specifically people with developmental disabilities currently served in the North Carolina system.

Results of the Expert the DD Expert Panel

On January 19, 2000, the State Auditor’s Office sponsored – in conjunction with the North Carolina Institute of Medicine, University of North Carolina, Chapel Hill – an Expert Panel comprised of state directors of developmental disabilities services. The purpose of the all day meeting was to highlight: service system goals and new trends; quality assurance and mechanisms for improving service quality; and organizational structure and relationship with Medicaid. Presenters included Valerie Bradley, HSRI, who presented information on the mental retardation system in Pennsylvania; James Toews, Oregon Office of Developmental Disabilities; Stan Butkus, South Carolina Department of Disabilities and Special Needs; and John Solomon, Missouri Division of Mental Retardation and Developmental Disabilities.

Each presenter represented a somewhat different organizational configuration. A summary and findings are presented in Attachment B at the end of this Report.

Input from Four Regional Informational Meetings

In order to gather feedback regarding preliminary recommendations from this portion of the larger PCG study, project staff in conjunction with staff from the North Carolina State Auditors Office conducted four regional meetings. Two meetings were held in Statesville and two meetings were held in Smithfield. Approximately 150 individuals participated.

Some of the concerns voiced by the participants included:

- Problems in the system of services to people with developmental disabilities required more than just an analysis of the State level structure;
- The larger scope of the PCG study should include an analysis of the impact of local system reconfiguration on services and supports to people with developmental disabilities;
- A new Division of Developmental Disabilities might create a greater administrative burden on Area Programs;
- There has been very little communication between Developmental Disabilities officials at the State level and local Developmental Disabilities administrators;
- Persons with disabilities and their families are the experts regarding their own life choices.
- The system should be inclusive, consumer driven and responsive to individuals and families
- It is important to the future of DD services at the community level that DD funding be categorical if such funding is to continue to pass through local MH centers.
- The State must maximize the flexibility of the waiver to serve individuals with developmental disabilities;
- Management, fiscal, and oversight of the DEC’s, ECI and ICFs should be consolidated into the Division for Developmental Disabilities;

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- Eligibility for all high resource services, including ICF-MR must be under the jurisdiction of the Division and managed by the local agency;
- Fiscal control must be returned to the Division;
- If there is a separate Division, there must be coordination between the new Division and DMH to prevent the recreation of documentation;
- If there is a reorganized Division, there must be respect for the needs and differences of individuals with developmental disabilities in need of long-term care.

The Cost of Creating An Independent Developmental Disability Division

Introduction

PCG has investigated the annualized costs of establishing an independent Developmental Disabilities Division in North Carolina. PCG's goal is not to provide an *exact* marginal cost of creating a separate Division, but rather to provide a reasonable estimate for discussion purposes. The analysis that follows assumes that service costs will not be impacted by the creation of an independent DD Division and, therefore, we focus only on those administrative costs that can be reasonably expected to increase. This analysis does not include first year start-up costs for a new division.

Methodology

In conducting the analysis, PCG worked directly with representatives of the DMHDDSAS Financial Services and Developmental Disability offices to obtain data and to develop the best methodology within the study's timeframe and expense parameters. We encountered a number of difficulties with this approach.

The single biggest roadblock to estimating the marginal cost is the lack of current and accurate data. Current salary and overhead expenses are not available. PCG used Fiscal Year 1999 data, which is not totally reflective of Fiscal Year 2000 costs. For example, there are a number of FTE positions which are listed as "vacant" in the dataset but which we know are currently filled. Another example is the inclusion of one-time costs that occurred in FY1999 but which are not recurring in FY2000 and therefore overstate the administration costs. Such one-time costs include the purchase and implementation of the HEARTS computer system (\$220,000) and a transfer of \$18,000 to the Division of Youth Services.

A second limitation in our analysis is the logistical concern of balancing the level of detail necessary to estimate the marginal cost for discussion purposes, versus the time and resources necessary for determining an exact dollar amount. While the data available to PCG to perform this analysis allows for a "general estimate" of the cost of creating a separate Developmental Disability Division, it is not specific enough to estimate the cost based on a position-by-position analysis. Such a precise analysis can and should be performed if it is determined that the estimated marginal cost justifies further review. PCG's estimate is based primarily on two data sources: the General Ledger Authorized Monthly Budget Report for the Fiscal Year Ending June 1999; and the Position Listing by Company/Account/Center by Department/Division Report for the same time period. The first report provides detailed cost information by fund code (e.g., General Administration State, Willie M. Program Services, etc.), while the second report provides salary and position listing for all State positions within the MH/DD/SA delivery system (e.g., Directors Office, Information Services, State Hospitals, etc.).

Essentially, PCG's marginal cost estimate is based on an allocation of the State administration overhead costs for the MH/DD/SA delivery system. PCG's experience in performing operational diagnostics shows that when two integrated Divisions are separated, administrative costs are not equally divided between the two Divisions; nor do total costs remain the same. In other words, the costs to administer a

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state-wide program with total administrative costs of \$40M (DMHDDSAS in FY1999) to increase when the program is separated into multiple smaller programs. The reasons are twofold. First, smaller Divisions are not able to achieve the same economies of scale as larger Divisions. Economies of scale occur when the unit cost of providing a service decreases as the number of units increases. With respect to creating an independent Developmental Disability Division, the cost of providing such services as network support, benefit administration and finance is not proportional to the number of services provided, e.g., the cost to support a 50 computer network is not twice the cost of supporting a 25 computer network. The second reason total administrative costs may increase is that some administrative costs must be borne regardless of the size of the Division. For example, if a separate Developmental Disability Division is created certain administrative positions will have to be duplicated between the MH/SA and newly created DD Divisions. Both Divisions will require such positions as Business Officers, Personnel Officers, Information System Administrators, etc. Some efficiencies may be realized by creating two smaller divisions but typically these efficiencies materialize in the form of successful program outcomes rather than in reduced Divisional costs. In other words, a separate DD Division may be able to provide better client outcomes because the administrative bureaucracy is focused solely on DD. However, the reduced bureaucracy comes at the price of slightly increased cost per person served.

Baseline Administrative Costs

The starting point in determining the marginal cost of creating an independent Developmental Disability Division is to estimate the current administrative overhead costs paid by the State. Based on the Monthly Budget Report, State administrative costs (excluding Federally funded overhead) for DMHDDSAS total \$6,866,000 and are comprised of the following:

Personnel	\$2,695,000
Purchased Services	2,038,000
Supplies	100,000
Property, Plant & Equipment	166,000
Other Expenses & Adjustments	46,000
Intragovernmental Transfers	1,821,000
<u>Total</u>	<u>\$6,866,000</u>

Included in these State administrative costs are direct and indirect expenses for the Director's Office, Medical Services, Personnel, Budget, Information Systems, Client Information, Crisis Management, and Management Services. Excluded from these costs are all non-State funded costs (e.g., Federal

Administration) and all operational costs (e.g., Mental Health Program Services, Developmentally Disability Program Services, etc.).

The state administration overhead costs of \$6,866,000 include non-applicable and non-recurring costs that artificially inflate the marginal cost estimate. Non-applicable costs are those costs that would not be affected by the creation of an independent DD Division (e.g., Crisis Services) and non-recurring costs are one-time costs that will not occur in the near future. Non-applicable and non-recurring costs are comprised of the following:

Transfer to J. Umstead Hospital	\$395,000
Transfer to Division of Youth Services	18,000
Transfer to Subsequent Fiscal Years	637,000
Transfer to State Auditor	750,000
Crisis Services	277,000
HEARTS	221,000
<u>Total</u>	<u>\$2,298,000</u>

Non-applicable and non-recurring costs are subtracted from State administration overhead costs to arrive at the net marginal cost for allocation purposes:

State Administrative Cost	\$6,866,000
Non-Applicable/Non-Recurring Cost	2,298,000
<u>Net Allocated Administrative Cost</u>	<u>\$4,568,000</u>

Using the Monthly Budget Report, the net allocated administrative cost (\$4,568,000) was divided between salary and non-salary costs. Salary costs include expenses such as social security contributions, health benefits, disability benefits, etc., and total \$2,695,000. Non-salary costs include such expenses as legal services, equipment, office supplies, telephone services, etc., and total \$1,873,000.

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Using our previous experience in operational diagnostics at the local and state level, and our knowledge of the North Carolina MH/DD/SAS delivery system, we estimate that salary and non-salary administration costs will increase between \$1,505,000 - \$2,283,000 or 33% - 50% if a separate Developmental Disability Division is created.

Cost	33% Increase	50% Increase
Salary: DD	\$1,433,000	\$1,617,000
Salary: MH/SA	2,150,000	2,425,000
Non-Salary: DD	996,000	1,124,000
Non-Salary: MH/SA	1,494,000	1,685,000
Total	6,073,000	6,851,000
Current Cost	4,568,000	4,568,000
<i>Net Cost Increase</i>	<i>\$1,505,000</i>	<i>\$2,283,000</i>

Per the Position Listing Report there are 53 State administration positions that cost an average of \$51,000 (\$2,695,000 in salary costs divided by 53 positions). Therefore, we estimate the number of positions will increase between 17-26 positions with the creation of an independent Developmental Disability Division.

As previously stated, PCG's analysis should be considered a starting point for discussion rather than a precise estimate of the marginal cost of creating a separate Developmental Disability Division. Given total State administration costs of approximately \$40M, the estimated costs to create an independent DD Division range from 4% to 6%. In context of the entire mental health care system expenditures of over \$1.2B, the marginal cost of creating a separate DD Division is negligible (less than .2%). It is not possible to estimate, at this time, how positions would be assigned in the new Division, and how the new positions and their costs would be allocated between the current Division and the new Division.

Due to the relatively minimal estimated cost impact of creating a separate Developmental Disability Division, PCG recommends that further analysis be performed to answer some of the detailed questions discussed above. The immediate next steps should include the development of a detailed organizational chart for both a new DD Division and a restructured MH/SA Division. This analysis should include all direct and indirect administration costs along with all operational costs. A position-by-position analysis should also be performed to determine what positions are required in both the MH/SA and DD Divisions. Salary adjustments should be reviewed for all affected positions within both Divisions. Logistical considerations should be analyzed including the location and operational costs of the new DD Division and transition costs (which are excluded from PCG's analysis and include expenses such as computer network development, relocation expenses, furnishings and equipment, recruitment, etc.). Federal government regulations and funding must also be reviewed to insure the new Developmental Disability Division remains compliant with all regulatory statutes and continues to maximize Federal revenue.

RECOMMENDATIONS FOR STRUCTURAL CHANGE

Criteria for Analysis of Organizational Options

Based on an analysis of all of the above input including interviews, reviews of previous reports, analysis of the allocation of resources in the State, and other demographic and service utilization information, the following criteria are proposed to govern the selection of the most promising structural arrangement for the State's developmental disabilities system. In order to maximize the positive benefits of system change for people with developmental disabilities and their families, the following factors should be satisfied:

Any new structure should:

1. Facilitate the coordination with and input into the implementation of the recommendations of the PCG *Study of State Psychiatric Hospitals and Area Mental Health Programs* in order to ensure that the interests of stakeholders in the developmental disabilities system are heard and responded to. Provide a platform and requisite authority for strong developmental disabilities program leadership at the State level.
3. Create momentum, resources, and direction for a unified programmatic and policy vision for the developmental disabilities system in the State.
4. Make it possible to secure fiscal accountability for the expenditure of DD funds, in alignment with system goals.
5. Facilitate the development and implementation of a flexible HCBS waiver geared to individual supports.
6. Ensure the ongoing stability of providers of developmental disabilities services across the State and enhance the importance of training and retaining direct support professionals.
7. Emphasize the measurement of outcomes that are relevant to the lives of people with disabilities and their families and enhance the performance of services and supports.
8. Make it possible to coordinate DD services and funding with other relevant services and funding streams.
9. Create a strong, meaningful role in State and local policy for people with developmental disabilities, their families, and advocates.
10. Minimize the administrative burden on local administrative structures (the County Programs recommended in this study) and build on their strengths, e.g., public accountability, local responsiveness, etc.
11. Minimize additional administrative cost and duplication of functions at the State level.

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Analysis

As noted in the introduction to Section 3, maintaining the status quo with respect to the current organization of developmental disabilities at the State level is not an option. Given the issues and challenges uncovered during this evaluation and a review of responsibilities and functions of DD agencies in other states, there are specific steps that the State should take to enhance the status of the state DD program regardless of the overall organizational option selected. These basic elements include : establishing a strong DD leadership position, creating separate categorical allocations, permitting direct policy-making over the conduct of DD programs at the local public entity level; developing quality assurance procedures relevant to the lives of people with developmental disabilities and their families, and creating a direct line of authority to the connection to local management authority. The two options under consideration in this analysis are:

- Create a new Division of Developmental Disabilities
- Restructure DD services within DMHDDSAS

In order to analyze the strengths and weaknesses of the two approaches, each of the criteria noted above are reviewed.

1. *Coordinate implementation of PCG system change recommendations* – The recommendations for comprehensive system reconfiguration included in the overall PCG report envision a significant and complex change in the way in which services are delivered to consumers of DMHDDSAS funded services and supports. The study mandate, however, did not include an analysis of the impact of these changes on services to people with developmental disabilities and their families. PCG’s charge was to analyze changes in the behavioral health portion of the study. To ensure that the needs and interests of DD consumers and their families are respected during any implementation process, strong and knowledgeable DD leadership will be required.

During the period of implementation, it is also assumed that the energies of the DMHDDSAS will be aimed at the broad changes anticipated in behavioral health. Given existing concerns reflected in the findings above that DD has not been fully involved in key policy decisions at the Division level (e.g., movement of early intervention, development of COA accreditation standards, and the development of the Utilization Management proposal), there is a danger that the flurry of activity generated by the changes in behavioral health will serve to even further marginalize the interests of DD consumers. The planning process recommended in this report would be greatly strengthened under the auspices of a new DD division.

Conclusion: This criteria is best met in a separate Division

2. *Create policy vision for DD system* – The study findings strongly suggest that the DD system in the State of North Carolina could benefit from the development of a unified vision for the future of the system that takes into account the core services and supports that will be required, the future utilization of private and public ICFs/MR, the individuals who should be eligible for services, the integration and protection of the Thomas S class, and steps necessary to respond to the *Olmstead* decision – to name just a few.

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These are all areas that are critical to the future viability of the system of services to people with DD in North Carolina and which, if not addressed, will continue to undermine the effective and equitable operation of the system. While it is certainly possible that such a vision could be developed by a strengthened DD Section, history suggests that it would take special efforts on the part of the Division leadership to make it happen. This seems particularly unlikely in light of the major challenges presented by the necessity to reform the behavior health system. A new Division with new leadership offers a stronger possibility that these issues will be addressed a participatory and focused fashion.

Conclusion: This criteria is best met in a separate Division

3. *Create a platform for strong leadership* – The findings indicate a pervasive concern at all levels of the system regarding the importance of renewed and stronger leadership of the system at the State level. The lack of leadership is felt at the Area Program level (e.g., lack of contact, direction, etc.), among advocates, and in the provider and advocacy communities. In part, this perception is a result of the organizational constraints experienced by the DD Section (e.g., historical fluctuations in control of the Waiver program, lack of influence over ICF/MR rates, lack of line authority over Area Program operations). However, some argue that more could have been done even in light of these restrictions.

The importance of strong leadership is underscored by the presence of contentious camps within the State that continue to spar with another to the disadvantage of people with developmental disabilities, their families, and the future of the DD system. Stronger leadership could flow from the creation of a strengthened Section. However, the prospect of a separate Division provides a more promising context and would likely be more attractive to a recognized figure in the DD community. Given the centrality of new leadership to the achievement of the recommendations in this report, a separate Division is a better platform from which to attract nationally recognized leadership.

Conclusion: This criteria is best met by a separate Division

4. *Secure fiscal accountability* – The review conducted as part of this study indicates that identifying the ultimate costs of DD services at the Area Program level as well as the ultimate destination of funds has been problematic. In addition, decisions regarding the development of rates for a significant portion of the DD system (private ICFs/MR) are made outside of the Division. Given the significant utilization of these facilities in North Carolina (see 3.11 above), stronger programmatic control should be exercised over these decisions by DD State managers.

Further, the monitoring that is in place tends to be aimed at assessing episodes of care more in keeping with a medical model of services. Thus, it would appear that fiscal accountability in general has been weak within the Division and that the methodologies that have been applied are not always consistent with a DD system of long-term supports. A strengthened DD Section that has categorical control over DD funding to the local public entity and that can participate in rate-setting for ICFs/MR will be in a far better position to ensure fiscal accountability than the current DD administrators. The same is true of a separate Division. However, in the latter case, the promulgation of rules and accounting protocols would not need to be filtered through another layer of the state system and negotiations with providers and local public entities could be conducted from a position of enhanced authority.

Conclusion: This criteria marginally better met in a separate Division.

5. *Facilitate implementation of a comprehensive and flexible HCB waiver* -- Many of the findings in this report point to the importance of expanding the HCB waiver to ensure the continuing movement of the system to a more individually tailored and flexible community system. First, Gary Smith notes that, compared to other states, North Carolina has not taken full advantage of the waiver in so far as

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persons served. Recommendations from the report by Robin Cooper to explore aggregate funding and to broaden the scope of the waiver were never acted upon given concerns by the Division of Medical Assistance. The state DD Commissioners who attended the Expert Panel all emphasized the importance of waiver policy and implementation in the movement of their systems in more progressive and expansive directions. Key informant as well as Area Program key informants expressed concern regarding the complexity of waiver eligibility, difficulties in enrolling individuals, and the inflexibility of service and support options. While the recent reorganization carried out by the Director of DMHDDSAS did address some of these concerns, there continue to be disagreements and differences in philosophy regarding the scope and content of the waiver between DD Section managers and staff of DMA.

Though all of the issues raised by this analysis are important, the future application of the waiver is perhaps one of the most crucial keys to moving the system toward innovation and best practice. A strengthened Section would be in a better position to bring about necessary changes than current DD managers. However, additional power and status conferred on a Division Director would provide a more equal footing in important negotiations with the Secretary of Health and Human Services and the Division of Medical Assistance regarding waiver amendments, implementation, and allocation of funds.

Conclusion: This criteria is best met in a separate Division

6. *Ensure system stability* – Comments received during key informant interviews, Area Program site visits, and during the regional forums indicate a growing concern regarding the viability of the provider system and its ability to continue to support people with DD given cut-backs in funding over the years, changes brought about by the cessation of court oversight in Thomas S., lack of timely reimbursement in some instances, and a sense of uncertainty about the future. A recent report prepared at UNC Charlotte (1999) also highlights another aspect of instability in the system – the rapid turnover in direct support staff and the difficulty encountered by providers in recruiting staff. Given the lack of a coherent vision for the system noted above, these not so early warning signs are doubly concerning. The combination of confusion about system direction coupled with a growing perception that the community system is vulnerable could stall further progress toward a person-centered, responsive community system.

To increase stability in the system will require multiple strategies : 1) creating a more predictable funding and programmatic environment; 2) working with providers to attract and keep qualified and competent direct support workers; 3) developing a more collaborative relationship with local public entities and with providers; 4) improving the business practices of the local public entities; 5) revising current provider reporting requirements to ensure that they are cost beneficial (i.e., are worth the investment of resources to collect); and 6) periodic collection of audit information from providers to track fiscal stability.

Again, these steps can be taken within a strengthened Section. However, given challenges facing the behavioral health system – both economic and programmatic – it is difficult to see how current Division leadership could devote sufficient time to the critical problems facing DD. A new Division, with strengthened leadership, could communicate a renewed commitment to the field and could focus unimpeded on this potentially serious issues.

Conclusion: This criteria is best met in a separate Division

7. *Emphasize outcomes* – Interviews at the state and local level indicated that while there was quality assurance and enhancement taking place with respect to the organizational and administrative capacity of Area Programs (Council on Accreditation), there was little programmatic oversight of Area Programs and providers directly relevant to the responsiveness of services and supports to people with developmental disabilities and their families. Current oversight is comprised primarily of very traditional licensing reviews, some case management monitoring (although not very substantive

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according to interviewees), and, until recently, accreditation reviews by the Council on Leadership of Thomas S. providers. In addition to COA monitoring, it is important to find ways to meet the specialized needs of the DD community both for information about provider performance and reassurance that the State's investment is yielding results. North Carolina is currently participating in a national effort called the Core Indicators Project which is a multi-state activity aimed at collecting indicators of performance across DD systems. Participation in this project is a definite step toward developing DD relevant performance measures.

The development of outcome-based measures of performance in DD services is something that could take place within a strengthened Section assuming that the current commitment at the Division level to move toward non-categorical oversight is modified and agreement reached that some combination of both would be preferable. In the absence to this agreement, it is hard to see how full cooperation could be secured. This is not an agenda item that would necessarily receive the support and leadership of the current Division.

Conclusion: This criteria is best met in a separate Division

8. *Coordination with other public programs* – This criteria creates a somewhat paradoxical conclusion. On the one hand, if the DD Section remains in the Division, the proximity to other related programs such as behavioral health will be maintained. While proximity is not a guarantee that coordination and collaboration will take place, it does provide a head start. On the other hand, a separate DD Division would have more power to negotiate with other agencies on an equal footing including the Division of Medical Assistance. However, proximity would be diminished.

Conclusion: This criteria can be met in either configuration

9. *Create a strong role for individuals and families in policymaking* – Self-advocacy among individuals with developmental disabilities is increasing in numbers and influence. Family advocacy is also a strong grassroots effort – especially among young families. Their voices are critical to the responsiveness of the DD in North Carolina. Our observations and interviews suggest that this voice is not always present when policy is made and that the voice of providers and administrators tends to dominate most public policy forums. To truly create a participative environment where self-advocates and families can be heard will require an aggressive effort and will require the provision of support and facilitation.

This extra effort is not apparent in the Division currently and while it is possible that a strengthened Section could give more prominence to the inclusion of self-advocates and family members in policy making, it would take a great deal of effort. A new Division would more likely be able to mobilize these voices and to devote the attention and facilitation it would require to make such input meaningful.

Conclusion: -- This criteria best met in a separate Division

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10. *Minimize burden on Area Programs* – It is important that changes at the State level do not result in undue or unnecessary burdens on the local public entity. There are, however, some irreducible disruptions given the nature of the changes anticipated in this report for the behavioral health system. Further, regardless of organizational structure, we are recommending categorical funding, changes in quality assurance and so forth. The question then is, given all of these anticipated changes which organizational configuration is more likely to ease the problems created by implementation. The recommendations of this report place the key decision making under the auspices of the Blue Ribbon Implementation Commission and Secretary of the Department of Health and Human Services. In the change process envisioned in this report, it is difficult to see that either structural alternative would be decidedly better than the other.

Conclusion: This criteria can be met in either configuration

11. *Minimize cost* – The preliminary estimates of the cost of creating a new Division of DD (see 3.17) indicate that the potential impact would range from between \$1 million to \$2 million. There are, however, no estimates of what a strengthened Section would entail, although certainly there would be added costs given the added responsibilities. The ultimate question for the State is whether the investment will yield the dividends and benefits noted above. Based on the analysis conducted as part of this project, the potential accomplishments of a new Division would more than justify the investment. However, it will be important to design a Division that takes full advantage of shared administrative functions and that justifies any staff increases based on the priorities and issues outlined in this evaluation. Further analysis should examine the opportunities for savings in the present \$1.2 Billion budget to identify a source for the small cost of the new Division, less than .2 of 1% of total cost.

Conclusion: -- This criteria can be met in a new Division

RECOMMENDATION

PCG recommends that the Secretary of Health and Human Services request the Legislature to authorize the creation of a new Division of Developmental Disabilities. It is extremely doubtful that under the current structure the State will be able to develop the necessary resources, leadership and momentum to meet the growing challenge and needs faced by persons with developmental disabilities and their families.

Action Steps

There are several steps that should be explored as part of the design and implementation of a new Division of Developmental Disabilities:

- Preparation of a DD implementation plan for the PCG recommendations creating the new County Programs. Include recommendations for necessary assurances in contracts with local public entities, and proposals regarding timelines and activities for the inclusion of Developmental Disabilities in all aspects of the new governance structure.
- An organizational and staffing plan for the new Division that demonstrates: a) the administrative cost and source of funds for the new organization; b) an organizational structure designed to administer the County Program contract and provide adequate oversight and technical assistance (see Section 2.1 on the proposal for joint MHSAS/DD regional offices); and c) the ability to work effectively with the

3. *Developmental Disabilities Structure*

new DMHSAS Division, under the auspices of the Blue Ribbon Implementation Commission and the Secretary of the Division of Health and Human Services.

- Exploration of the mechanisms that will be required to separate current DD allocations from the current unified Area Program budgets.
- Development of eligibility criteria for Developmental Disabilities services and supports regardless of funding stream (e.g., ICF/MR, waiver, state funding, etc.).
- Expansion of Division responsibilities to include development of rates for ICF/MR facilities.
- Movement of the Early Intervention program into a reconstituted Division.
- Development of flexible HCBS waiver options and implementation plans.
- Creation of an outcome-based performance management system that reflects those accomplishments valued by people with developmental disabilities and their families;
- Support for increased participation of self-advocates and family members in policy making throughout the system;
- Preparation of a plan to address the implications of the *Olmstead* decision;
- Development of a strategic plan to address, among other things, the future of the Regional MR Centers.

NOTES

1 This is the third edition of “Where Does North Carolina Stand?” The original version was released in 1997 as an appendix to **Choice, Change and Community** In 1998, an update was prepared on behalf of the North Carolina Council on Developmental Disabilities, which sponsored the preparation of **Choice, Change and Community** This edition updates the figures that appeared in the last version and provides additional information

2 In preparing this report, we have relied on three national data sets. The first is data compiled by the University of Minnesota’s Research and Training Center on Community Living (RTCCL). Each year RTCCL researchers conduct an in-depth survey to compile both nationwide and state-by-state data concerning residential and other related services for people with developmental disabilities. The RTCCL data contained here is from the Center’s most recent report: Robert Prouty and K. Charlie Lakin (Eds.) (May 1999). **Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1998**. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. In certain cases, information published by RTCCL has been further updated from figures that state developmental disabilities authorities share with the National Association of State Directors of Developmental Disabilities Services, Inc. (NASDDDS). The final source of data is the quadrennial survey of state expenditures for developmental disabilities services that is conducted by the Department of Disability and Human Development at the University of Illinois at Chicago (DHD/UIC). This information is contained in: David Braddock, Richard Hemp, Susan Parish, and James Westrich (1998). **The State of the States in Developmental Disabilities** (5th edition). Washington DC: American Association on Mental Retardation. The RTCCL figures are current through 1998. [N.B., RTCCL expects to release figures for 1999 in May/June 2000. DHD/UIC’s latest publication contains information that has been updated through 1996. As mentioned in the narrative, each organization that compiles nationwide data does so by conducting periodic surveys of the states. In other words, state officials directly supply the figures that are compiled and reported in the publications these organizations issue.

3. Fiscal effort is calculated by dividing total spending by a state’s total personal income. Fiscal effort measures the relative willingness of a state’s citizens to earmark dollars to pay for developmental disabilities services

4. North Carolina’s large state-operated facilities are the Black Mountain, Caswell, Murdoch, O’Berry, and Western Carolina Centers.

5. An ICF/MR is a facility that serves 4 or more individuals. In order for a facility to be certified as ICF/MR and thereby become eligible for Medicaid payments, it must comply with an extensive set of federal regulations and requirements.

6. The services presently offered through the CAP/MR-DD program include: (a) service coordination; (b) personal care; (c) supported employment; (d) prevocational services; (e) developmental day care; (f) community inclusion; (g) environmental accessibility adaptations; (h) adult day health; (i) personal emergency response systems; (j) family training; (k) in-home aide; (l) adult day care; (m) supported living; (n) vehicle adaptations; (o) crisis stabilization; (p) supplies and equipment; (q) augmentative communication devices; (r) nursing respite; and, (s) other respite services.

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7. The adjustment that was made accounts for difference between the HCB waiver and ICFs/MR programs with regard to “room and board” costs. Such costs are included in ICF/MR payments but not in HCB waiver expenditures.

8. Robin Cooper, Ph.D., National Association of State Directors of Developmental Disabilities Services, was contracted by the Department of Health and Human Services to prepare a response to provisions of SB 1366 regarding reduction of the waiting list. The recommendations, included in *Report to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Human Resources*, submitted on May 1, 1999, recommended aggregate funding through the CAP waiver in order to give Area Programs more flexibility in the allocation of resources.

MENTAL HEALTH EXPERTS PANEL

To complement the review of the current mental health and substance abuse delivery system in North Carolina, the Office of the State Auditor sponsored an Expert's panel that included various health professionals from six other states. The information discussed during the two-day meeting allowed us to gain a more thorough understanding of the delivery of Mental Health and Substance Abuse delivery services in states other than North Carolina. The experts discussed the methodology, work plan, implementation, costs and outstanding issues of recent attempts within their own states to modify the existing system of care. The following pages include a summary of the conference, a copy of the agenda and a description of each of the participants. The meeting proved to be a valuable resource to learn about the successes and failures of other States as well as to understand structure, financing and payment options available for review throughout the course of our study.

**STUDY OF THE STATE PSYCHIATRIC HOSPITALS AND
THE MENTAL HEALTH DELIVERY SYSTEM
Summary of the State Auditor's Expert Panel Meeting
September 21-22, 1999**

The Office of the State Auditor sponsored an Expert Panel Meeting to address "Organization and Financing of Public Mental Health Services in North Carolina". The meeting, facilitated by the North Carolina Institute of Medicine, was held September 21-22 at the Carolina Inn in Chapel Hill. This conference is part of the Mental Health Study mandated by the General Assembly and being conducted by the State Auditor's Office. Mental health professionals representing six other states participated as panel members. These individuals were instrumental in reshaping other states mental health delivery systems. The panel included:

- ◆ **Paul Barreira, M.D.**, Deputy Commissioner for Clinical and Professional Services
– Massachusetts Department of Mental Health

- ◆ **Patrick Barrie**, Director of Managed Care for Specialty Services – Michigan
Department of Community Health

- ◆ **Joseph J. Bevilacqua, Ph.D.**, (retired) former Commissioner of Mental Health of
Rhode Island, Virginia and South Carolina

- ◆ **Charles G. Curie**, Deputy Secretary for the Office of Mental Health and Substance
Abuse Services – Pennsylvania Department of Public Welfare

- ◆ **Michael Hogan, Ph.D.**, Director – Ohio Department of Mental Health

- ◆ **Pamela S. Hyde, J.D.**, Senior Consultant, Technical Assistance Collaborative, Inc.
of Boston, Massachusetts

Approximately 30 participants attended the meeting representing the General Assembly, the Department of Health and Human Services, various consumer advocacy groups, as well as the Office of the State Auditor and its contractor, Public Consulting Group, Inc. The conference was structured in segments designed to address a variety of topics relative to restructuring the delivery of mental health services. A summary of each topic and discussion points are listed on following page.

I. CREATING A SOUND CONTINUUM OF CARE IN THE COMMUNITY

Joseph Bevilacqua, The South Carolina Experience

Ten years ago South Carolina began the process of redesigning the state's mental health system. A Transition Leadership Committee was developed to oversee the change process.

Results of this initiative:

- resistance to efforts to redesign the system
- reduction in the number of state hospitals
- redefined relationship between hospitals and communities
- reduction in appropriations
- each community submitted a plan for community placement

Outcomes:

- one hospital closed
- increased community support

Paul Barreira, The Massachusetts Experience

In Massachusetts the idea was to get away from state hospitals where there was a disconnect and have acute hospital care closer to the community. The two principles used by the Department of Mental Health were to:

- 1) Transition people with mental illness out of an inpatient setting.
- 2) Provide intervention that helps individuals remain in the community in a stable environment.

Results of this initiative:

- closed 4 state hospitals
- replacement beds are provided by community hospitals
- expanded community support programs developed
- resulted in savings of \$9 million

Patrick Barrie, The Michigan Experience

The legal basis of the evolution of the Community Based System in Michigan resulted from revisions to its mental health codes in 1974 and 1996. The financial basis changed to a concept of "full management" and Medicaid funding to support Community Based Care.

Results of this initiative:

- closed 15 hospitals in 9 years
- pledge that the money would follow clients back to the community
- use of community inpatient options
- more interagency collaboration
- more performance based accountability

Discussion

At the end of the segment, the other panel members added comments on the presentations. Ms. Hyde stated that she saw several themes coming out of the presentations. These themes included:

- integration of steam funds
- lack of resources
- role of local entities
- need to develop common vision
- align financing mechanism with the goal and vision
- outside pressures
- role of state hospital
- relationships or entity's turf
- need for more/better information

Dr. Hogan suggested that the state:

- identify the things that do not work
- build up and keep momentum for change
- allow local programs to design their own programs, this gives the program a sense of ownership
- the role of the state hospital may change

Question: How can you focus on people with greatest need given limited funds?

Response: Get money to follow patient, use Medicaid funds.

Question: Hospital funds are adjusted for inflation where community funds are not. How can the community programs deal with the fact that funding will lose ground each year?

Response: Try to maximize federal funds, develop clear eligibility guidelines for non-Medicaid clients, and redefine the role of the hospital, transfer hospital employees to the community programs, and try for cost of living adjustments on state funds.

Question: Do "hard to serve" numbers increase in state facility as cases move to the community?

Response: Massachusetts's data shows no change. You need to look at what's the right thing to do clinically. Many clients in the state hospitals do not need the level of care they receive.

II. APPROACHES TO ORGANIZING SUCCESSFUL COMMUNITY-BASED CARE

Charles Curie, The Pennsylvania Experience

The population and budget of the Pennsylvania state mental hospitals have been significantly reduced since 1965 with the funds going toward community services as shown in the two tables below.

State Mental Hospitals		
Year	Population	Budget
1965	35,514	98%
1975	14,279	83%
1988	7,469	74%
1998	3,590	44%

Community Services		
Year	Population	Budget
1965	24,000	2%
1975	175,000	17%
1988	233,000	26%
1998	200,000	56%

Under this plan, when a hospital bed is closed, 75% of that money goes to the local program. Pennsylvania is a purchaser of mental health services rather than a provider of services. Pennsylvania determined that the following was necessary:

- have a clear vision with all parties buying into the plan
- define priority populations
- have consumer and family involvement
- increase county management responsibility
- need for funding integration
- move drug and alcohol funds out of mental health funds
- standards should drive system

Michael Hogan, The Ohio Experience

Ohio now refers to its state hospitals as Behavioral Health Care Organizations. With the change in the Ohio Mental Health system, the community boards became responsible for all types of services including inpatient services. The number of state hospitals went from 17 in 1988 to 9 Behavioral Healthcare Organizations/Inpatient sites in 1998. The number of state hospital staff went from 4,100 in 1985 to 2,600 in 1997. However, some of those employees got jobs working in the community programs.

Results of reorganized Mental Health System in Ohio:

- dramatic reductions in hospital use and resources
- virtual elimination of long-term hospitalization
- locally managed community support

Pamela Hyde, Ohio and Related Experiences

To have successful Community Based Care you must have the following:

- plan first - managed care problems may be due to lack of planning
- values and people based – not based on financing mechanisms
- decide who will be served and who will not be served
- build coalitions
- begin to manage utilization
- maximize resources by using client resources such as SSI and SSDI
- build an effective information system

Discussion

In the discussion part of this session, these were the major points addressed:

- efficiency dominates everything
- little support for mental health services by most citizens
- information systems are very important
- state hospitals deliver good primary medical care, while local governments do not.

Question: What role do the counties play as deliverers or purchasers of services?

Response: Pennsylvania has option of delivering or purchasing. Currently, there are only three counties that still deliver services. Michigan operates under a capitated system. Ohio centers provide services but boards really don't. In this system the belief is that the funder and planner should be separate from the provider. If a county decides to be the funder and provider, it must be able to separate the two roles.

Question: Has who's paying what been worked out?

Response: No, it basically is still state's responsibility but a local program.

III. SUCCESSFUL MODELS FOR FINANCING CARE

Charles Curie, The Pennsylvania Experience

- phase in behavioral health managed care
- one size does not fit all for the urban and rural areas
- Pennsylvania gives the counties the “right of first opportunity” to provide services
- counties have different options
- cost capitated
- counties have reinvestment options

Paul Barreira, The Massachusetts Experience

- Massachusetts does not have counties; there is only a state system
- must move all acute inpatient out of the state hospitals
- must have very well defined work relationship between the Division of Mental Health and Division of Medical Assistance
- overall savings of \$9 million were realized by Massachusetts

Pamela Hyde, Other State Experiences

- Medicaid is pushing toward states learning to be purchaser not just funder
- issues of competition will arise
- clear parameters about eligibility and benefits must be set
- contracts are very important
- provider choice
- there may be different rates for different areas
- realize you can redirect money
- use performance based criteria
- case based rates don't seem to work
- use global budgets and do as much as can
- blending funding not figured out yet
- vouchers to clients to choose
- if the state changes current structure, be sure not to add layers of administrative costs
- need to do network management, report and use data, keep rules for all funding sources, manage utilization, manage quality, have sanctions to force needed changes
- assure all needed services will be available

Discussion

- system will do what you set incentives to do
- link other funding sources like vocational rehabilitation
- maybe consolidated management, use of different money
- county based purchasing allowed in some system
- include families/consumers in deciding what performance indicators should be
- use consumers and families to do quality reviews, pay them

Question: How do you fund children's services and blend funding?

Response: There are different ways to do it, no one good way. You will need to collaborate with all agencies.

Question: What are the pros and cons of case rates?

Response: Case rates helps with risks. Rates determine the number of classes identified.

IV. BUILDING CONSENSUS FOR POSITIVE SYSTEM CHANGE

Joseph Bevilacqua

- getting all parties together is important
- understand political issues
- identify successes
- revisit issues periodically

Pamela Hyde

- success takes cooperation from all
- understand what it takes to make other players successful
- willing to change to succeed
- let go of turf
- must agree on common vision

Discussion

- group can shape individuals
- can't tell people what to do
- write down consensus, sign it, make it public
- state has to help develop coalitions
- start with feeling of "that's not right" to make changes
- dialogue must be ongoing
- willingness to change & even "die" to succeed
- learn how to be a purchaser rather than a funder
- competition issue
- must have a common vision of success
- ownership is a large issue

WRAP UP

Marc Fenton of Public Consulting Group, Inc. spoke on what he observed during the two-day conference and what he sees as the issues North Carolina must address as it reevaluates the mental health system.

1. There must be a common vision for the public system, supported by the key constituencies. (For some this may be a reaffirmation of their current vision.)
2. The state strategy must recognize and coordinate Medicaid and Department of Mental Health goals, constraints and financing mechanisms.
3. The role of the state hospital is in transition. The state hospital of the future may:
 - not be a hospital, but a secure, residential facility
 - handle more specialized and difficult to serve populations
 - provide services to more forensic clients
4. The public hospital system in North Carolina is at a critical juncture. Currently, it provides beds approximately 32 beds per 100,000 adults. To move to the next level of utilization – 15 to 20 beds per 100,000 as represented by current patterns in Massachusetts, Ohio and Michigan (and planned for in Pennsylvania and South Carolina) -- a number of community service strategies must be considered:
 - acute care replacement units
 - 24 hour emergency service systems that can divert clients and make all state hospital admission decisions
 - aggressive case managers dedicated to keeping people out of state hospitals and reducing their length of stay
 - use of state hospital staff for community residential and rehabilitation programs
5. There is a need to create financial vehicles that tie state hospital use to local areas and create appropriate incentives and costs for their use. Michigan and Ohio have created mechanisms for this purpose.
6. There needs to be local service systems, designed to meet and deliver services in the community, within state standards, that provides consumers with choices. There may be not be a “one size fits all” model to meet the wide range of North Carolina communities.
7. The state needs to create a “resource driver” for community services as state hospital beds are reduced, to protect resource erosion from inflation and other cost increases.
8. There are at least two “third rail” issues that must be addressed carefully:
 - the role and responsibility of local governments
 - the role of Area Program as a provider, system manager, or both.
9. North Carolina must create a unified leadership coalition (no single leader) that will avoid the typical mental health firing squad approach—everyone standing in a circle pointing his/her gun at the others in the circle.

To close the conference, Secretary David Bruton and State Auditor Ralph Campbell summarized their impressions of the conference. Dr. Bruton noted that “we have a long way to go to build a consensus” and that everyone will have to be willing to work together to be successful. After thanking the panel, Auditor Campbell expressed his appreciation to the North Carolina Institute of Medicine for facilitating the conference. “Overall, the conference stimulated discussion, identified a number of key issues, and helped to define a direction to move forward with the study,” Auditor Campbell noted. “I agree with Dr. Bruton in that we all have to work together. There is no greater burden for the folks in this room than for us to come forward with a successful plan for the citizens of the great State of North Carolina. We have some challenges, but I am of the belief that here, in North Carolina, we can do it.” Plans are underway to have a similar 1-day conference in early January 2000 to discuss developmental disability issues.

NORTH CAROLINA INSTITUTE OF MEDICINE

CITIZENS DEDICATED TO IMPROVING THE HEALTH OF NORTH CAROLINIANS

**"ORGANIZATION AND FINANCING OF PUBLIC MENTAL
HEALTH SERVICES IN NORTH CAROLINA"**

STATE AUDITOR'S EXPERT PANEL MEETING

CAROLINA INN, CHAPEL HILL, NC

SEPTEMBER 21-22, 1999



AGENDA

TUESDAY, SEPTEMBER 21st

1:00p ORIENTATION & WELCOME

Hon. Ralph Campbell
State Auditor

Gordon H. DeFriese
N.C. Institute of Medicine

I: CREATING A SOUND CONTINUUM OF CARE IN THE COMMUNITY

1:30p-2:15p Facilitator: Joseph Morrissey
Presenters: Joseph Bevilacqua, The South Carolina Experience
Paul Barreira, The Massachusetts Experience
Patrick Barrie, The Michigan Experience

2:15p-2:30p Comments: Pamela Hyde, Michael Hogan, Charles Curie

2:30p-3:00p Discussion

3:00p-3:30p **BREAK**

II: APPROACHES TO ORGANIZING SUCCESSFUL COMMUNITY-BASED CARE

3:30p-4:15p Facilitator: Marvin Swartz
Presenters: Charles Curie, The Pennsylvania Experience
Pamela Hyde, Ohio I and Related Experiences
Michael Hogan, The Ohio II Experience

4:15p-4:30p Comments: Joseph Bevilacqua, Paul Barreira, Patrick Barrie

4:30p-5:00p Discussion

**DAY I WRAP-UP: REFLECTING ON STATE EXPERIENCES,
ANTICIPATING CHALLENGES IN FINANCING AND CONSENSUS-
BUILDING**

5:00p-5:15p Presenter: Michael Hogan

6:00p-8:00p **DINNER**

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"Organization and Financing of Public Mental Health Services in North Carolina"
State Auditor's Expert Panel Meeting
Carolina Inn, Chapel Hill, NC
September 21-22, 1999

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NORTH CAROLINA INSTITUTE OF MEDICINE

CITIZENS DEDICATED TO IMPROVING THE HEALTH OF NORTH CAROLINIANS

Profile of Expert Panel Members

Paul Barreira, M.D. has been Deputy Commissioner for Clinical and Professional Services in the Massachusetts Department of Mental Health since 1996. In this capacity he is the Department's chief psychiatrist and is responsible for overseeing all of its clinical activities in state mental hospitals and in CMHCs; approving the credentialing and clinical program descriptions for the statewide Medicaid managed care organization; licensing of psychiatric units in general hospitals and private psychiatric hospitals; quality assurance and development of clinical practice guidelines; and research and training. He also is Associate Professor of Psychiatry at the Mass Medical School in Worcester, MA. Previously, he served as Director of Rehabilitation Core (1994-96), Center for Psychosocial and Forensic Services Research, UMass Medical Center; Area Medical Director (1993-94) for Central Massachusetts; Medical Director (1986-89) of Worcester State Hospital; and Residency Training Director (1984-86) in the Department of Psychiatry at the UMass Medical Center. He received an undergraduate degree from Boston College, a M.D. degree from the Georgetown University Medical School, and residency training in psychiatry at Beth Israel Hospital in Boston, MA.

Patrick Barrie has served as Director of Managed Care for Specialty Services in the Michigan Department of Community Health since 1997. In this capacity he is involved in the design and implementation of managed care programs for mental health, substance abuse, and developmental disabilities services. Formerly, he served as Coordinator of Managed Care (1995-97) for the Department; Director of Program Development and Clinical Services (1985-95) for the Lenawee County Community Mental Health Board in Adrian, MI; Program Director (1978-85) for the Dickinson-Iron Community Mental Health Board in Iron Mountain, MI; and Outpatient Therapist (1975-78) at the Mellwood Mental Health Center in Pittsburgh, PA. He was extensively involved with the Michigan Association of Community Mental Health Boards in developing the Medicaid managed inpatient mental health care program that took effect in August 1995. Mr. Barrie has master's degrees in psychology and history from Duquesne and Michigan State Universities and holds a limited license in psychology in the State of Michigan.

Joseph J. Bevilacqua, Ph.D. served twenty-one years as Commissioner of Mental Health in three states-Rhode Island (1975-81), Virginia (1981-85), and South Carolina (1985-95). A major priority of his work in each of these states has been active and strong support for consumers of mental health services and their families. Prior to state service, he served in the United States Army as a social work officer in psychiatric hospitals and mental health clinics, both in the states and overseas. Since his retirement from state service, he has been a Professor in the College of Social Work at the University of South Carolina (1995-96) and Director, State Initiatives Office, Bazelon Center for Mental Health Law in Washington, DC (1996-98). He also has served as President of the National Association of State Mental Health Program Directors (two terms) and currently serves on the boards of The Green Door, a psychosocial rehabilitation program in Washington DC; Fellowship Health Resources, Inc., a not-for-profit residential and support services provider in Lincoln, RI; and the Rhode Island chapter of the National Alliance for the Mentally Ill. He is the recipient of an undergraduate degree from Canisius College, a M.S.W. from the University of Buffalo, and a Ph.D. from Brandeis University.

Charles G. Curie has served as Deputy Secretary for the Office of Mental Health and Substance Abuse Services in the Pennsylvania Department of Public Welfare since 1995. In this position, he manages a service system consisting of 10 state mental hospitals and 45 county and jointer community mental health programs. Recently, the office was successful in developing a statewide carve-out for Medicaid behavioral health services with annualized funding of \$100 million for community care. Formerly, he was Director of Risk Management Services (1990-95) for Henry S. Lehr, Inc., a firm that provided consultation to 420 health and human service providers in 42 states; President/CEO (1988-90) of Stevens Mental Health Center in Carlisle, PA; and Executive Director/CEO (1979-88) of the Sandusky Valley Center in Tiffin, OH. In the latter two positions, he was involved in establishing intensive case management programs for persons with a serious mental illness, expanding provision of substance abuse services, and developing children's mental health services. He holds a master's degree from the School of Social Services Administration at the University of Chicago and is a member of the Academy of Certified Social Workers.

Michael Hogan, Ph.D. has served as Director of the Ohio Department of Mental Health since March 1991. He has held leadership positions and led reform in the mental health systems of three states. In Massachusetts (1976-84), he served as Regional Administrator and Superintendent of Northampton State Hospital in the western part of the state which was transformed into one of the only regions in the U.S which serves citizens with a mental illness or developmental disability in a completely community-based system. In Connecticut (1984-91) he served as both Deputy Commissioner and Commissioner of Mental Health during a period of innovation in which state hospital use and costs were reduced, community services expanded and improved, and purchase of services and information systems were implemented. In Ohio, he has been responsible for implementing legislation that calls for the unification of mental health care and leadership at the community level. During his tenure, the ODMH has carefully and successfully closed four state facilities, privatized one, consolidated administrative services and costs, and increased community mental health resources by over \$700M. He has served on the board of the National Mental Health Advisory Council and is president of the board of the National Association of State Mental Health Program Directors Research Institute. He holds an undergraduate degree from Cornell and a Ph.D. from Syracuse University.

Pamela S. Hyde, J.D. is a Senior Consultant with the Technical Assistance Collaborative, Inc., a Boston-based non-profit organization founded by the Robert Wood Johnson Foundation to assist state and local governments with behavioral health and human service issues. She is an attorney with twenty years experience in public administration at both state and local levels. She started her career in Ohio as an advocate, attorney, and then Executive Director of Ohio Legal Rights Service (1977-83), a statewide protection and advocacy agency. She then served as Director of the Ohio Department of Mental Health (1983-90); Director of the Ohio Department of Human Services (1990-91), the state's Medicaid and child welfare agency; Director of the Seattle Department of Housing and Human Services (1991-93), and President/CEO of COMCARE (1994-96), a Phoenix-based behavioral health managed care company. She has received special acknowledgement from the National Governor's Association for her ability to build teams, develop coalitions and consensus, and develop strategic plans that form the basis for action in a constantly changing political environment. In Ohio, she led major mental health system change that resulted in greater community control over state hospital and local services. She also spearheaded legislative efforts that resulted in a new drug and alcohol services department. She holds an undergraduate degree from Southwest Missouri State University, a law degree from the University of Michigan, and postgraduate education from the John F. Kennedy School of Government at Harvard.

DEVELOPMENTAL DISABILITIES EXPERTS PANEL

On January 19, 2000, the State Auditor's Office sponsored – in conjunction with the North Carolina Institute of Medicine, University of North Carolina, Chapel Hill – an Expert Panel comprised of state directors of developmental disabilities services. The purpose of the all day meeting was to highlight: service system goals and new trends; quality assurance and mechanisms for improving service quality; and organizational structure and relationship with Medicaid. Presenters included Valerie Bradley, HSRI, who presented information on the mental retardation system in Pennsylvania; James Toews, Oregon Office of Developmental Disabilities; Stan Butkus, South Carolina Department of Disabilities and Special Needs; and John Solomon, Missouri Division of Mental Retardation and Developmental Disabilities.

Each presenter represented a somewhat different organizational configuration:

- James Toews is head of an agency that is located in an umbrella human services agency. He reports to an administrator with responsibility for overseeing both DD and mental health in Oregon;
- John Solomon is the director of a Division of MR/DD that reports to the director of the Department of Mental Health (with two other behavioral health divisions) in Missouri;
- Stan Butkus is the director of a separate disabilities department in South Carolina; and
- Nancy Thaler (whose system was presented by Val Bradley) is the assistant secretary for the Office of Mental Retardation reporting directly to the Secretary of Human Services in Pennsylvania.

Though the presenters described a range of structural and governance alternatives, there were several themes that recurred in each presentation and that represent the necessary ingredients – in the view of these state representatives – for successful state oversight and policy direction of MR/DD services and supports:

- Categorical funding from the state for MR/DD services to the local point of service delivery or purchase of service; This was true even when the local entity was an MH/DD county program (Pennsylvania, and Oregon),
- The MR/DD agency had control and influence over Medicaid waiver policy and reimbursement. In two states – Pennsylvania and Oregon, the umbrella human services agency is the single state Medicaid agency which therefore confers authority to administer waiver programs across the department;
- Each administrator noted the central importance of the HCBS waiver in shaping the kinds of services and supports offered and in making the system more responsive to individual consumers and families;
- Two of the states, Pennsylvania and Oregon, have mounted comprehensive plans to phase down public institutional programs;
- Each administrator acknowledged the importance of person-centered planning and respect for individual choices and preferences;

- Each agency has developed outcome based performance expectations specifically for MR/DD services;
- Each agency has a direct line of authority to the local service delivery/purchase of service agency.

As a backdrop to this panel discussion, PCG reviewed the structures of all 50 states. Approximately 40% of all states include Mental Health and Developmental Disabilities in separate divisions, but 50% of states North Carolina's size or larger have separate divisions.

The agenda, list of participants, and profiles of presenters at the January 19 Experts Panel meeting follows.

NORTH CAROLINA INSTITUTE OF MEDICINE

CITIZENS DEDICATED TO IMPROVING THE HEALTH OF NORTH CAROLINIANS

STATE AUDITOR'S EXPERT PANEL ON DEVELOPMENTAL DISABILITIES

Carolina Inn, Chapel Hill, NC
JANUARY 19, 2000



AGENDA

7:45a **CONTINENTAL BREAKFAST**

8:15a **ORIENTATION & WELCOME**

Honorable Ralph Campbell
State Auditor

H. David Bruton, M.D.
Secretary, N.C. Department of Health & Human Services

MORNING SESSION

8:30a **1: SERVICE SYSTEM GOALS AND NEW TRENDS**

Moderator: Marvin Swartz

Presenters: Valerie Bradley, Overview of Funding & Programs
James Toews, Oregon Developments
Stan Butkus, South Carolina Developments
Jon Solomon, Missouri Developments

10:30a **BREAK**

10:45a **2: QUALITY ASSURANCE AND IMPROVING SERVICE QUALITY**

Moderator: Joseph Morrissey
Panelists: Jon Solomon
 Stan Butkus
 James Toews
 Valerie Bradley

12:15p **BUFFET LUNCH**

AFTERNOON SESSION

1:15p **3: ORGANIZATIONAL STRUCTURE AND RELATIONSHIP WITH
 mEDICAID**

Moderator: Marvin Swartz
Panelists: Stan Butkus
 James Toews
 Valerie Bradley
 Jon Solomon

2:30p **BREAK**

2:45p **4: QUESTIONS & ANSWER SESSION**

Moderator: Joseph Morrissey

3:45p **5: CLOSING REMARKS**

Honorable Ralph Campbell

Attachment B: Developmental Disabilities Experts Panel

LIST OF PARTICIPANTS

First Name	Last Name	Title	Organization
George S.	Baroff	Director	Developmental Disabilities 1
Jimmy	Benson	Deputy State Auditor	Office of the State Auditor
Grant	Blair	Manager	Public Consulting Group, In
Valerie J.	Bradley	President	Human Services Research I
H. David	Bruton, M.D.	Secretary	N.C. Department of Health
Stanley J.	Butkus, Ph.D.	State Director	South Carolina Department
Honorable Ralph	Campbell, Jr.	North Carolina State Auditor	Office of the State Auditor
Connie	Cochran, M.Ed.	Executive Director	United Cerebral Palsy of NC
Paula	Cox, Ph.D.	Vice President	Mental Retardation Associa
Gordon H.	DeFriese, Ph.D.	President & C.E.O.	N.C. Institute of Medicine
Representative Beverly	Earle		General Assembly - NC Ho
James B.	Edgerton	Assistant Secretary for Budget, Management & Planning	N.C. Department of Health
Marc	Fenton	Principal	Public Consulting Group, In
April M.	Gerard	Parent Co-Chair	N.C. Self-Determination Le
Karen	Hammonds-Blanks, M.P.H.	Senior Fiscal Analyst	N.C. General Assembly
Jann	Harris	Special Assistant to the Director	N.C. Division of Mental He
Janet	Hayes	Audit Manager	Substance Abuse Services
J. Michael	Hennike	Director	Office of the State Auditor
Jill	Hinton Keel	Executive Director	Murdoch Center
Representative Verla	Insko		Autism Society of NC
Tara	Larson	Assistant Director	General Assembly - NC Ho
Sally	Ludlum, DSW, NHA	Facility Director	N.C. Division of Mental He
Jerry	Lyall, Ph.D.	Director	Substance Abuse Services
Senator William N.	Martin		Black Mountain Center
Peyton	Maynard	President	O'Berry Center
			General Assembly - NC Se
			Developmental Disabilities 1

Attachment B: Developmental Disabilities Experts Panel

Angela Emily H.	McCants Moore	Family Advocate Chairman, N.C. Commission	UNC Center for Developme N.C. Division of Mental He Substance Abuse Services
Joseph P. Michael Elizabeth	Morrissey, Ph.D. Moseley, M.Ed. Owens	Deputy Director for Research Director President	Cecil G. Sheps Center for F Caswell Center First In Families
Paul R. Spencer Senator Jim W. Patrica	Perruzzi, M.B.A., M.H.A. Phillips Phillips, Sr. Porter, Ph.D.	Director Audit Supervisor Chief, Developmental Disabilities Services Executive Director	N.C. Division of Medical A Office of the State Auditor General Assembly - NC Se N.C. Division of Mental He Substance Abuse Services The Arc/NC
Dave Holly Iverson Patrice Pam John G. Allan Jack Walter W.	Richard Riddle Riddle, M.D. Roesler Shipman Solomon, M.Ed. Spader St. Clair, Ed.D., N.H.S. Stelle, Ph.D.	Executive Director Executive Director Director Director, Intergovernmental Programs Assistant Area Director Division Director Executive Director Area Director Deputy Director	NC Council on Developmer Western Carolina Center & N.C. Association of County Piedmont Area MH/DD/SA Division of Mental Retardat NC Council of Community Duplin-Sampson MH/DD/S N.C. Division of Mental He Substance Abuse Services Public Consulting Group, In Department of Psychiatry & Governor's Advocacy Coun Office of Developmental Di Community Support Provid North Carolina General Ass
Kate Marvin Cynthia James D. Fred Gann	Sutherland Swartz, M.D. Temoshenko Toews Waddle Watson	Senior Consultant Professor DD Coordinator Assistant Administrator State Director Staff Attorney	

NORTH CAROLINA INSTITUTE OF MEDICINE

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Profile of Expert Panel Members

Valerie J. Bradley is President of Human Services Research Institute in Cambridge Massachusetts. She is a nationally recognized policy analyst in the field of mental retardation and developmental disabilities. She has directed numerous Federal, state, and local projects aimed at assessing and improving the quality and delivery of services to persons with developmental disabilities. She has published widely on system change; consumer-driven approaches to control, funding, and delivery of services; and quality assurance. Currently, she is directing projects with the National Association of Directors of Developmental Disabilities Services on state-level performance indicators and with the Robert Wood Johnson Foundation on self-determination projects. She also is the current Chair of the President's Committee on Mental Retardation. Her educational background includes a master degree in political science from Rutgers University.

Stan Butkus, Director of the South Carolina Department of Disabilities and Special Needs since 1996, has extensive experience in the field of developmental disabilities at the local, regional, and state levels. He was worked to develop policies and practices to increase self-determination for persons with disabilities, to simplify funding and equalize services resources through a capitated-funding model, and to establish outcome evaluation methodologies. He has worked in the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, where he directed the office of mental retardation, served as CEO of a large institution, and later as associate commissioner for community and facility services. His academic training includes a Ph.D. in social welfare (Brandeis University); masters degrees in social work (Virginia Commonwealth University), public administration (University of New Hampshire), and educational psychology (University of Nebraska), and an undergraduate degree in political science (St. Francis Xavier University).

John Solomon is Director, Division of Mental Retardation and Developmental Disabilities, Missouri Department of Mental Health. He was appointed to this position in June 1996. He has held a variety of positions within that Department since 1970 including Deputy Division Director, Deputy Director for Administration, and District Director with overall supervision for two state habilitation centers and several regional centers for persons with developmental disabilities. Mr. Solomon has been instrumental in implementing family programs, including home-based services and family purchase of local services through Medicaid waivers, quality assurance through volunteer alliances, and innovative funding of community-based services. He holds an undergraduate degree from Southwest Baptist College and a graduate degree in educational administration and guidance counseling from Lincoln University.

James Toews is Assistant Administrator, Programs for Developmental Disabilities, Mental Health Division, Oregon Department of Human Resources, a position he has held since 1985. Concurrently, he has been a member of the Governmental Affairs Committee of the National Association of State Mental Retardation Program Directors He worked for several years with the Association of Retarded Citizens of Oregon and served as its Director from 1983-85. In the early 1970s he was with the Association of Retarded Citizens in Indiana where he also held residential and vocational services positions in the developmental disabilities field. His educational background includes an undergraduate degree from Goshen College (1974) graduate studies in guidance and counseling at Indiana University (1977-78).

THE FOLLOWING LETTER IS EXCERPTED FROM THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) WEB PAGE: www.hcfa.gov

January 14, 2000

Dear State Medicaid Director:

The recent Supreme Court decision in *Olmstead v. L. C.*, 119 S.Ct. 2176 (1999), provides an important legal framework for our mutual efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. The Court's decision clearly challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.

This decision confirms what this Administration already believes: that no one should have to live in an institution or a nursing home if they can live in the community with the right support. Our goal is to integrate people with disabilities into the social mainstream, promote equality of opportunity and maximize individual choice.

The Department of Health and Human Services (DHHS) is committed to working with all affected parties to craft comprehensive, fiscally responsible solutions that comply with the Americans with Disabilities Act of 1990 (ADA). Although the ADA applies to all State programs, Medicaid programs play a critical role in making community services available. As a consequence, State Medicaid Directors play an important role in helping their States comply with the ADA. This letter conveys our initial approach to *Olmstead* and outlines a framework for us to respond to the challenge.

The Olmstead Decision

The *Olmstead* case was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the ADA to live in the most integrated setting appropriate. The *Olmstead* decision interpreted Title II of the ADA and its implementing regulation, which oblige States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." (28 CFR 35.130(d)). In doing so, the Supreme Court answered the fundamental question of whether it is discrimination to deny people with disabilities services in the most integrated setting appropriate. The Court stated directly that "Unjustified isolation . . . is properly regarded as discrimination based on disability." It observed that (a) "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and (b) "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the State's

responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

Under the ADA, States are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." (28 CFR 35.130(b)(7)). The Supreme Court indicated that the test as to whether a modification entails "fundamental alteration" of a program takes into account three factors: the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the State; and how the provision of services affects the ability of the State to meet the needs of others with disabilities. Significantly, the Court suggests that a State could establish compliance with title II of the ADA if it demonstrates that it has:

- a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and
- a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

Olmstead and the Medicaid Program

Olmstead challenges States to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate. Medicaid can be an important resource to assist States in meeting these goals. We want to work closely with States to make effective use of Medicaid support in your planning and implementation of Olmstead. As an example of the interface between Olmstead's explanation of the State's ADA obligation and your Medicaid program we would point to the State's responsibility, under Medicaid, to periodically review the services of all residents in Medicaid-funded institutional settings. Those reviews may provide a useful component of the State's planning for a comprehensive response to Olmstead. States must also be responsive to institutionalized individuals who request that their situation be reviewed to determine if a community setting is appropriate. In such a case the State has a duty to redress the situation, subject to the limits outlined by the Court and the ADA. As another example, States may choose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support.

Comprehensive, Effectively Working Plans

As we have noted, the Supreme Court in Olmstead indicated that a State may be able to meet its obligation under the ADA by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated. The Department believes that comprehensive, effectively working plans are best achieved with the active involvement of individuals with disabilities and their representatives in design, development and implementation.

The Court's Olmstead decision regarding the integration requirement applies to all individuals with disabilities protected from discrimination by title II of the ADA. Although Olmstead involved two individuals with mental disabilities, the scope of the ADA is not limited only to such individuals, nor is the scope of Olmstead limited to Medicaid beneficiaries or to services financed by the Medicaid program. In addition, the requirement to provide services in the most integrated setting appropriate applies not only to persons already in institutional settings but to those being assessed for possible institutionalization.

The enclosure to this letter offers some recommendations about key principles and practices for States to consider as they develop plans. We recognize that there is no single plan that is best suited for all States, and accordingly that there are many ways to meet the requirements of the ADA. We certainly hope States and people with disabilities will expand and improve on these ideas. Although these plans encompass more than just the Medicaid program, we realize the important role played by State Medicaid Directors in this area. As just one example, Federal financial participation will be available at the administrative rate to design and administer methods to meet these requirements, subject to the normal condition that the changes must be necessary for the proper and efficient administration of the State's Medicaid program. Because of your significant role, we have taken this opportunity to raise these issues with you.

The principles and practices contained in the accompanying technical assistance enclosure also serve as an important foundation for the DHHS Office for Civil Rights' (OCR) activities in this area. As you know, OCR has responsibility for investigating discrimination complaints involving the most integrated setting issue. OCR also has authority to conduct compliance reviews of State programs and has already contacted a number of States to discuss complaints. OCR strongly desires to resolve these complaints through collaboration and cooperation with all interested parties.

Next Steps for the Department of Health and Human Services

Consultation: We have begun consultation with States (including State Medicaid Directors and members of the long term care technical advisory group, who share responsibility for Medicaid) and with people with disabilities. We look forward to building on this start. Many States have made great strides toward enabling individuals with disabilities to live in their communities. There is much that we can learn from these States. We are interested in your ideas regarding the methods by which we might accomplish such continuing consultation effectively and economically.

Addressing Issues and Questions Regarding Olmstead and Medicaid: As we move forward, we recognize that States may have specific issues and questions about the interaction between the ADA and the Medicaid program. In response to the issues and questions we receive, we will review relevant federal Medicaid regulations, policies and previous guidance to assure that they (a) are compatible with the requirements of the ADA and the Olmstead decision, and (b) facilitate States' efforts to comply with the law.

Technical Assistance: In response to any issues raised by the States, the DHHS working group will develop a plan to provide technical assistance and information sharing among States and stakeholders. Responses to questions and technical assistance materials will be published on a special website. We are also funding projects in a number of States to assist with nursing home transition. Finally, we seek your ideas on the additional forms of technical assistance you would find most helpful for home and community-based services and conferences for State policy makers. We will use your suggestions to facilitate the implementation of the integration requirement. We invite all States and stakeholders to submit questions and recommendations to our departmental workgroup co-chaired by the Director of HCFA's Center for Medicaid and State Operations and the Director of the DHHS Office for Civil Rights. Please send such written correspondence to:

DHHS Working Group for ADA/Olmstead
c/o Center for Medicaid and State Operations
HCFA, Room S2-14-26, DEHPG
7500 Security Blvd.
Baltimore MD 21244-1850

Conclusion

The Administration and DHHS have a commitment to expanding home and community-based services and offering consumers choices in how services are organized and delivered. Over the past few years, DHHS has focused on expanding and promoting home and community-based services, offering support and technical assistance to States, and using the flexibility of the Medicaid program. The Olmstead decision affirms that we are moving in the right direction and we intend to continue these efforts. We recognize that this interim guidance leaves many questions unanswered; with your input, we expect to develop further guidance and technical assistance. We recommend that States do the following:

- Develop a comprehensive, effectively working plan (or plans) to strengthen community service systems and serve people with disabilities in the most integrated setting appropriate to their needs;
- Actively involve people with disabilities, and where appropriate, their family members or representatives, in design, development and implementation;
- Use the attached technical assistance material as one of the guides in the planning process;
- Inform us of questions that need resolution and of ideas regarding technical assistance that would be helpful.

We look forward to working with you to improve the nation's community services system.

Sincerely,

Timothy M. Westmoreland
Director
Center for Medicaid and State Operations
Health Care Financing Administration

Thomas Perez
Director
Office for Civil Rights

Enclosure

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators, Division of Medicaid and State Operations
American Public Human Services Association
National Association of State Alcohol and Drug Abuse Directors, Inc.
National Association of State Directors of Developmental Disabilities Services
National Association for State Mental Health Program Directors
National Association of State Units on Aging
National Conference of State Legislatures
National Governors' Association

Enclosure

Developing Comprehensive, Effectively Working Plans Initial Technical Assistance Recommendations

In ruling on the case of *Olmstead v L.C.*, the Supreme Court affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. The Supreme Court indicated that a State can demonstrate compliance with its ADA obligations by showing that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

We strongly urge States to increase access to community-based services for individuals with disabilities by developing comprehensive, effectively working plans for ensuring compliance with the ADA. There is no single model plan appropriate for all States and situations. In developing their plans, States must take into account their particular circumstances. However, we believe there are some factors that are critically important for States that seek to develop comprehensive, effectively working plans. Our intent in this enclosure is to identify some of the key principles, including the involvement of people with disabilities throughout the planning and implementation process. These principles also will be used by the Office for Civil Rights as it investigates complaints and conducts compliance reviews involving "most integrated setting" issues. We strongly recommend that States factor in these principles and practices as they develop plans tailored to their needs.

Comprehensive, Effectively Working Plans

Principle: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings. When effectively carrying out this principle:

- The State develops a plan or plans to ensure that people with disabilities are served in the most integrated setting appropriate. It considers the extent to which there are programs that can serve as a framework for the development of an effectively working plan. It also considers the level of awareness and agreement among stakeholders and decision-makers regarding the elements needed to create an effective system, and how this foundation can be strengthened.
- The plan ensures the transition of qualified individuals into community-based settings at a reasonable pace. The State identifies improvements that could be made.
- The plan ensures that individuals with disabilities benefit from assessments to determine how community living might be possible (without limiting consideration to what is currently available in the community). In this process, individuals are provided the opportunity for informed choice.
- The plan evaluates the adequacy with which the State is conducting thorough, objective and periodic reviews of all individuals with disabilities in institutional settings (such as State institutions, ICFs/MR, nursing facilities, psychiatric hospitals, and residential service facilities for children) to determine the extent to which they can and should receive services in a more integrated setting.
- The plan establishes similar procedures to avoid unjustifiable institutionalization in the first place.

Plan Development and Implementation Process

Principle: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up. When effectively carrying out this principle:

- The State involves people with disabilities (and their representatives, where appropriate) in the plan development and implementation process. It considers what methods could be employed to ensure constructive, on-going involvement and dialogue.
- The State assesses what partnerships are needed to ensure that any plan is comprehensive and works effectively.

Assessments on Behalf of Potentially Eligible Populations

Principle: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities. When effectively carrying out this principle:

- The State has a reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community-based settings. The plan considers what information and data collection systems exist to enable the State to make this determination. Where appropriate, the State considers improvements to data collection systems to enable it to plan adequately to meet needs.
1. The State evaluates whether existing assessment procedures are adequate to identify institutionalized individuals with disabilities who could benefit from services in a more integrated setting.
 2. The State also evaluates whether existing assessment procedures are adequate to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.
 3. The plan ensures that the State can act in a timely and effective manner in response to the findings of any assessment process.

Availability of Community-Integrated Services

Principle: Ensure the Availability of Community-Integrated Services. When effectively carrying out this principle:

- The plan identifies what community-based services are available in the State. It assesses the extent to which these programs are able to serve people in the most integrated setting appropriate (as described in the ADA). The State identifies what improvements could be accomplished, including in information systems, to make this an even better system, and how the system might be made comprehensive.
- The plan evaluates whether the identified supports and services meet the needs of persons who are likely to require assistance in order to live in community. It identifies what changes could be made to improve the availability, quality and adequacy of the supports.
- The State evaluates whether its system adequately plans for making supports and services available to assist individuals who reside in their own homes with the presence of other family members. It also considers whether its plan is adequate to address the needs of those without family members or other informal caregivers.
- The State examines how the identified supports and services integrate the individual into the community.
- The State reviews what funding sources are available (both Medicaid and other funding sources) to increase the availability of community-based services. It also considers what efforts are under

way to coordinate access to these services. Planners assess the extent to which these funding sources can be organized into a coherent system of long term care which affords people with reasonable, timely access to community-based services.

- Planners also assess how well the current service system works for different groups (e.g. elderly people with disabilities, people with physical disabilities, developmental disabilities, mental illness, HIV-AIDS, etc.). The assessment includes a review of changes that might be desirable to make services a reality in the most integrated setting appropriate for all populations.
- The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

Informed Choice

Principle: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings. When effectively carrying out this principle:

- The plan ensures that individuals who may be eligible to receive services in more integrated community-based settings (and their representatives, where appropriate) are given the opportunity to make informed choices regarding whether -and how- their needs can best be met.
- Planners address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices.

Implications for State and Community Infrastructure

Principle: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan. When effectively carrying out this principle:

- Planners evaluate how quality assurance and quality improvement can be conducted effectively as more people with disabilities live in community settings.
- The State also examines how it can best manage the overall system of health and long term care so that placement in the most integrated setting appropriate becomes the norm. It considers what planning, contracting and management infrastructure might be necessary to achieve this result at the State and the community level.

FACT SHEET

Assuring Access to Community Living for the Disabled

Overview: On June 22, 1999, the U.S. Supreme Court affirmed that policy by ruling in *Olmstead v. L.C.* that under the Americans With Disabilities Act (ADA) unjustifiable institutionalization of a person with a disability who, with proper support, can live in the community is discrimination. In its ruling, the Court said that institutionalization severely limits the person's ability to interact with family and friends, to work and to make a life for him or herself.

The *Olmstead* case was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs were receiving mental health services in state-run institutions, despite the fact that their treatment professionals believed they could be appropriately served in a community-based setting.

In accordance with that Court ruling, the U.S. Department of Health and Human Services (HHS) today issued guidance to state Medicaid directors on how to make state programs responsive to the desires of disabled persons to live in appropriate community-based settings. The Administration's goal is to integrate people with disabilities into the social mainstream with equal opportunities and the chance to make choices.

In addition, HHS Secretary Donna E. Shalala wrote to the governor of each state, underlining the Department's commitment to community services for those with disabilities and noting that the *Olmstead* decision applied to all relevant state programs, not just Medicaid.

The Olmstead Decision

The Court based its ruling in *Olmstead* on sections of the ADA and federal regulations that require states to administer their services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Under the Court's ruling, certain principles have emerged:

- unjustified institutionalization of people with disabilities is discrimination and violates the ADA;
- states are required to provide community-based services for persons with disabilities otherwise entitled to institutional services when the state's treatment professionals reasonably determine that community placement is appropriate; the person does not oppose such placement; and the placement can reasonably be accommodated, taking into account resources available to the state and the needs of others receiving state-supported disability services;
- a person cannot be denied community services just to keep an institution at its full capacity; and,
- there is no requirement under the ADA that community-based services be imposed on people with disabilities who do not desire it.

The Court also said that states are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." Meeting the fundamental alteration test takes into account three factors: the cost of providing services in the most integrated setting; the resources available to the state; and how the provision of services affects the ability of the state to meet the needs of others with disabilities.

Olmstead and the Medicaid Program

The Medicaid program can be an important resource to assist states in meeting the principles set out in Olmstead. In its letter/guidance to State Medicaid Directors, the Health Care Financing Administration, which oversees the Medicaid and Medicare programs, reminds states they have an obligation under Medicaid to periodically review the services of all residents in Medicaid-funded institutions.

The letter also reminds states they may chose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support.

HCFA urges states to develop comprehensive working plans to strengthen community service systems and to actively involve people with disabilities and their families in the design, development and implementation of such plans. HCFA also encourages states to take steps to prevent future inappropriate institutionalization of persons with disabilities and to assure the availability of community-based services.

Next Steps

Over the past few years, HHS has focused on expanding and promoting home and community-based services, offering support and technical assistance to states and using the flexibility of the Medicaid program. The Olmstead decision affirms that we are moving in the right direction.

To help states comply with the Court ruling, HCFA and the HHS Office for Civil Rights have begun working with states and the disability community toward the goals of promoting home and community-based services; honoring individual choice in service provision; and acknowledging that resources available to a state are limited by the need to serve both community-based and institutionalized persons. In addition to continued technical assistance to states, HHS will review relevant federal Medicaid regulations, policies and previous guidance to assure that they are compatible with requirements of the ADA and Olmstead decision and that they facilitate states' efforts to comply with the law.

[mcaidpti.htm Return to Medicaid Professional/Technical Information Page](#)

Last Updated January 19, 2000

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<http://www.hhs.gov/>
<http://www.hhs.gov/>

***Bibliography for Section 3:
Developmental Disabilities Structure***

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April 1, 2000

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