

MARYLAND HEALTH CARE COMMISSION

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STATE HEALTH PLAN FOR FACILITIES AND SERVICES: OVERVIEW, PSYCHIATRIC SERVICES, AND EMERGENCY MEDICAL SERVICES

COMAR 10.24.07

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Note: Since its initial promulgation, this Chapter has been revised several times to repeal individual sections or chapters and replace them with the following separately-codified chapters: **COMAR 10.24.08, 10.24.10, 10.24.11, 10.24.14, and 10.24.17**. Additional subjects have been addressed in **COMAR 10.24.09, 10.24.15, and 10.24.16**. Collectively, **COMAR 10.24.07-.17** constitute the State Health Plan.

The Overview found in this Chapter originally applied to the entire State Health Plan. By action of the below-cited provisions in the newer chapters, the Overview in this Chapter does not apply to services addressed in **COMAR 10.24.08** (subsection .02F(1)), **10.24.09** (subsection .02F), **10.24.10** (subsection .02F(3)), **10.24.11** (subparagraph .02F(3)(a)(i)), **10.24.14** (subsection .02F(3)), or **10.24.17** (subsection .02E(4)).

In addition, by action of section .02E of **COMAR 10.24.10**, the Overview of this Chapter does not apply to services addressed in either the Psychiatric Services or Emergency Medical Services sections of this Chapter, to which instead **COMAR 10.24.10** applies where appropriate.

Applicability of the Overview in this Chapter to services addressed by **COMAR 10.24.15** and **10.24.16** is limited to rules not otherwise found in any of those chapters. Specifically, with respect to General Plan Standards found in the Overview, service-specific standards in **COMAR 10.24.15** and **10.24.16** apply when there is similarity between them and standards found in the Overview.

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THE MARYLAND STATE HEALTH PLAN: AN OVERVIEW

Purpose of the State Health Plan

The Maryland Health Resources Planning Commission has prepared this State Health Plan (SHP) in order to further the mission of health planning, which is the development of a health care system that provides financial and geographic access to quality health care at a reasonable cost for all citizens. In every aspect of the Plan, and in its individual Certificate of Need decisions, the Commission must carefully weigh issues of access to services against the cost of those services to society, particularly in today's environment of rapidly escalating health care costs.

There are two purposes that the Plan is intended to serve.

1. As a policy document, the Plan establishes health care policy to guide the Commission's actions and those of other health-related public agencies, and to foster specific actions in the private sector. The Commission has not limited itself to policies it can directly carry out. The purpose of the Plan is to serve as a blueprint for shaping a better health care system in Maryland through the action of public agencies and the cooperation of private entities.

2. As a regulatory document, the Plan is the planning and legal foundation for the Commission's regulatory decisions in its Certificate of Need (CON) program. CON is an integral arm of the State's regulatory control of the health care industry. The purpose of the CON program is to ensure that changes in service capacity and major expenditures for health care facilities are needed and affordable, and consistent with the Commission's policies. As required by statute, it functions in coordination with the hospital rate-setting program of the Health Services Cost Review Commission to assure access to care at reasonable costs.

As a regulation, the State Health Plan therefore contains the service-specific need projection methodologies, standards, and policies that the Commission will adhere to in making Certificate of Need decisions. The law also requires other state agencies to conform their activities to the Plan.

Organizational and Legal Setting of the State Health Plan

Statutory Authority. This is the first Plan to be developed under Maryland's new health planning law, adopted by the General Assembly in 1982 in the form of House Bill 1637. This statute retains Maryland's health planning program and its regulatory approach to the health care industry, regardless of the outcome of policy debates in the national arena.

The Commission, which took office on October 1, 1982, has the legal responsibility to adopt a State Health Plan at least every five (5) years and to review and amend the plan annually, or as necessary. The specific provisions for the Plan are contained in the Health-General Article, Section 19-114, Annotated Code of Maryland (1982 Supplement).

Although located within the Department of Health and Mental Hygiene for budgetary purposes, the Commission is an independent agency. It has sole authority to prepare and adopt the Plan and to issue Certificate of Need decisions. The Secretary of Health and Mental Hygiene has the duty of making annual recommendations to the Commission on the Plan and commenting on the specifications used in its development. The Secretary may not approve or modify any determinations the Commission makes regarding the State Health Plan. The Governor is empowered to notify the Commission of his intent to effect changes in the Plan within 45 days of its receipt. In practice, the Commission's policy is to pursue effective coordination with the Secretary and state health-related agencies in the course of developing its plans and plan amendments.

The statute gives the Commission very broad authority as to the scope of coverage of the State Health Plan. Section 19-114(a)(2) states that the Plan shall include:

- (i) A description of the components that should comprise the health care system;
- (ii) The goals and policies for Maryland's health care system;
- (iii) Identification of unmet needs, excess services, minimum access criteria, and services to be recognized;
- (iv) An assessment of the financial resources required and available for the health care system; and
- (v) The methodologies, standards, and criteria for certificate of need review.

This first State Health Plan to be adopted by the Commission addresses each of these areas with the exception of item (iv), which will be addressed separately.

The authority of the Plan with respect to the responsibilities of other state agencies and departments is provided in Section 19-114(g). In addition, Section 19-109 provides that the Governor shall direct, as necessary, state agencies to cooperate with the Commission.

Local Health Plans. The law further requires that the State Health Plan include local health plans. Local plans are to be developed in accordance with specifications of the Commission. Local plan sections have been used in preparing state health plan sections. Variant and additional local standards have been included where deemed appropriate.

The Commission's policy is that, as much as possible, service-specific plan sections should be developed through the collaborative efforts of state and local health planners. Differentiation between the planning function of the state and that of local health planning agencies will be based on the

concept that the Commission will place a relatively greater emphasis on health policy development, while local agencies are expected to emphasize implementation planning and systems development activities.

The Commission designates local health planning agencies. At least through FY 1984, the local health planning agencies officially recognized by the Commission under state statute will continue to be the five (5) Health Systems Agencies designated under the federal law. These are listed and illustrated in Figure 1.

Public Input. Broad public input to the Plan has been received from public agencies, private providers, health care interest groups, local health planning agencies, and the general public. The Commission's policy is to foster such input through various measures including, but not limited to, the following:

- o The use of task forces or technical advisory groups to provide input on selected issues.
- o The use of staff work groups to coordinate planning with local health planning agencies and/or with other agencies.
- o Analysis of existing or proposed plans of other agencies.
- o Circulation of draft Plan components to interested parties and provision of opportunity for written or oral comment before the Commission's Plan Development Committee, prior to submittal of the Committee-approved Plan or components of the Plan to the full Commission for adoption as the Proposed State Health Plan.
- o General circulation of the Proposed State Health Plan, or components of the Plan, and publication of it in the Maryland Register.
- o Solicitation of written and oral public input through scheduled public hearings before final Commission adoption or the Plan.

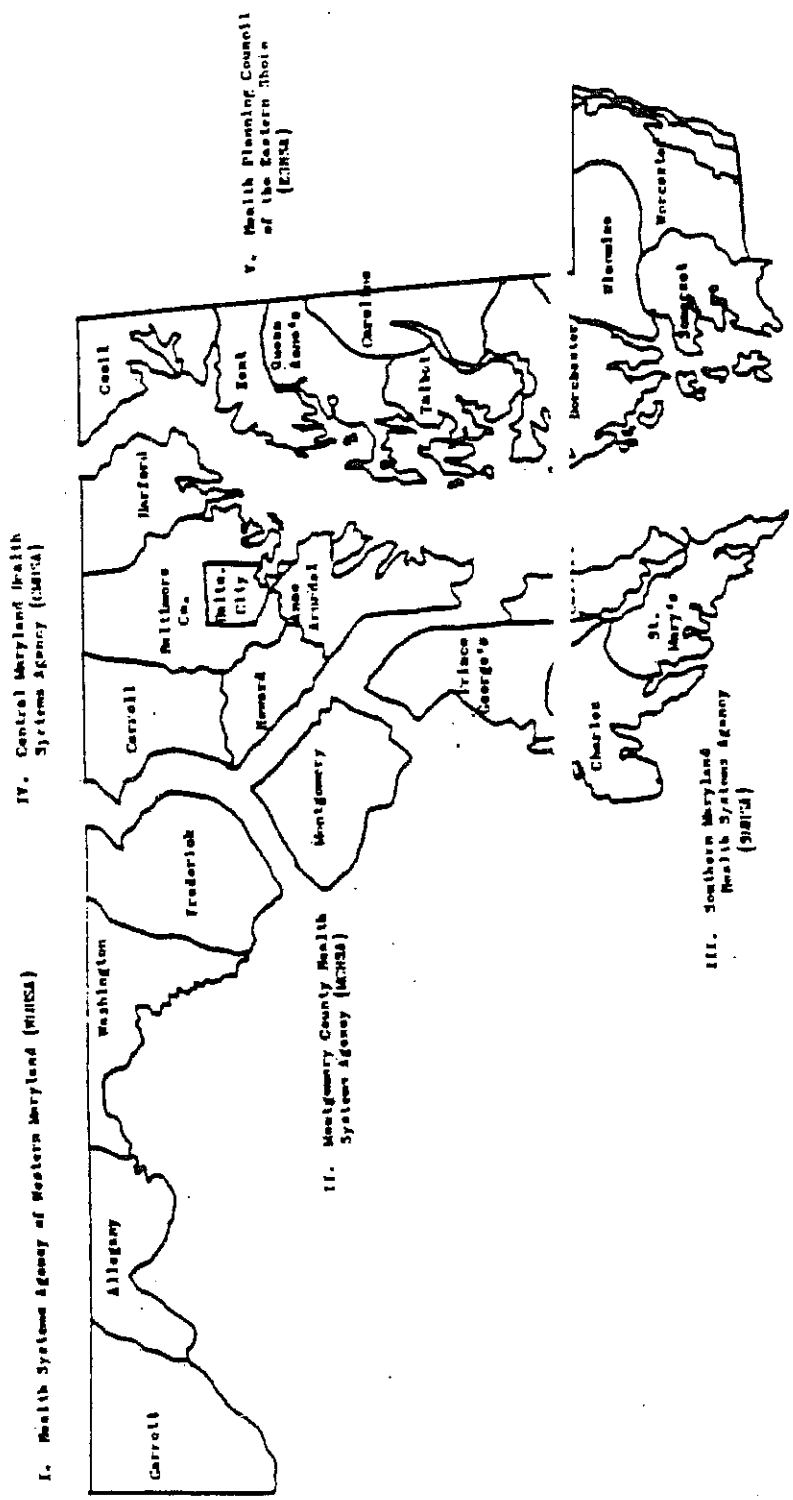


Figure 1
Maryland Health Service Areas and Health Systems Agencies

This Plan also fulfills federal statutory and regulatory requirements for a State Health Plan.

Plan Organization and Content

This Plan is composed of two volumes. Volume I contains the Commission's policies, standards, need projection methodologies, and other material appropriate for promulgation as regulation under the Administrative Procedure Act. These will be applicable in the CON process as well as in other Commission decision making.

Volume I also includes variant and additional local health planning agency standards that will be used during project reviews in a specified health service area.

Some of the service specific sections include more numerous and detailed criteria and standards than other sections. This occurs in those instances where the service is new or emerging, where evaluation of the service by health planning agencies has received less focus than other services, and where the service is not subject to monitoring and evaluation by other regulatory or accreditation authorities.

Volume II contains the substance of Volume I, and also includes the following types of information and analysis:

- o Issue analyses
- o Resource inventories
- o Analyses and explanation of criteria and standards
- o Resource need projections
- o Goals, objectives and recommended actions
- o Other relevant data and resource information.

The Commission intends Volume II to amplify and explain the derivation and intent of material in Volume I, without burdening

the regulation itself with lengthy narrative and tabular information. Volume II can be viewed as regulatory "history" and as a resource document but is not itself a part of regulation.

The two volumes are similarly organized by chapter into major health care sectors or groupings of services, and by service-specific sections within those chapters. Overview sections to the Acute Care and Long Term Care chapters contain adopted Commission policies in those areas.

Not all services have been addressed in this 1983-1988 Maryland State Health Plan. Of course, the service sections that are included in this Plan serve to repeal in the entirety, sections addressing the same service in previous State Health Plans and Health Systems Plans. For those areas not addressed at this time, the Commission will adopt a second series of service specific plans in the future, for incorporation into the State Health Plan. These areas include primary care, high technology, rehabilitation, CT scanning, mental health (not acute inpatient), end stage renal disease, and neonatal intensive care services. Until such incorporation occurs, these service sections, as contained in the (1981) Revision to the State Health Plan will remain in full force and effect and be the guiding planning documents for all relevant Certificate of Need reviews.

Resource Need Projections

The quantitative projections of resource needs for specific services are presented in Volume II of this Plan. The following policies govern the development and application of resource need projections:

1. Need projections in this Plan are those which will be applied by the Commission in its Certificate of Need decisions and supercede need projections contained in the previous State Health Plan and in local health plans.
2. The Commission will not recompute any specific need

projection prior to the formal adoption by regulation of amendments to any service section affected, except in the following cases:

- (a) To correct an error in the data or computation.
- (b) To incorporate revised population projections.
- (c) To incorporate data not available at the time of adoption of this Plan where the intention to incorporate such data was specifically stated in the Plan.
- (d) Cardiac surgery/cardiac catheterization need projections may be updated annually, as provided in that plan section.
- (e) The Commission may, on an annual basis, re-evaluate the utilization of acute inpatient care services and may update its projections to reflect changes in utilization (length of stay or admissions), based on utilization data from a more recent base year than that of this plan (which currently uses CY '81 utilization data). Any updated projections will be used for Certificate of Need (CON) purposes. Prior to use of these projections for CON, notice of such revised projections will be provided to the public and applied uniformly to CON applicants. Notice of revised projections will be published in the Maryland Register.
- (f) Bed need projections for comprehensive care (nursing home) beds will be updated within one year of the effective date of this Plan, utilizing data from the Commission's 1984 nursing home survey and any other recent data applicable to its methodology for calculating comprehensive care bed need, including data related to the development of community based services and other Commission policies related to the development of the long term care system. Updated projections will be used for Certification of Need (CON) purposes. Prior to use of these projections for CON, notice of such revised projections will be

provided to the public and applied uniformly to CON applicants. Notice of the revised projections will be published in the Maryland Register.

3. The Commission may, at its discretion, calculate need for years prior to the end date of the Plan (in this case 1988) for purposes of allowing needed capacity to be phased in. Prior notice of such calculation will be provided to the public and applied uniformly to CON applicants.
4. The end date of a projection will be extended only at the time of regulatory adoption of amendments to any service section affected.
5. The mere failure of the Plan to address a particular project or health care service will not alone be deemed sufficient to render the project inconsistent with the Plan. If a project is not addressed or if the Plan does not contain need projections for a regulated service, the burden will be on each Certificate of Need applicant to demonstrate need.
6. Application of each methodology shall be consistent with the policies, assumptions, and specified data sources included in its description in the Plan.
7. Population projections shall be those prepared by the Department of State Planning.
8. Occupancy calculations shall be based on the number of beds licensed by the Department of Health and Mental Hygiene.
9. In the methodologies, and elsewhere in the Plan, the

following definitions apply:

- Jurisdiction: One of the twenty-three counties or
Baltimore City
- Area: One of the five health service areas
designated by the Governor.

General Plan Standards

The standards presented below (General Plan Standards) are applicable to all services addressed in this Plan unless otherwise specified. Chapter Standards, which are applicable to each section of a specific chapter (or as otherwise specified) may be presented in the overview section of a chapter. Service specific standards are presented in their respective sections of this Plan.

In any case where a standard appears in a service specific section, and the standard is more specific than a similar standard in either a Chapter Overview, or this Plan Overview, the service specific standard will apply.

0 1. The services listed below must be no more than the following one-way average automobile travel times under normal driving conditions for at least 90% of the population:

- a. 30 minutes: inpatient M/S/G, critical and progressive care, obstetrical, and pediatric, except in the Eastern Shore health service area; acute inpatient psychiatric, except in the Western MD. health service area; hospice; and emergency, inpatient, and residential alcoholism, except in the Western MD. health service area;
- b. 45 minutes: inpatient M/S/G, critical and progressive care, and pediatric in the Eastern Shore health service area; and acute psychiatric and residential alcoholism in

the Western MD health service area;

c. 60 minutes: ambulatory surgery;

d. 2 hours: cardiac surgery and catheterization.

O 2a. Ability to pay must not be a barrier to services. Each facility and organized service provider must document, if requested by the Commission, that it has established and maintained access to all services regardless of an individual's ability to pay. Requested data must list the number of patients presenting for and served by each of the following methods of assistance:

- (i) uncompensated care (the facility's or provider's own policy and also, in the case of a hospital, its applicable Hill-Burton policy);
- (ii) referrals for financial assistance to charitable and other special interest groups with whom the facility or provider has established formal arrangements;
- (iii) special payment plans (including sliding fee scales) provided by the facility or provider for individuals who are unable to make payment in full for services to be rendered; and
- (iv) for a facility or provider not otherwise supplying patient discharge data to the Commission, services reimbursed by Medicare and Medicaid.

This standard does not apply to institutional long term care facilities or to life care communities.

O 2b. Each facility and organized service provider must inform patients and/or their responsible parties at the time of preadmission or admission about their possible eligibility for

services under its policies for uncompensated care. Within two working days following the request for uncompensated services, the facility must make a determination of eligibility.

This standard does not apply to institutional long term care facilities.

O 2c. Each facility and organized service provider must publicize information concerning the availability of uncompensated services. Public notice of availability of uncompensated services must include, at a minimum, the following:

- (i) annual publication in a newspaper serving the facility's or provider's area;
- (ii) posted notices in the admission, business office, and (if existing) emergency room areas within the facility; and
- (iii) individual notice provided to each person who seeks services in the facility or from the provider.

This standard does not apply to institutional long term care facilities or to life care communities.

O 3. Each facility and organized service provider must provide to the public, upon inquiry, information concerning charges for and the range and type of services provided.

This standard does not apply to institutional long term care facilities.

O 4. The Commission will not approve a Certificate of Need unless a facility seeking to establish or expand a service (or construct a new facility) documents that the proposal will not duplicate existing services beyond that allowed by this Plan, and that will not adversely affect existing similar services within the target community.

O 5. Each organized facility must be able to demonstrate upon request by the Commission, compliance with all mandated federal, state, and local health and safety regulations, and applicable Joint Commission on Hospital Accreditation, other appropriate national accrediting organization standards, or applicable state certification standards unless otherwise exempted by an appropriate waiver.

O 6. Each facility and organized service provider must institute and/or maintain, and be able to document upon request by the Commission, standardized in-service orientation and continuing education programs, with specified minimum informational content, for all categories of direct service personnel, whether paid or volunteer.

This standard does not apply to institutional long term care facilities or to life care communities.

O 7a. Every facility or organized service provider must have written transfer and referral agreements with:

- (i) facilities capable of managing cases which exceed its own capabilities; and
- (ii) facilities which provide inpatient, outpatient, long-term, home health, aftercare, followup, and other alternative treatment programs appropriate to the types of services it offers.

O 7b. All inpatient and residential facilities and organized service providers must participate in or have utilization review programs and treatment protocols, including written policies governing admission, length of stay, and discharge planning and referral, and must document such programs and protocols when applying for Certificate of Need for new or expanded services and when otherwise required by the Commission.

This standard does not apply to institutional long term care facilities or to life care communities

Policy Framework

The State Health Plan incorporates several policy themes. This overview will describe those themes; the specific policies adopted by the Commission are contained in the chapters that follow. Additional policy statements for areas not covered will accompany the next cycle of plan development.

Mission and Philosophy. The mission of the Commission is stated in its statute and is identical to the stated goal of the federal health planning law (P.L. 93-641):

To promote the development of a health care system that provides, for all citizens, financial and geographic access to quality health care at a reasonable cost.

The Commission views this Plan as a policy blueprint for reshaping the health care system toward these ends. It has assumed an active role in proposing needed changes in the system, including the reallocation of resources to achieve a health care system that is cost-effective, and which balances considerations of affordability, access, and quality.

Central Policy Emphasis. In its first decade or so, health planning placed a greater emphasis on improving access than it did on costs or quality of care. While the mission has not changed, conditions have. Health care costs are rising rapidly while there still exist access problems and unmet needs. Some parts of the system are out of balance. There is a preponderance of resources in expensive modes of care and limited resources in less intensive, but equally effective, alternatives. The central theme of the 1983-1988 plan is to develop strategies to control

costs, to reallocate resources and to channel growth into the most cost-effective and appropriate services and settings.

Related Policy Development Areas. The Commission has identified five areas for policy development. This Plan addresses acute care and long term care; future plans will address the remaining three areas.

1. Acute inpatient services consume 48% of personal health care dollars in Maryland, a proportion higher than the national average. Costs per admission and case mix adjusted average length of stay are higher than the national average. The Medicare waiver under which our all-payor hospital rate-setting system functions is threatened. Policies have been developed to:

- o Retain the state's all-payor rate-setting system.
- o Bring about appropriate and efficient use of inpatient resources.
- o Project appropriate and acceptable levels of inpatient utilization in bed need methodologies.
- o Reallocate resources to accommodate needs while controlling system capacity and costs.
- o Develop a capital investment policy and standards to reinforce acute care priorities and to reward efficiency and productivity in the industry.

2. Long term care services and the allocation of resources among these services are becoming increasingly important public policy concerns as the population becomes older. High rates of use of the most expensive modes of care by the elderly are not consistent with the goals of appropriate utilization and cost control. Enormous cost pressures can be expected to result from the growth of the elderly population, unless major changes in long term care occur. Institutionalization of the impaired elderly who could live more independently, given the proper supports, should not be the result of public action or inaction.

Several aspects of long term care are addressed in Plan policies:

- o Expansion of community-based services to maintain the elderly at home.
- o Development of case management systems to match people to the appropriate mix of services.
- o Availability of community residential alternatives for those who need an out-of-home residential environment less intensive than comprehensive care.
- o Projection of future nursing home capacity consistent with these policy directions.

3. Medical Technology has advanced rapidly, with major effects on the nature of medical practice, costs of care, and quality of care. Future development of high technology equipment and new treatments may have an even more dramatic effect on health care and poses a continuing challenge to regulators. Advanced diagnostic tools and procedures can ultimately result in decreased hospital stays and less surgery. Computerization and advanced communication technology can lead to a decentralization of health care, with less emphasis on the hospital as the focus of treatment. Policies in this area will be presented in the next cycle of plans.

4. Ambulatory Services and Preventive Health Care Services are viewed by the Commission as priorities for increased resources and as focal points for system change. These services are not financially or geographically accessible to the entire population to the extent they should be. Hospital outpatient departments are the primary mode of ambulatory care for much of the poorer population, despite their relative costliness. Preventive health care is not practiced to the extent it should be due to the lack of incentives in the payment system and failure to recognize its longer term payoff.

The Commission's acute care policies address issues related

to hospital outpatient departments and propose incentives to foster cost-effective freestanding ambulatory care providers. Additional policies and plans in this area will be presented in the next planning cycle.

5. Underserved populations continue to experience special problems in gaining access to appropriate medical care. These groups include the uninsured and underinsured, many of whom are unemployed or marginally employed. This so-called "grey area" population is largest in times of economic distress, when public dollars tend to be scarcest. The mentally ill and substance abusers often have difficulty gaining access to appropriate care. These issues are addressed in a variety of ways in the plan sections, and will be dealt with further in the next plan cycle. The issues include:

- o The threat of continuing cost escalation toward the concept of a single class of care regardless of ability to pay. Loss of the Medicare waiver under the rate-setting program would impact the hospital bad debt allowance and access to hospital care by the grey area population.
- o Incentives in the payment system encourage the poor and grey area population to use the most expensive health care settings.
- o Social trends may tend to expand the size of the grey area population (e.g., family disunions, structural unemployment).
- o The role of the public health system in providing care to these groups is not well defined.

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PSYCHIATRIC SERVICES

DEFINITIONS

Acute Psychiatric Services means mental health services provided in a hospital setting to patients with short lengths of stay of generally 30 days or less. The major functions of acute psychiatric care include: crisis intervention, acute treatment, correction of decompensation, prevention of chronicity and the promotion of patient maintenance in the community. The acute psychiatric services covered in this chapter are limited to patients with a mental disease or emotional disorder defined as Diagnosis Related Groups (DRGs) codes 424-428 and 430-432.

Child means an individual ages 0-12.

Adolescent means an individual ages 13-17.

Juvenile Sex Offenders are youth who, prior to their eighteenth birthday, have been charged and subsequently adjudicated for a sexual offense and remain under the jurisdiction of the court and the Department of Juvenile Justice until their twenty-first birthday.

RTC-Appropriate Violent Juvenile Sex Offenders are the most violent, predatory, hard-core and aggressive juvenile sex offenders. These individuals may have serious coexisting mental and behavioral problems and could be multiple offenders. These individuals include serial pedophiles, rapists, and others who are deemed to be of imminent risk to the public safety and therefore must be treated in DJJ admission-controlled facilities.

Child and Adolescent Acute Psychiatric Care treats acute disabling symptoms, including impaired reality testing, disordered or bizarre behavior, psychosis, depression, anxiety, hysteria,

phobias, compulsion, insomnia, and eating disorders. This excludes primary diagnoses of alcohol and drug abuse, mental retardation and organic brain syndrome.

A Residential Treatment Center (RTC) means a related institution as defined in Health-General Article, §19-301 *et seq.*, Annotated Code of Maryland, and licensed under COMAR 10.07.04, that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbance or mental illness who require a self-contained therapeutic, educational, and recreational program in a residential setting whose average length of stay averages between 12 and 18 months. RTCs typically also offer outpatient day treatment services and schooling for children and adolescents who are able to live at home.

Graduate Medical Education National Advisory Committee (GMENAC) Study means a nationally recognized study updated in 1991 that estimates, for the year 2000 & 2010, the prevalence of mental disorders and appropriate norms of care for these disorders across diagnostic classifications and treatment settings.

Multi-agency review teams means a committee of senior officials from the Departments of Health and Mental Hygiene, Human Resources, Education, and Juvenile Justice that review the discharge plan and tracking forms of each State psychiatric hospitalized child who is ready for discharge or whose tracking form indicates possible difficulty in obtaining timely and appropriate discharge to assist in resolving problems that might require interagency action or planning.

Psychoeducational Care means care that increases the physical, intellectual and emotional functioning by extending the client's skills in a variety of areas including: personal hygiene, physical fitness, use of recreational facilities, use of job and educational tools, interpersonal skills, socialization skills, self-control, problem-solving and job-seeking skills.

Proxy Bed Inventories are estimated bed equivalent inventories of State and private psychiatric facilities based on the number of psychiatric patient days for patients whose length of stay is less than or equal to 30 days.

Total Bed Need is the gross bed need projection calculated by the methodology in this chapter.

COMAR 10.24.07

Unadjusted Total Bed Need is the Total Bed Need not adjusted for the 13-17 age population.

Adjusted Total Bed Need is the Total Bed Need adjusted for the 13-17 age population.

Net Acute Psychiatric Bed Need is the Total Bed Need projection minus the inventory which does not include the conversion of State hospital bed need to community beds in acute general and private psychiatric hospitals.

Unadjusted Net Acute Psychiatric Bed Need is the Net Acute Psychiatric Bed Need unadjusted for the 13-17 population.

Adjusted Net Acute Psychiatric Bed Need is the Net Acute Psychiatric Bed Need adjusted for the 13-17 population.

State Hospital Conversion Beds are the Proxy Bed Inventories of the State psychiatric hospitals that are added to the Net Acute Psychiatric Bed Need to obtain a Total Adjusted Net Acute Psychiatric Bed Need.

Total Adjusted Net Acute Psychiatric Bed Need is the sum of the Net Adjusted Acute Psychiatric Bed Need plus the State Hospital Conversion Beds.

POLICIES

1. THE COMMISSION SUPPORTS A STATEWIDE POLICY OF DEINSTITUTIONALIZATION.

It is the Commission's policy that patients be treated in the least restrictive setting appropriate to their condition. The Commission will support a policy of deinstitutionalization, not solely as a means to reduce capital and operating costs in State hospitals but rather as part of a planned continuum of psychiatric services. Deinstitutionalization of the State institutions should not take place until community resources are available to care for individuals in their community.

2. ACUTELY MENTALLY AND EMOTIONALLY ILL ADULTS SHOULD BE CARED FOR IN A DISCRETE PSYCHIATRIC UNIT OF A HOSPITAL RATHER THAN IN A GENERAL MEDICAL/SURGICAL BED.

The quality of care is enhanced if patients receive care in an established unit which is staffed with specialists trained in all aspects of psychiatric care rather than merely receiving care in a medical/surgical bed.

3. **CHILDREN MUST BE TREATED IN SEPARATE PSYCHIATRIC UNITS WITHOUT ADULTS. GENERALLY, ADOLESCENTS AGES 13-17 SHOULD BE TREATED IN A SEPARATE PSYCHIATRIC UNIT FROM THAT OF ADULTS AND CHILDREN.**

For the purpose of the methodology for computing acute psychiatric bed need, children are defined as ages 0-12 and adolescents are defined as 13-17. Due to the variability of psychiatric conditions, some children may be treated in a pediatric or adolescent unit; and some adolescents may be appropriately treated in either a child or adult unit consistent with their psychiatric diagnosis. For the majority, the quality of care is enhanced for children and adolescents when they are treated in a separate unit. Children and adolescents have different therapeutic needs than adults and also require specialized educational and recreational programs. Because the length of stay for children and adolescents tends to be longer than that for adults, it is particularly important that they each be served in a discrete unit designed to meet their special needs.

4. **A FACILITY WHICH OPERATES CHILDREN, ADOLESCENT AND ADULT ACUTE PSYCHIATRIC UNITS IN THE SAME SITE MUST PROVIDE THAT PHYSICAL SEPARATIONS AND CLINICAL/PROGRAMMATIC DISTINCTIONS ARE MADE BETWEEN DIFFERENT PATIENT GROUPS.**

In some regions of the State, the number of needed beds for child and adolescent psychiatric units is small. Requiring units to have separate staffing and to be strictly separated from each other may prevent their development and preclude their availability to the population, due to economic feasibility and staffing considerations. Allowances should be made for each age specific unit to provide both physically and programmatically separate treatment programs. However, the facilities should have the opportunity to save costs by employing staff who are qualified to serve each population. Applicants applying for such service combinations must meet all applicable child, adolescent, or adult standards.

5. **UNLESS ACUTE PSYCHIATRIC SERVICES ARE UNAVAILABLE IN A GEOGRAPHIC AREA, PATIENTS SHOULD NOT BE ADMITTED TO STATE PSYCHIATRIC HOSPITALS FOR ACUTE CARE IF THEY CAN BE MORE APPROPRIATELY TREATED IN GENERAL HOSPITALS OR PRIVATE PSYCHIATRIC HOSPITALS.**

It is the Commission's position that patients should be treated in a general hospital or private psychiatric hospital in lieu of a state hospital. It is recognized in a few instances,

based on geographic accessibility and clinical factors, that state hospitals may have to provide acute care services.

6. ACUTE GENERAL AND PRIVATE PSYCHIATRIC HOSPITALS WITH LICENSED INPATIENT PSYCHIATRIC UNITS SHOULD ADMIT INVOLUNTARY PATIENTS.

Admission and treatment of involuntary patients would improve patient access to acute general and private psychiatric hospitals and reduce the stigma attached to hospitalization by allowing the patient to be placed in a less restrictive setting. The Commission acknowledges that there are some increased costs that must be borne by general hospitals when they accept involuntary patients and encourages the Mental Hygiene Administration to work with general hospitals to provide assistance and financial incentives to accept involuntary patients.

7. THE GENERAL ASSEMBLY, THE GOVERNOR AND THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE ARE ENCOURAGED TO PROVIDE INCREASED FUNDING TO CARE FOR UNINSURED AND UNDERINSURED PSYCHIATRIC PATIENTS ADMITTED TO ACUTE GENERAL AND PRIVATE PSYCHIATRIC HOSPITALS.

Many of the patients currently admitted to state facilities are there because they cannot afford treatment in general hospitals and are not receiving Medical Assistance. For those receiving Medical Assistance, it is recognized that the ceiling on patient days sometimes acts as a barrier to acute psychiatric care.

8. ALL GENERAL HOSPITALS AND PRIVATE PSYCHIATRIC HOSPITALS PROVIDING INPATIENT SERVICES MUST IDENTIFY AND COORDINATE OUTPATIENT MENTAL HEALTH TREATMENT AND SUPPORT SERVICES TO PROVIDE FOR A CONTINUUM OF TREATMENT IN PREPARING EACH PATIENT FOR DISCHARGE. WHERE SUCH SERVICES ARE NOT AVAILABLE IN THE JURISDICTION WHERE THE HOSPITAL IS LOCATED, THE HOSPITAL MUST PROVIDE THESE SERVICES DIRECTLY.

To provide continuity of mental health care, it is imperative that providers identify and coordinate necessary services both for treatment and support to maintain the client at his/her optimum level of functioning within the community. Where access to services does not exist, providers must make available outpatient and support services.

9. **WITHIN ITS REGIONAL GEOGRAPHIC AREA, EACH LOCAL HEALTH PLANNING AGENCY (LHPA) SHALL ALLOCATE THE NUMBER OF BEDS PROJECTED BY THE ACUTE PSYCHIATRIC BED NEED METHODOLOGY. IN NO INSTANCE SHALL THE REGIONAL ALLOCATION EXCEED THE TOTAL NUMBER OF BEDS PROJECTED BY THE CURRENT METHODOLOGY FOR EACH REGION. THE ALLOCATION OF BEDS SHALL BE BASED ON POLICIES AND ASSUMPTIONS APPROVED BY THE LHPA AND THE COMMISSION.**

IF THE LHPA CHOOSES NOT TO ADOPT AN ALLOCATION PLAN OR DOES NOT ADOPT SUCH A PLAN WITHIN THE TIME FRAME AGREED UPON BETWEEN THE COMMISSION AND THE LHPA, THEN THE COMMISSION WILL ASSUME RESPONSIBILITY FOR ALLOCATING THE BEDS NEEDED WITHIN THAT REGION.

The Commission recognizes the value of allowing local community determination regarding where psychiatric beds are needed, and therefore allows the designated LHPA to develop allocation plans for these beds. However, in the event that a LHPA does not provide an allocation plan, the Commission will distribute beds projected as needed in that region.

Standards

The current State Health Plan Overview standards and policies and the current standards of the Overview of Acute Care Section in the State Health Plan shall also apply to the Acute Psychiatric Section. In instances of inconsistency between these standards and the (1983-1988) State Health Plan, these standards supersede. The following specific standards are expressly overridden: OAC 4, OAC 5, OAC 11, and OAC 15, a, b, and c.

Availability

AP 1a. The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

AP 1b. A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

AP 1c. The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

- (i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;
- (ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;

- (iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and
- (iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

AP 1d. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need", as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP 1c.

AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.*

AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.*

AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.*

AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must

*(Unless otherwise exempted by DHMH as provided by Maryland law Health General Article Sec. 10-620(d)(2))

include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

AP 3b. In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

AP 4a. A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

AP 4b. Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Accessibility

AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

- (i) intake screening and admission;
- (ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or
- (iii) necessary evaluation to define the patient's psychiatric problem and/or
- (iv) emergency treatment.

AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.

AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Accessibility: Variant LHPA Standard

(Western Maryland) One-way travel time by car for 90 percent of the population from the jurisdiction(s) where acute psychiatric bed need is identified should be within 30 minutes for adults and 45 minutes for children and adolescents. (This standard supersedes the 1983-1988 State Health Plan Overview Standards 0 1a and 0 1b.

Cost

AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

<u>Psychiatric Bed Range (PBR)</u>	<u>Occupancy Standards</u>
PBR < 20	80%
20 < PBR < 40	85%
PBR > 40	90%

AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (< 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Quality

AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

AP 12b. Staffing of acute psychiatric programs should include therapists for patients without a private therapist and

aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.

AP 12c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Continuity

AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Acceptability

AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

- (i) the local and state mental health advisory council(s);
- (ii) the local community mental health center(s);
- (iii) the Department of Health and Mental Hygiene; and
- (iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Need Projection Methodology

A. Policies

1. A need-based methodology is used to determine acute psychiatric bed need. The purpose in utilizing a need-based methodology is to estimate unmet psychiatric need in a community including the need for services when there are no psychiatric units in a jurisdiction.
2. The methodology addresses the maldistribution of acute psychiatric beds throughout the State and allows for a better distribution of beds to undersupplied areas.
3. The methodology projects bed need for three specific age categories: children 0-12, adolescents 13-17, and adults 18+. It is recognized that certain aged patients on either end of each age group could be treated in a higher or lower age treatment setting. Clinical diagnosis will determine the most appropriate treatment setting.
4. The methodology is adjusted to allow for some patient migration.
5. The methodology takes into account the projected changes in population provided by the Department of State Planning.
6. The methodology uses the inventory of services based upon acute psychiatric care in general medical/surgical hospital beds and pediatric beds used exclusively for psychiatric care, private and state proxy psychiatric beds, and licensed acute psychiatric beds in general hospitals.

7. The methodology uses socio-economic/demographic characteristics of the Maryland population to assist in the calculation of the acute psychiatric bed need projections.
8. The methodology encourages acute psychiatric care providers to treat those patients who would otherwise be admitted to a state psychiatric hospital. The methodology encourages acute general and private psychiatric facilities to sign an agreement with the Mental Hygiene Administration to accept uninsured and underinsured patients, involuntary, and Medicare and Medicaid recipients.
9. The projected acute psychiatric bed need is determined through application of the Commission's methodology. Projections are regionalized by health systems area. Jurisdictional bed need allocations within the regions are based upon criteria, policies and assumptions developed by the local health planning agencies and approved by the Commission.
10. The policies and assumptions used in this methodology will be reviewed on an annual basis. Assumptions which annually can be reviewed and revised, if appropriate, include:
 - population projections,
 - social indicator composite scores,
 - migration data,
 - average length of stay,
 - on-site bed count inventories, and
 - proxy inventories.

11. This methodology includes the diagnosis for neurosis and psychosis and excludes diagnosis of substance abuse, mental retardation, and organic brain syndrome diagnoses. The methodology does not project acute psychiatric bed need for forensic patients.
12. The bed need projections in this methodology are determined for the year 1990. Intermediate years will not be interpolated.

B. Technical Assumptions

1. The Graduate Medical Education National Advisory Committee (GMENAC) Report is used to estimate psychiatric disorder prevalence rates and the percentage of adults and children/adolescents needing acute inpatient care for the year 1990.
2. The 1980 National Institute of Mental Health's Mental Health Demographic Profile and other Maryland specific indicators associated with predicting acute mental illness are used to adjust the bed need methodology.
3. There are separate acute psychiatric bed need projections for children, adolescents, and adults.
4. The On-Site Counts of Acute Care Hospital Beds in Maryland, May 1985, is used to determine the acute psychiatric inventories for the general hospitals. Proxy bed counts for private and state psychiatric hospitals are determined by calculating bed equivalents from the acute utilization in these institutions (LOS < 30 days). Recent Department of Health and Mental Hygiene licensure reports have been used to update inventories, February, 1986.

5. The Health Services Cost Review Commission's Discharge Abstract Tapes and the Washington Council of Governments' discharge tape are used to adjust the methodology for migration.
6. The average length of stay for adults (12.27 days) has been calculated using five year trended data with the assumption that the average length of stay will level off in 1988. The average length of stay is projected through to 1990.
7. An 85% occupancy rate is used in the calculations to project acute psychiatric bed need.

C. Steps for Calculating Acute Psychiatric Bed Need
Methodology Projections

1. Estimate the overall prevalence of mental illness in adults, children and adolescents in the population. Apply the GMENAC set prevalence rates uniformly to the child/adolescent populations for all Maryland counties. The 1990 prevalence rates are 18% for adults (18+) and 25.75% for children and adolescents (0-17).
2. Sum the prevalence estimates for these two age groups into a total uniform prevalence estimate for 1990.
3. Adjust the uniform prevalence estimates by the social indicator composite score values to obtain the number of Marylanders who will need mental health services in the year 1990.

Six social indicators are chosen, standardized, and calculated into a composite score using 1980 data. The composite scores are used for predicting the population in need of mental health services in each jurisdiction of Maryland. This procedure transforms the uniform prevalence estimates into need estimates by a well-defined relationship between the two. This step assumes that the relative distribution of social indicators will not change significantly between 1980-1990.

4. Separate the overall need figures obtained in Step #3 into a children/adolescent and adult need. This separation is calculated according to the ratio of children/adults in the uniform prevalence estimate.
5. The percentage of adults needing psychiatric intervention is 65.97% of the total need for adults (GMENAC projection).
6. The percentage of children/adolescents needing psychiatric intervention is 11.58% of the total children/adolescent need (GMENAC projection).
7. The number of adults who need acute psychiatric hospital care with symptoms of psychoses and neuroses is 4.49% of the total number of adults needing psychiatric intervention (GMENAC projection). This represents the number of adults from Maryland counties who need acute psychiatric treatment anywhere in/out of the state.
8. The number of children/adolescents who need acute psychiatric hospital care with symptoms of psychoses and neuroses is 15.52% of the total number of children/adolescents needing intervention

(GMENAC projection). This represents the number of children from Maryland counties who need acute psychiatric treatment anywhere in/out of the state.

9. The acute psychiatric hospitalization need data are then adjusted for migration out of Maryland to hospitals in Washington, D.C. and Virginia using the most recent Council of Governments hospital utilization tape.

The 1990 out-migration projections to acute general hospitals in the District of Columbia are made on the basis of 1982 out-migration patterns while the Virginia projections are based upon 1981 out-migration patterns. The out-migration discharges are then subtracted from the estimated total acute psychiatric hospitalization need to calculate the number of Maryland residents requiring acute psychiatric hospitalization inside Maryland. This step is done for the two age groups. No adjustment can be made for out-migration to Delaware, Pennsylvania and West Virginia and for out-migration to private/state hospitals due to the lack of data.

10. For each age group, in-migration of non-Maryland residents to Maryland's acute general, state, and private hospitals is added to the projected 1990 acute psychiatric hospitalization need.

It is assumed that in-migration stays at the 1984 level in each jurisdiction. This step produces, for each jurisdiction, the total number of Marylanders and non Marylanders who need acute psychiatric hospitalization in Maryland for 1990.

11. Multiply the adjusted adults-in-need figures by the projected average length of stay of 12.27 days to calculate the 1990 adult patient days.

The same average length of stay is used for all admissions to acute general, state, and private psychiatric hospitals with the objective that state and private facilities should have the same length of stay as exists in acute general facilities.

12. Multiply the adjusted child/adolescent-in-need figures by the projected 1990 ALOS of 21.28 days to calculate the 1990 child/adolescent patient days. This projected ALOS is applied to the total 0-17 population in need of acute psychiatric hospitalization.

13. The projected bed need is obtained by dividing the projected patient days in each HSA by 365 days multiplied by an 85 percent occupancy rate. The projected bed need is calculated separately for the two age groups.

14. The projected bed need is then adjusted for a normal migration factor in and out of the regions within Maryland.

The existing inter-jurisdictional (county) migration patterns reflect both service availability and people's choice. The people's choice component is not distinctly quantifiable, and therefore cannot be identified separately. In order to alleviate this problem to some extent, it is assumed that 50 percent of the migration between regions reflects people's choice. The remaining 50% represents service availability problems and therefore is added back to the region of origin.

15. Identify adult, child, and adolescent acute psychiatric bed inventories.
16. Subtract the combined child/adolescent bed inventory from the total child/adolescent bed need, and subtract the adult inventory from the total adult bed need to obtain the 1990 unadjusted net acute psychiatric need in each age group.
17. a) Child Bed Need 0-12

From the child/adolescent unadjusted total acute psychiatric bed need, subtract 75% of it, reflecting the percentage of acute psychiatric discharges for the age group 13-17 years of the acute psychiatric discharges 0-17 years (C.Y. 84). This is the 0-12 adjusted total child bed need. Subtract the adolescent bed inventory from the child/adolescent combined inventory to calculate the child bed inventory. Subtract the child inventory from the adjusted total child bed need to obtain a net adjusted acute psychiatric child bed need.

- b) Adolescent Bed Need 13-17

Add the 75% of the child/adolescent unadjusted total bed need to the adult total bed need. This is the 13+ adjusted total bed need, adolescent/adults. Use 9% of the total adjusted acute psychiatric bed need, which reflects the percent of population of the 13-17 age group of the 13+ population in 1990, to obtain 13-17 adjusted total bed need. Subtract the adolescent inventory to obtain

the net adjusted acute psychiatric adolescent bed need.

c) Adult Bed Need 18+

Subtract the 13-17 total adjusted bed need from the 13+ total adjusted bed need, to obtain the adjusted total adult bed need, ages 18+. Subtract the adult inventory to obtain the net adjusted acute psychiatric adult bed need.

18. For both age groups, add the state hospital bed-proxy, i.e. state hospital conversion bed need to the net bed need to obtain the total adjusted net acute psychiatric bed need.

The state hospital conversion bed need represents the conversion of state bed need to community need in acute general and private psychiatric hospitals. Applicants for Certificates of Need may apply for conversion beds only if they sign a contract with the Mental Hygiene Administration to admit those individuals who would otherwise be admitted to state hospitals. Preference will be given to applicants applying for the net bed need (without conversion beds) who sign an agreement with the Mental Hygiene Administration to admit those who would otherwise be admitted to state hospitals.

19. Apply HSA Bed Allocation plans

D. ALLOCATION PLANS

1. WMHSA

Policy 1: A Certificate of Need applicant must address all of the policies, criteria, and standards for acute psychiatric services in the State Health Plan.

Criterion 1: Certificate of Need applications for acute psychiatric inpatient beds shall be considered only when proposed beds are to be located in jurisdictions where adjusted net bed need exists using the State methodology (See Volume II).

Standard 1a: The Health Systems Agency of Western Maryland will determine the adjusted net acute psychiatric adult beds for its health service area by jurisdiction. First, the number of adults estimated to need psychiatric inpatient care (See Volume II State Methodology) only for the jurisdictions showing an adjusted net acute bed need is totaled. The percent of the total estimated number of persons in need contributed by each of these jurisdictions is then calculated. This percent distribution of estimated need is then applied to the total number of psychiatric beds projected for the region (health service area) by the State methodology.

- (i) CON applicant(s) proposing to serve the needs of a bi-county area may request the sum of beds allocated to the corresponding jurisdictions by Standard 1a.

- (ii) CON applicant(s) proposing to serve the needs for only a single county shall request the number of beds allocated to that specific jurisdiction by Standard 1a.

Standard 1b: A CON applicant for children/adolescent acute psychiatric beds should request the total number of beds projected by the State methodology. Consistent with the methodology, the applicant may request up to a maximum of 19 child and adolescent psychiatric beds.

- (i) The volume of patients should be sufficient to financially support the number of beds requested for a child/adolescent unit(s).
- (ii) Child/adolescent unit(s) should be located in a jurisdiction where availability and accessibility to this care is most restricted.

Standard 1c: The distribution of "state conversion beds" will follow the same proportional distribution based on need as calculated in Standard 1a for all of the jurisdictions showing adjusted net bed need. CON applicants for these beds must negotiate contracts with the Mental Hygiene Administration for reimbursement.

Criterion 2: Certificate of Need applications for acute psychiatric inpatient beds should improve travel access for persons from the corresponding jurisdiction(s).

Standard 2: One-way travel time by car for 90 percent of the population from the jurisdiction(s) where acute psychiatric bed need is identified should be within:

- o 30 minutes for adults;
- o 45 minutes for children/adolescents.

Policy 2: CON applicants must demonstrate efforts toward the delivery of a systematic and coordinated continuum of mental health services.

Criterion 1: Bi-County Delivery of Care
Preference will be given to applicant(s) for Certificates of Need for acute psychiatric services proposing the delivery of acute psychiatric inpatient services on a bi-county basis.

Standard 1a: Acute psychiatric services will be allocated according to the following sub-regions (bi-county) within the health service area:
o Allegany/Garrett
o Frederick/Washington.

Standard 1b: Certificate of Need applicant(s) proposing a bi-county approach to care should document, through formal memoranda with appropriate facilities/organizations within its respective bi-county area, referral agreements and service protocols for the following groups: the elderly, children/adolescents, involuntary admissions, and indigent patients.

Criterion 2: Single-County Delivery of Care
Single county delivery of care should be consistent with Standard 1a, under Policy 1, Criteria 1.

- Standard 2a: A Certificate of Need applicant for a single county delivery of care should document how it will serve the needs of the following groups: the elderly, children/adolescents, involuntary admissions, and indigent patients.
- Criterion 3: CON applicant(s) proposing acute psychiatric inpatient services must demonstrate coordination with outpatient mental health services providers.
- Standard 3: CON applicants should develop either direct delivery or through referral the following:
- (i) comprehensive outpatient programs with linkages to community mental health organizations;
 - (ii) outreach programs that target at-risk population groups that need psychiatric services;
 - (iii) additional linkages with the community mental health centers within the 30 minute travel time standard; and
 - (iv) emergency psychiatric services.

2. MCHSA

Child and Adolescent Acute Psychiatric Beds

- Standard 1: Preference will be given to Certificate of Need applicants who develop comprehensive outpatient programs with linkages to community mental health organizations.
- Standard 2: Any inpatient unit developed for child or adolescent acute psychiatric services should not be less than 10 beds. If the number of acute psychiatric beds needed for either children or

adolescents is less than 10, preference will be given to CON applicants who propose to develop an acute adolescent psychiatric unit in conjunction with an acute child psychiatric unit. These units shall be separate and distinct but share staffing and other resources.

Standard 3: Preference will be given to Certificate of Need applicants who propose to accept Medicaid patients.

Standard 4: Preference will be given to Certificate of Need applicants who currently provide both inpatient psychiatric and pediatric/adolescent medical services.

3. SMHSA

Policy 1: Adjusted net adult acute psychiatric beds shall be allocated to the Tri-County area (Calvert, Charles, and St. Mary's Counties), and to Southern Prince George's County. Southern Prince George's County is that part of the county south of Route 214 (Central Avenue).

Policy 2: Adolescent and adult state hospital conversion beds shall be allocated on a region-wide (health service area) basis.

Standard 1: A CON applicant shall not be approved for adjusted net adult acute psychiatric care beds unless the applicant also applies for state conversion bed(s).

Policy 3: Adjusted net acute adolescent psychiatric beds shall be allocated to the Tri-County area only.

- Policy 4: Acute child psychiatric beds shall be allocated on a region-wide (health service area) basis.
- Standard 1: Preference will be given to CON applicants who propose to apply for: (1) both child and adolescent services, or (2) both child and adult acute psychiatric services, or (3) the entire child acute psychiatric bed allocation.
- Policy 5: Preference will be given to hospitals which propose to convert excess acute care beds to acute child psychiatric beds.
- Policy 6: The minimum size of all acute psychiatric units should be 15 beds unless a smaller sized unit can be justified for accessibility and staffing reasons. The financial feasibility of such a smaller sized unit must be documented.

4a. CMHSA Children's Acute Psychiatric Bed Distribution

1. The methodology for allocating children's acute psychiatric beds in the Central Maryland region begins with the unadjusted patient need by jurisdiction for children ages 0-12 based on step 10 of the statewide acute psychiatric bed methodology under "Steps for Calculating Acute Psychiatric Bed Need Methodology Projections". The need for ages 0-12 shall be extrapolated from the ages 0-18 need based on the frequency distribution for psychiatric discharges for the current year, by jurisdiction.
2. An adjustment for migration is made following steps 2a through e of the adult allocation methodology, using current year HSCRC hospital discharge data sets for, (a) pediatric admissions and (b) psychiatric admissions, for ages 0-12.

3. The adjusted net need and the distribution of beds using steps 3 and 4 of the adult allocation methodology are then determined.
4. Bed need should then be grouped by subregional totals, as follows:

Subregion A: Baltimore City

Subregion B: Anne Arundel
Baltimore County
Carroll County
Harford County
Howard County

The total number of beds which are needed for all five jurisdictions in Subregion B are combined and may be distributed to any part of that subregion. If the number of beds for Subregion B is less than 6, all of the beds needed for children's acute psychiatric care should go to Baltimore City.

5. Standards to be used to determine which facilities could be CON approved include the following:
 - a. Preference will be given in a comparative review to hospitals which propose to convert excess acute care beds to acute child psychiatric beds.
 - b. Preference will be given in a comparative review to facilities which have: (1) an existing psychiatric unit, or (2) an existing pediatric unit, or (3) a CON application for an adult or adolescent psychiatric unit and an acute child psychiatric unit for a facility with no existing psychiatric unit or pediatric unit.

4b. CMHSA Adolescent Acute Psychiatric Bed Distribution

1. The methodology for allocating adolescent acute psychiatric beds in the Central Maryland region begins with the unadjusted patient need for ages 13-17, based on step 10 of the statewide acute psychiatric methodology under "Steps for Calculating Acute Psychiatric Bed Need Methodology Projections". The need for ages 13-17 shall be extrapolated from the ages 0-18 need, based on the frequency distribution for psychiatric discharges for the current year, by jurisdiction.
2. An adjustment for migration is made following steps 2a through e of the adult allocation methodology, using current year HSCRC hospital discharge data sets for (a) pediatric and medical/surgical/gynecological admissions (combined) and (b) psychiatric admissions, for ages 13-17.
3. The adjusted net need and the distribution of beds using steps 3 and 4 of the adult allocation methodology are then determined.
4. Bed need is then be grouped by subregional totals, as follows:

Subregion A: Baltimore City

Subregion B: Anne Arundel
Baltimore County
Carroll County
Harford County
Howard County

The total number of beds which are needed for all five jurisdictions in Subregion B are combined and may be distributed to any part of the subregion.

5. Standards to be used to determine which facilities could be CON approved include the following:
 - a. Preference will be given in a comparative review to hospitals which propose to convert excess acute care beds to adolescent psychiatric beds.
 - b. Preference will be given in a comparative review to facilities which have: (1) an existing psychiatric unit, or (2) have submitted a CON application for an adult or child acute psychiatric unit and an adolescent psychiatric unit for a facility with no existing psychiatric unit.
 - 4c. CMHSA Adult Acute Psychiatric Bed Distribution
 1. The methodology for allocating adult care psychiatric beds in the Central Maryland region begins with the unadjusted patient need by jurisdiction for persons ages 18+ based on step 10 of the statewide acute psychiatric methodology under "Steps for Calculating Acute Psychiatric Bed Need Methodology Projections".
 2. An adjustment for migration is made as follows:

- a. Begin with the matrices showing patient inflow and outflow for all central Maryland counties, using current year data from the HSCRC hospital discharge data set for, (a) medical/surgical gynecological admissions, and (b) psychiatric admissions, for ages 18+.
 - b. Develop percentages of patient inflow/outflow for each matrix cell.
 - c. Assume 50% of inflow from other Maryland regions will continue, and add it in. Subtract 50% of outflow to other Maryland regions from the jurisdictional need totals.
 - d. Distribute the remaining jurisdictional need over the jurisdictions based on the percentages of patient inflow/outflow for M/S/G and psychiatric based matrices. Sum the need for each jurisdiction, and calculate the percentage of total need for each jurisdiction.
 - e. Average the percentage need for the two approaches (M/S/G and psychiatric) by jurisdiction.
3. For each jurisdiction, multiply the percentage need by the total need; and subtract the existing beds from the total need to get net need. Add the additional state need to obtain the adjusted net need.
 4. Determine the distribution of beds by the following approach:
 - a. The total of beds given to jurisdictions shall equal the total adjusted net need for the region, using the Commission's methodology to determine regional need. Beds will be allocated to jurisdictions which have a

positive adjusted net need from step 3 above. If there is a negative net need, the jurisdiction will be considered to have "zero" need.

- b. The beds will be distributed so that each jurisdiction with unmet need has the same percentage of its total need met, where total need includes calculated need plus additional state need.
- c. Prior to July 1, 1987, beds shall only be allocated to hospitals located in jurisdictions which have been identified by this allocation plan as needing beds. The number of acute psychiatric beds approved for any hospital shall not exceed the number of beds identified as needed in the jurisdiction.

If an application has not been received by the Commission from a hospital located in the jurisdiction of need by July 1, 1987, hospitals from adjacent jurisdictions in Central Maryland may be allocated the beds if the applicant: (1) demonstrates a commitment to serve residents from the jurisdiction of need; (2) provides written documentation, at the time of CON review of the application, of such commitment, including but not limited to transfer agreements, patient origin data, case finding efforts, and agreements with mental health agencies of the jurisdiction in need; and (3) agrees to provide future documentation, as the Commission may request regarding its obligation to serve the patients from the jurisdiction in need.

5. ESHSA

Policy 1: Adult acute inpatient psychiatric beds will be allocated according to existing mental health catchment areas. These areas and the jurisdictions therein are as follows:

Upper Eastern Shore - Cecil, Kent, Queen Anne's, Caroline and Talbot

Lower Eastern Shore - Dorchester, Wicomico, Somerset and Worcester countries

Policy 2: There should be an equitable geographical distribution of beds. Allocation of beds between the mental health catchment areas will be approximately equal and will be guided by the difference in size of population between the two areas. Beds should be distributed so as to yield equal bed to population ratios. Approximately equal allocation is defined as varying by no more than 7-10 beds.

Policy 3: Allocation of acute adult psychiatric beds will be limited to acute care general hospitals. Allocation of acute child and adolescent beds will be limited to acute care general hospitals unless an applicant:

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- (a) agrees to admit and treat Medicaid patients; and
- (b) documents strong referral agreements with the closest or next closest local acute care general hospital which is designated as an emergency psychiatric care facility in Maryland.

Policy 4: A discrete adult inpatient psychiatric unit shall be no less than 15 and no more than 25 beds.

Policy 5: Certificate of Need applicants for discrete adult inpatient psychiatric services in an acute care hospital should consider accepting patients from State psychiatric facilities.

[The next page is AP-35 (113.15)]



Policy 6: The acute inpatient psychiatric beds for children or adolescents shall be considered as a regional need. Therefore there may only be one child and one adolescent acute psychiatric unit to serve the Eastern Shore region.

Policy 7: Certificate of Need applicants proposing to develop acute inpatient psychiatric services for children or adolescents shall provide assurance that the appropriate service professionals are, or will be, available.

Policy 8: Preference will be given to Certificate of Need applicants who propose to provide child and/or adolescent acute psychiatric services and who provide access to less intensive child and adolescent psychiatric services, such as outpatient, day care, and counseling services in schools, and as a result of the development of these less intensive services, will provide additional employment opportunity in the service area for qualified child and adolescent psychiatric care providers.

E. METHODOLOGY FORMULAESTEP 1

$CAP_{(1..24)}$ = 1990 Population Ages 0-17 in Maryland's 24 Jurisdictions

$AP_{(1..24)}$ = 1990 Population Ages 18+ in Maryland's 24 Jurisdictions

PR_1 = 1990 Mental Illness Prevalence Rate for 0-17 in Maryland (GMENAC)

PR_2 = 1990 Mental Illness Prevalence Rate 18+ in Maryland (GMENAC)

$PRC_{(1...24)}$ = $CAP_{(1...24)} * PR_1$ = (1990 Prevalence Estimate for Children and Adults, 0-17)

$PRA_{(1...24)}$ = $AP_{(1...24)} * PR_2$ = (1990 Prevalence Estimate for Adults, 18+)

STEP 2

$UTP_{(1...24)}$ = $PRC_{(1..24)} + PRA_{(1..24)}$ = Uniform Total Prevalence (UTP)

STEP 3

$(1..24)_X(1..6)$ = value of each of the six indicators in each jurisdiction

$X_{(1..6)}$ = mean value for the state

S.D. = standard deviation

Z score = $\frac{x - X}{S.D.}$

$PPND_{(1...24)}$ = $UTP_{(1...24)} * (1 + .2z)$ = (Population in Need)

STEP 4

$$ADJ1_c(1...24) = \frac{PRC(1...24)}{UTP(1...24) * PPND(1...24)}$$

$$ADJ1_a(1...24) = \frac{PRA(1...24)}{UTP(1...24) + PPND(1...24)}$$

STEPS 5 & 6

CRI = percentage of children requiring intervention out of those at risk (GMENAC)

ARI = percentage of adults requiring intervention out of those at risk (GMENAC)

$$ADJ1_c(1...24) * CRI(1...24) = ADJ2_c(1...24)$$

$$ADJ1_a(1...24) * ARI(1...24) = ADJ2_a(1...24)$$

STEPS 7 & 8

CAC = percentage of children needing acute care of those requiring intervention

AAC = percentage of adults needing acute care of those requiring intervention

$$ADJ2_c(1...24) * CAC(1...24) = ADJ3_c(1...24)$$

$$ADJ2_a(1...24) * AAC(1...24) = ADJ3_a(1...24)$$

STEP 9

OMC = out-migration for children

OMA = out-migration for adults

PCRC = population change ratio for 0-17 in Maryland

PCRA = population change ratio for 18+ in Maryland

OMC * PCRC = 0-17 adjusted out-migration for 1990 (OMC₁)

OMC * PCRC - 18+ adjusted out-migration for 1990 (OMA₁)

ADJ3_c (1...24) - OMC₁ (1...24) = ADJ4_c (1...24)

ADJ3_a (1...24) - OMA₁ (1...24) = ADJ4_a (1...24)

STEP 10

IMC (1...24) = in-migration for children, 1984.

IMA (1...24) = in-migration for adults, 1984

ADJ4_c (1...24) + IMC (1...24) = ADJ5_c (1...24)

ADJ4_a (1...24) + IMA (1...24) = ADJ5_a (1...24)

STEPS 11, 12, 13

ALOSC = 1990 Projected average length of stay for
children for acute psychiatric care

ALOSA = 1990 Projected average length of stay for

adults for acute psychiatric care

APDC (1...24) = $ADJ5_c(1...24) * ALOSC$ = (1990 acute psychiatric patient days for children)

APDA (1...24) = $ADJ5_a(1...24) * ALOS$ = (1990 acute psychiatric patient days for adult)

STEP 14

APBC (1...24) = $\frac{APDC(1...24)}{365 * .85}$ = (1990 acute psych beds needed for children)

APBA (1...24) = $\frac{APDA(1...24)}{365 * .85}$ = (1990 acute psych beds needed for adults)

.51HSAMC = half of the inter-HSA (M_1) migration for children

.51HSAMA = half of the inter-HSA (M_2) migration for adults

APBC (1...24) (+) M_1 = $ADJ6_c(1...24)$

APBA (1...24) (+) M_2 = $ADJ6_a(1...24)$

STEP 15

Child

LPC = licensed psychiatric beds for children

LPDC = licensed pediatric beds being used exclusively for psychiatric care

PPC = proxy private children beds

POSC = proxy other state children beds
PRSC = proxy regional state children beds

LPC+LPDC+PPC+POSC+PRSC = Total Acute Child Psychiatric
Inventory (TACPI)

Adolescents

LPAD = licensed psychiatric beds for adolescents
PPDA = proxy private adolescent beds
POSAD = proxy other state adolescent beds
PRSAD = proxy regional state adolescent beds
LPAD + PPAD + POSAD + PRSAD = Total Acute Adolescent
Psychiatric Bed Inventory (TAAPI)

Adults

LPA = licensed psychiatric beds for adults
LMSA = licensed medical/surgical beds being used for
psychiatric care
PPA = proxy private adult beds
POSA = proxy other state adult beds
PRSA = proxy regional state adult beds

LPA+LMSA+PPA+POSA+PRSA = Total Acute Adult Psychiatric
Inventory (TAAPI)

STEP 16

(1...5) represents values for the five HSAs.

$BNCAD_{(1...5)} = ADJ6_C_{(1...5)} - TACPI_{(1...5)} = \text{Net}$
Child/Adolescent Acute Psychiatric Bed Need (BNC_1)

$BNA_{(1...5)} = ADJ6_a_{(1...5)} - TAAPI_{(1...5)} = \text{Net Adult Acute}$
Psychiatric Bed Need (BNA_1)

STEP 17

$BNCAD_{(1...5)} * .75 = \text{13 through 17 Acute Psychiatric Bed Need}$
Adjustment for Adolescents (13-17 APBNA) (1...5)

$BNCAD_{(1...5)} - (13-17 APBNA)_{(1...5)} = BNC_{(1...5)}$ Bed Need
for Children, 0-12

$BNA_{(1...5)} + (13-17 APBNA)_{(1...5)} = BNADA_{(1...5)}$ Bed Need
for Adolescents/Adults

$BNADA_{(1...5)} * .09 = BNAD_{(1...5)} = BNA1_{(1...5)}$ Adjusted Bed
Need for Adults, 18+

Step 18

$BNC_{(1...5)} + (POSC + PRSC)_{(1...5)} = \text{Total Acute Psychiatric Bed Need for Children, 0-12}$

$BNAD_{(1...5)} + (POSAD + PRSAD)_{(1...5)} = \text{Total Acute Psychiatric Bed Need for Adolescents}$

$BNA_1_{(1...5)} + (POSA + PRSA) = \text{Total Acute Psychiatric Bed Need for Adults}$

Step 19

Apply HSA bed allocation plans.

F. Residential Treatment Centers for Juvenile Sex Offenders.

(1) Bed Need.

(a) The Commission will approve no more than four residential treatment center (RTC) units for RTC-appropriate violent juvenile sex offenders until 1998.

(b) The Commission bases bed need on the following:

(i) The Department of Juvenile Justice estimates that 1,100 violent juvenile sex offenders will be referred by the end of 1997.

(ii) 6.5 percent of juvenile sex offenders are estimated to require RTC placement by the Department of Juvenile Justice.

(iii) This results in a gross bed need of 72 beds.

(iv) The 1995 20-bed RTC inventory for juvenile sex offenders is subtracted, resulting in a maximum of 52 beds that will be needed in 1998.

(c) The Department of Juvenile Justice will supply the Commission; the Subcabinet for Children, Youth, and Families; and the State Coordinating Council with revised data to update the bed need beyond 1998.

(2) **Certificate of Need Review Standards.** Except as provided in (n) below, the Commission will use the following standards to review applications to provide residential treatment center care to RTC-appropriate violent juvenile sex offenders.

(a) *Need.* Each applicant shall document the need for residential treatment center care for the juvenile sex offender population in the community it intends to serve, consistent with F(1)(b) above.

(b) *Age- and Sex-Specific Programs.* Each applicant shall document age- and sex-specific programs, and provide a separate therapeutic environment and, to the extent necessary, a separate physical environment consistent with the treatment needs of each group it proposes to serve.

(c) *Special Clinical Needs.* Each applicant shall document treatment programs for developmentally-disabled youth and for those youth who have major psychiatric diagnoses in addition to their sex-offending behavior.

(d) *Minimum Services.* Each applicant shall propose and document services which include, at a minimum: patient supervision, assessment, screening, evaluation including psychiatric evaluation, psychological testing and individual treatment plan; ward activities; individual, group and family treatment; patient and family education; medication management; treatment planning; case management; placement and aftercare/discharge planning.

(e) *Treatment Planning and Family Involvement.* Each applicant shall document that the required minimum services will be provided by a coordinated multi-interdisciplinary treatment team that addresses daily living skills within a group setting; family involvement in treatment to the greatest extent possible, restoration of family functioning; and any other specialized areas that the individualized diagnostic and treatment process reveals is necessary for the patient and family.

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(f) *Education.* Each applicant shall document that it will:

(i) Provide comprehensive educational program that includes general, special education, pre-career and technology instruction consistent with **COMAR 13A.05.01 and COMAR 13A.09.09 Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities;**

(ii) Provide educational services for Level V non-public and Level VI students on the same campus as the treatment facility;

(iii) Enter into agreements with local education agencies for the education of all other students; and

(iv) Provide a pre-vocational and vocational program that provides a variety of training programs for students who require job training.

(g) *Medical Assistance.* Each applicant shall meet Maryland Medical Assistance Program requirements to establish an Early and Periodic Screening and Diagnosis and Treatment program, called "Healthy Kids" in Maryland.

(h) *Staff Training.* Each applicant shall document that it will:

(i) Provide a minimum of 40 hours of training to new employees prior to their assuming full job responsibilities;

(ii) For each category of direct service personnel in Section (2)(i)(i) below, provide the curriculum for this training and show how the training will help staff meet the clinical needs of this population; and

(iii) Provide a continuing education programs for all categories of direct-service personnel.

(i) *Staffing.*

(i) Except as provided in (iii) and (iv) below, each applicant shall propose at least the following full-time equivalent (FTE) direct-care staffing positions for each 26-bed unit:

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<i>Discipline</i>	<i>Number of FTEs</i>
Registered Nurses	7.0
Direct Care Workers/Aides	7.0
Mental Health Counselors/Associates	17.0-21.0
Psychiatrist	1.0
Psychologist	1.0
Speech Pathologist/Audiologist	0.3
Occupational Therapist	1.0
Recreational Specialists	2.0
Art, Dance, and Music Specialist	1.0
Social Workers	2.0
Total FTEs	39.3-43.3.

(ii) The applicant shall document how the level of staffing will provide active treatment and fulfill the goals of its proposed treatment programs.

(iii) The applicant may adjust the staffing mix, but not the number of minimum full-time equivalent direct-care staff in Section (2)(i)(i), only if it documents how its revised staffing mix will meet the treatment needs of patients and that the mix is consistent with its treatment program and philosophy of the facility.

(iv) The applicant may adjust the staffing mix and the number of full-time equivalent direct-care staff in Section (2)(i)(i) only if the applicant is applying for 13-20 RTC beds under Section F(1) and documents that the number and mix of staff will meet the needs of RTC-appropriate violent juvenile sex offenders. No less than 22 full-time equivalent direct-care staff may be proposed for units of 13-20 beds.

(j) *State Regulations.* Each applicant shall document its compliance, or state its intention to comply, with all mandated federal, State, and local health and safety regulations and applicable licensure and certification standards.

(k) *Accreditation and Certification.* Each applicant proposing a new facility shall agree in writing to apply for JCAHO accreditation and Medicaid certification as soon as permissible after opening.

(l) *Criminal Background Investigations.* Each applicant shall document its procedure for:

(i) Complying with Family Law Article, §5-560 through 568, Annotated Code of Maryland, governing criminal background investigations for employees; and

(ii) Subjecting volunteers to criminal background investigations.

(m) *Security.* Each applicant shall document a comprehensive plan to maintain security both on- and off-site. Within the comprehensive security plan, the applicant shall document:

(i) A program and a physical plant that takes into consideration public safety;

(ii) An elopement prevention program;

(iii) Physical site security deficiencies and programmatic remedies for these deficiencies;

(iv) Staff training in the use of appropriate and safe physical restraint techniques; and

(v) Situations that warrant one-to-one, group, and off-site programming and security measures and supervision to effectively ensure the safety of staff, youth, and the community in these situations.

(n) *Quality of Care Review by Licensing and Certification Administration.* The Commission shall review applications against standards (d), (h), (i), and (l) until the

Licensing and Certification Administration amends COMAR 10.07.04 Related Institutions--Residential Treatment Centers for Emotionally Disturbed Children and Adolescents to include quality of care standards addressing the subjects of these standards.

(3) **Certificate of Need Preference Rules.** In a comparative review, the Commission will give preference to applications for residential treatment centers for juvenile sex offenders that address one or more of the following criteria:

(a) *Meeting Special Needs.* The applicant proposes to treat individuals who, in addition to their sexual abuse disorder, are arsonists, assaultive or highly-aggressive emotionally disturbed individuals, dually-diagnosed (mentally-ill, addicted or developmentally-disabled) individuals, or physically-disabled individuals.

(b) *Community-Based Services.* The applicant proposes to provide aftercare services for juvenile sex offenders in community-based settings, such as shelters, short-term residential care, therapeutic group homes, respite care, alternative living units, day treatment programs, outpatient, and other community-based transitional settings.

(c) *Excess Capacity.* The applicant proposing to use excess health care facility capacity or existing buildings to house these facilities.

(d) *Linkage With Existing Institutions.* The applicant proposes to provide services on the same campus with other related health care services or an institution providing services to other kinds of juvenile delinquents.

(4) **Certificate of Need Approval Rules.**

(a) *Maximum Unit Size.* The Commission will approve a Certificate of Need application for residential treatment center beds for juvenile sex offenders only if each unit has 13 or fewer beds.

(b) *Maximum Facility Size.* The Commission will approve a Certificate of Need application for a residential treatment center exclusively for RTC-appropriate violent juvenile sex offenders only when the resulting facility would have 26 or fewer beds.

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(c) *DJJ Admission Control.* The Commission will approve a Certificate of Need application for residential treatment center beds for juvenile sex offenders only if the applicant agrees:

(i) To exclusively serve RTC-appropriate violent juvenile sex offenders;

(ii) That DJJ will have exclusive control over admissions to the units approved in accordance with this regulation, consistent with federal Certification of Need for Services standards for each child found in 42 CFR 441.1152, which requires an independent team to certify the need for inpatient psychiatric treatment and, in this case, the medical need for RTC level of care;

(iii) Whenever the program has openings, to accept all referrals from the Maryland Department of Juvenile Justice;

(iv) To conform to the Department of Juvenile Justice priority for admissions, should a waiting list occur; and

(v) To delicense approved beds upon expiration or cancellation of a DJJ contract.

(5) **Performance Requirements.** The Commission will use the following requirements to review compliance with this Chapter after a Certificate of Need is granted:

(a) *Monthly Reporting.* Each applicant shall commit to reporting revenue and cost data, changes in licensed capacity, utilization data, and patient-specific data, including demographic data, admission and discharge data, and diagnostic and functional data to the Department of Juvenile Justice in a form and format specified by the DJJ, or any other Department of Health and Mental Hygiene or interagency data acquisition system acceptable to the Subcabinet for Children, Youth, and Families.

(b) *Annual Report.* The applicant shall commit to prepare an annual report and send it to the Commission to address its compliance with this Chapter.

G. Interim Residential Treatment Center Capacity.

(1) Core Principles.

(a) A seamless child and adolescent mental health system that offers a comprehensive continuum should be available in Maryland.

(b) In-state resources should be developed to meet the mental health needs of children and adolescents.

(c) The Maryland child and adolescent mental health system should evaluate the efficacy of programs based upon outcome measures.

(2) Bed Need.

(a) The Commission will approve no more than three residential treatment center (RTC) units for adolescents ages 12-17. The Commission may approve only two 12-bed adolescent RTC units in CY 1997. The Commission may approve one additional 12-bed adolescent RTC unit in C.Y. 1998 only if a review of RTC utilization deems it necessary that additional RTC capacity is required. The data for this analysis will be provided by the Mental Hygiene Administration and a final determination will be made by the Commission.

(b) The Commission will approve the above three RTC units only in special hospital-psychiatric facilities with excess capacity located within the Central Maryland region. These units shall be dually licensed as special psychiatric-hospital and RTC beds.

(c) The Commission will approve no less than 12 RTC beds in each unit.

(d) The Commission bases bed need on the following:

(i) There are approximately 80 adolescents in State or private psychiatric hospitals or in State custody that require intensive psychiatric treatment services.

(ii) Approximately 40 of these children require RTC care.

(iii) Three 12-bed RTCs will serve older adolescents ages 12-17.

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(e) The Subcabinet will supply to the Commission revised data to update the bed need. The Commission must receive a quarterly report from the Subcabinet that addresses funding for community-based services, utilization of RTC beds, and the number of children and adolescents treated in RTCs that are awaiting placement and the impact of the 1115 waiver upon this waiting list.

(3) Commission will use the following standards to review applications to provide residential treatment center care.

(a) *Need.* Each applicant shall document the need for residential treatment center care in the community it intends to serve, consistent with G(2)(a)-(e) above.

(b) *Sex-Specific Programs.* Each applicant shall document sex-specific programs, and provide a separate therapeutic environment and, to the extent necessary, a separate physical environment consistent with the treatment needs of each group it proposes to serve.

(c) *Special Clinical Needs.* Each applicant shall document treatment programs for those youth with a coexisting mental health and a developmental disability.

(d) *Minimum Services.* Each applicant shall propose and document services which include, at a minimum: patient supervision, assessment, screening, evaluation including psychiatric evaluation, psychological testing and individual treatment plan; ward activities; individual, group and family treatment; patient and family education; medication management; treatment planning; case management; placement and aftercare/discharge planning.

(e) *Treatment Planning and Family Involvement.* Each applicant shall document that the required minimum services will be provided by a coordinated multi-interdisciplinary treatment team that addresses daily living skills within a group

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setting; family involvement in treatment to the greatest extent possible, restoration of family functioning; and any other specialized areas that the individualized diagnostic and treatment process reveals is necessary for the patient and family.

(f) *Education.* Each applicant shall document that it will:

(i) Provide a comprehensive educational program that includes general, special education, pre-career and technology instruction consistent with COMAR 13A.05.01 and COMAR 13A.09.09 Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities;

(ii) Provide educational services for Level V non-public and Level VI students on the same campus as the treatment facility;

(iii) Enter into agreements with local education agencies for the education of all other students; and

(iv) Provide a pre-vocational and vocational program that provides a variety of training programs for students who require job training.

(g) *Medical Assistance.* Each applicant shall meet Maryland Medical Assistance Program requirements to establish an Early and Periodic Screening, Diagnosis, and Treatment program, called in Maryland, "The Maryland Healthy Kids Program".

(h) *Staff Training.* Each applicant shall document that it will:

(i) Provide a minimum of 40 hours of training to new employees prior to their assuming full job responsibilities;

(ii) For each category of direct service personnel provide the curriculum for this training and show how the training will help staff meet the clinical needs of this population; and

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(iii) Provide a continuing education program for all categories of direct-service personnel.

(i) *Staffing.*

(i) The applicant shall document that it will provide, either directly or by agreement, sufficient number of qualified professional, technical, and supportive staff to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by a comprehensive assessment and individualized treatment and education plan.

(ii) The applicant shall document how the level of staffing will provide active treatment and fulfill the goals of its proposed treatment programs and meet the needs of the patients.

(j) *State Regulations.* Each applicant shall document its compliance, or state its intention to comply, with all mandated federal, State, and local health and safety regulations and applicable licensure and certification standards.

(k) *Accreditation and Certification.* Each applicant proposing a new facility shall agree in writing to apply for JCAHO accreditation and Medicaid certification as soon as permissible after opening and be jointly licensed as a Special Hospital-Psychiatric Facility (COMAR 10.07.01) and as a Residential Treatment Centers (COMAR 10.07.04).

(l) *Criminal Background Investigations.* Each applicant shall document its procedure for:

(i) Complying with Family Law Article, §5-560 through §568, Annotated Code of Maryland; governing criminal background investigations for employees; and

(ii) Subjecting volunteers to criminal background investigations.

(m) *Security.* Each applicant shall document it can provide capacity to provide care in secure units, as necessary.

(4) **Certificate of Need Preference Rules.** In a comparative review, the Commission will give preference to applications for residential treatment centers that address one or more of the following criteria:

(a) *Meeting Special Needs.* The applicant proposes to treat individuals who are arsonists, assaultive or highly-aggressive emotionally disturbed individuals, dually-diagnosed (mentally-ill, addicted or developmentally-disabled) individuals, or physically-disabled individuals.

(b) *Community-Based Services.* The applicant proposes to provide aftercare services in community-based settings, such as shelters, short-term residential care, therapeutic group homes, respite care, alternative living units, day treatment programs, outpatient, and other community-based transitional settings.

(5) **Certificate of Need Approval Rules.**

(a) *Minimum Unit Size.* The Commission will approve a Certificate of Need application for residential treatment center beds only if each unit has no less than 12 beds.

(b) *Multi-Agency Review Team (MART) Admission Control.* The Commission will approve a Certificate of Need application for residential treatment center beds only if the applicant agrees:

(i) To exclusively serve patients referred by the MART;

(ii) That the MART will have exclusive control over admissions to the units approved in accordance with COMAR 01.04.03 and with federal Certification of Need for Services standards found in 42 CFR 441.1152, which requires an independent team to certify the need for inpatient psychiatric treatment and, in this case, the medical need for RTC level of care;

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(iii) Whenever the program has openings, to accept all referrals from the MART;

(iv) To conform to the MART priority for admissions, should a waiting list occur;

(v) To delicense approved RTC beds upon expiration or cancellation of an agreement signed with the MART; and

(vi) To sign a written agreement with the MART implementing (i)-(v).

(c) The Commission will approve the RTC on a time-limited basis that will be reviewed for continued consistency with all applicable review standards and bed need two years after the opening date of these RTCs.

(d) If the Commission concludes that the RTC is no longer consistent with these standards or is no longer needed, and the applicant does not delicense the beds, the Commission may initiate proceedings to withdraw the CON.

(e) The applicant must dually license the unit as a residential treatment center and special hospital-psychiatric facility and notify the Commission and the Licensing and Certification Administration of the facility's current use. Each applicant must agree that it will use these dually-licensed units as a residential treatment center.

(f) Mixed use of a unit for both hospital and residential treatment is prohibited.

(6) **Performance Requirements.** The Commission will use the following requirements to review compliance with this Chapter after a Certificate of Need is granted:

(a) *Monthly Reporting.* Each applicant granted a Certificate of Need shall commit to reporting revenue and cost data, changes in licensed capacity, utilization data, and patient-specific data, including demographic data, admission and discharge data, and diagnostic and functional data to the Department of Health and Mental Hygiene or

interagency data acquisition system acceptable to the Subcabinet for Children, Youth, and Families.

(b) *Annual Report.* The applicant granted a Certificate of Need shall prepare an annual report and send it to the Commission to address its compliance with this Chapter. The annual report shall describe the measures used by the facility to evaluate patient outcomes and analyze the extent to which expected outcomes were achieved.

(The next page is EMS-1)

EMERGENCY MEDICAL SERVICES**Definition**

Emergency medical services (EMS) may be defined as services utilized in responding to a perceived need for immediate medical care to prevent death or aggravation of physiological illness or injury.

Policies

1. **STATE AGENCIES SHOULD WORK TOGETHER TO SECURE LEGISLATION TO ASSIST IN PREVENTING AVOIDABLE ILLNESS, DISABILITY, AND DEATH.**

The operational costs of an EMS system as well as the medical expenses of EMS patients are high. With our growing understanding of the causes of and risk factors for certain diseases and conditions, opportunities are present to promote change in individual attitudes and life styles and to reduce societal barriers to improved health through the development of health promotion and prevention programs and passage of appropriate legislation.

2. **THERE SHOULD BE A SUFFICIENT NUMBER OF PROGRAMS TO TRAIN THE PREHOSPITAL PHASE PERSONNEL NEEDED STATEWIDE.**

The lack of training programs has been cited as an important cause of an inadequate number of individuals trained at the basic level recommended for prehospital phase ambulance personnel.

3. **DETERMINATIONS OF CRITICAL CARE AND MEDICAL/SURGICAL BED NEED TO SERVE EMS PATIENTS ARE PART OF THE MEDICAL/SURGICAL/GYNECOLOGICAL BED NEED PROJECTIONS IN THE ACUTE CARE SECTION OF THIS PLAN.**

Emergency patients requiring hospitalization are admitted to critical care or medical/surgical beds. Care of emergency patients is only one factor affecting the number of critical care and medical/surgical beds required. Thus, bed need projections are considered in the context of the total demand for such beds.

4. THE COMMISSION WILL CONTINUE TO WORK WITH MIEMSS IN EVALUATION OF THE EMS SYSTEM.

Because both the Commission and MIEMSS are empowered to plan for emergency care in the state, it is important that they cooperate in planning for and evaluating services. Areas of primary concern include establishing a core data base for the assessment of care provided in the prehospital phase; determining the number and type of prehospital phase personnel required to meet state needs; assuring that transport services are available to all Marylanders, and developing mechanisms for the designation of specialty referral centers.

5. THE COMMISSION SUPPORTS THE EXISTING STATEWIDE EMS SYSTEM AND STRONGLY ENCOURAGES IMPROVED COOPERATIVE ARRANGEMENTS WITH NEIGHBORING JURISDICTIONS, PARTICULARLY THE DISTRICT OF COLUMBIA.

To date, an interstate agreement for transport of patients exists only between Maryland and West Virginia. Agreements are needed with, Washington, D.C., Virginia, Delaware, and Pennsylvania.

6. EMERGENCY ROOMS SHOULD BE USED FOR EMERGENCY AND URGENT SERVICES AND NOT FOR THE PROVISION OF PRIMARY CARE.

Use of emergency rooms for primary services is not preferable for several reasons. Not only are such desirable elements as comprehensiveness and continuity of services difficult to achieve in this setting, but cost of the visit is higher than in other ambulatory settings.

7. DECISIONS REGARDING REGULATION OF FREESTANDING EMERGENCY CENTERS WILL BE MADE ONLY WHEN DATA REGARDING SUCH FACILITIES IN MARYLAND HAVE BEEN COLLECTED AND EVALUATED.

A recent development in the provision of emergency services is the establishment of freestanding emergency centers. Because these centers focus on the delivery of ambulatory care, they compete with both hospitals and private physicians. Questions have been raised about misleading the public by use of the term "emergency" in their title and about cost-benefit and quality of care issues. The number of freestanding emergency centers is difficult to determine because they are not subject to approval or regulation.

Standards

Availability: Prehospital Services

EMS 1. There should be an adequate number of ambulances to meet established response times: 10 minutes for metropolitan and 20 minutes for rural areas for 95% of the calls. (Response time is the time elapsed between the call reaching the dispatch center or ambulance company and assistance arriving on the scene.)

Accessibility: Prehospital Services

EMS 2a. Access to transport services must not be constrained because of residency requirements of patients or geographical restrictions.

EMS 2b. Emergency transport must be provided without prior inquiry of the patient's ability to pay.

EMS 2c. A central statewide communications system should link all personnel, facilities, and equipment of the emergency system.

EMS 2d. The 911 system should be implemented in all Maryland counties by 1985.

EMS 3. Written agreements should exist between Maryland and its contiguous states for transport of patients to the nearest appropriate medical facility.

Quality: Prehospital Services

EMS 4a. All ambulance and helicopter personnel providing care to patients should be graduates of approved training programs and be certified and recertified according to state standards.

EMS 4b. Core data on patients transported should be collected by all ambulance companies in the state. This information should become a part of the patient's permanent medical record. The hospital is not responsible for the completeness or accuracy of the information on the ambulance run sheet.

Availability: Hospital Services

EMS 5. Areawide trauma centers must be capable of meeting MIEMSS' established standards prior to their designation.

EMS 6. Critical care beds must be available consistent with the medical/surgical/gynecological bed need projections in the acute care section of this Plan.

EMS 7. Emergency care for life-threatening and urgent problems must be provided without prior inquiry or proof of ability to pay.

Cost: Hospital Services

EMS 8a. There should be written protocols for prehospital

phase personnel for the triage of patients to the most appropriate hospital capable of caring for their problems.

EMS 8b. There should be an annual evaluation by MIEMSS, in conjunction with the participating hospitals, to assess whether proper triage by the EMS transport system is occurring.

Quality: Hospital Services

EMS 9. MIEMSS should establish criteria for the designation and evaluation of specialty centers.

EMS 10. The patient medical record should include care received in both the prehospital and hospital phases. This record should serve as the link for rehabilitative services and for follow-up services with the patient's usual source of care.

Need Projection Methodology

No projection of service needs in non-regulated settings has been developed for this Plan. Projection of critical care and medical/surgical/gynecological bed needs by emergency patients are included with the general projections for these two services elsewhere in the Plan.

