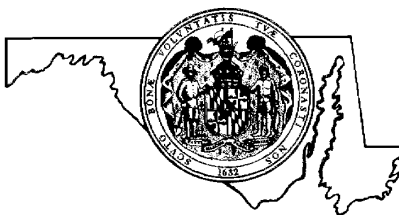


Andrew N. Pollak, M.D.
CHAIR



Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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December 30, 2019

The Honorable Delores Kelley
Chair, Senate Finance Committee
Miller Senate Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

The Honorable Shane Pendergrass
Chair, House Health and Government
Operations Committee
House Office Building, Room 241
Annapolis, Maryland 21401

**Re: House Bill 626 (Chapter 15, 2019) and Senate Bill 649 (Chapter 473, 2019)
Report on review of the chapter of the State Health Plan on Psychiatric Services;
Emergency Medical Services**

Dear Senator Kelley and Delegate Pendergrass,

The Maryland Health Care Commission (MHCC) is pleased to submit this letter to fulfill the reporting requirement under House Bill 626 (Chapter 15, 2019 Laws of Maryland) and Senate Bill 649 (Chapter 473, 2019 Laws of Maryland). These laws require MHCC to report to the House Health and Government Operations Committee and the Senate Finance Committee on its review of the chapter of the State Health Plan (SHP) on Psychiatric Services and Emergency Medical Services (Psychiatric Services Chapter)¹ if regulations that update that chapter of the State Health Plan are not adopted on or before December 30, 2019.

As part of the process for updating the Psychiatric Services Chapter, MHCC staff convened a workgroup that includes representatives from hospitals, the Department of Health, the Maryland Institute of Emergency Medical Services Systems, the Health Services Cost Review Commission, and patient advocacy organizations. This workgroup met three times between May 2019 and August 2019 and will continue to meet in early 2020. At the August 2019 meeting, the workgroup recommended forming a Psychiatric Services Clinical Advisory Group (CAG) to provide insight on the challenges of delivering acute psychiatric services to hard-to-place and hard-to treat patients. The workgroup agreed to delay further meetings until the CAG had completed a more in-depth examination of the clinical factors at work. The CAG met twice during November, and MHCC staff anticipates that the CAG will continue to meet in early 2020. Both the CAG and

¹ The MHCC will not examine emergency transport services issues because these services are not regulated under the Certificate of Need program. The MHCC heard many concerns from the workgroup about hospital emergency department services (which are often a patient's entry point for accessing acute psychiatric services). Hospital emergency services are addressed in a separate chapter of the State Health Plan and could be changed in a subsequent update.

The Honorable Delores Kelley
The Honorable Shane Pendergrass
December 30, 2019

workgroup have provided valuable feedback to MHCC staff. Attached is a membership roster for each group, as well as meeting summaries for the meetings held by each group. Additional materials that were distributed at these meetings and the agendas for each meeting are available on MHCC's web site:

https://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_pysch_services.aspx

As reflected in the meeting summaries, the focus of the workgroup and CAG has been on the development of updated standards for the review of psychiatric hospital services. The workgroup discussed select standards from the Psychiatric Services Chapter and reached consensus on the elimination of some of standards and the modification of others. Staff will recommend these changes to SHP Chapter because they are consistent with the final MHCC report on the Modernization of the Maryland Certificate of Need Program, which recommended the deletion of standards that the Commission determines are unnecessary.

The workgroup has not reached consensus on key issues, including how to evaluate and define the need for additional acute psychiatric bed capacity and how to improve access for subpopulations that are currently underserved, as evidenced by long boarding times in emergency departments. MHCC staff conducted additional analysis of the utilization of emergency departments and hospitals by patients with a primary psychiatric diagnosis for specific subpopulations, as suggested by the workgroup, based on input from the CAG. This analysis was provided to CAG members at the meeting held on November 6, 2019, and staff anticipates that further analyses will be provided at a future meeting. This additional analysis has been useful in validating trends that have been reported by stakeholders. Workgroup members and CAG members have discussed the factors that may indicate an unmet need for acute psychiatric services, but they have not reached consensus on specific thresholds for the evaluation of CON projects to add acute psychiatric bed capacity. MHCC staff plans to continue to work with stakeholders to understand the factors contributing to inadequate access and how MHCC can play a role in resolving this issue.

MHCC staff appreciates the participation of all the stakeholders in the process of updating the Psychiatric Services Chapter. The staff will continue to work with members of its workgroup, its Clinical Advisory Group, and other stakeholders with the goal of developing a draft Psychiatric Services Chapter in the second quarter of 2020. The staff will seek feedback from stakeholders on the draft Psychiatric Services Chapter prior to submitting the draft Chapter to the Commission. Please do not hesitate to contact me at Ben.Steffen@maryland.gov or 410-764-3566 with questions or comments about MHCC's progress on updating the Psychiatric Services Chapter.

Sincerely,



Ben Steffen
Executive Director

Enclosures (7)

The Honorable Delores Kelley
The Honorable Shane Pendergrass
December 30, 2019

cc: Andrew N. Pollak, M.D., Chair, Maryland Health Care Commission
Sarah Albert, Department of Legislative Services
Eileen Fleck, Chief, Acute Care Policy & Planning
Paul E. Parker, Director, Health Care Facilities Planning and Development

Roster for MHCC Psychiatric Workgroup

Name	Organization	Title
Marian Bland	Behavioral Health Administration	Director, Clinical Services, Adults and Older Adults
Adrienne Breidenstine	Behavioral Health System Baltimore	Vice President, Policy & Communications
John B. Chessare, M.D., M.P.H.	Greater Baltimore Medical Center HealthCare System	President and CEO
Erin Dorrien	Maryland Hospital Association	Director of Policy
Kate Farinholt	National Alliance on Mental Illness	Executive Director
Stacy C. Fruhling, M.B.A.	CareFirst BlueCross BlueShield	Senior Director, Behavioral Health Evaluation and Oversight
Patricia Gainer, J.D., M.P.A.	Maryland Institute for Emergency Medical Services Systems	Deputy Director
Ruth Ann Jones*	University of Maryland Shore Regional Health	Senior Vice President & Chief Nursing Officer
Nicki McCann	The Johns Hopkins Hospital	Chief of Staff
Thomas Merrick	Behavioral Health Administration, Office of Child, Adolescent and Young Adult Services	Senior Program Manager
Joe Petrizzo	Holy Cross Health	Director of Behavioral Health Services
Dennis Phelps	Health Services Cost Review Commission	Associate Director, Audit and Compliance
Jeff Richardson	Vice President and Chief Operating Officer	Mental Health Association of Maryland
Renee B. Webster	Maryland Department of Health	Assistant Deputy Director for Non Long Term Care Federal Programs
Jennifer Wilkerson	Sheppard Pratt Hospital	Chief Strategy Officer
Christine R. Wray, F.A.C.H.E	President	MedStar St. Mary's Hospital
Marcel Wright	Adventist HealthCare	Vice President of Behavioral Health Services

*retired August 2019

Roster for MHCC Psychiatric Services Clinical Advisory Group

Name	Organization	Title
Jeffrey Bracken	Johns Hopkins Hospital	Acting Senior Director of Care Management; Director of Psychiatry Social Work
Anthony Chico, D.O.	Greater Baltimore Medical Center	Medical Director of Emergency Psychiatry, GBMC Emergency Department
Sarah Edwards, D.O.	University of Maryland Medical Center	Medical Director, Child and Adolescent Psychiatry Services; Program Director, Child and Adolescent Psychiatry Fellowship
Stephanie Knight, M.D.	University of Maryland Midtown	Chief of Psychiatry, UMMC Midtown; VP of Medical Staff, UMMC-Midtown; Assistant Professor of Psychiatry UM School of Medicine
Sarah Kubel, L.C.S.W.	University of Maryland Midtown	Social Work Team Lead- Midtown Campus
Todd Peters, M.D.	Sheppard Pratt Health System	Vice President and CMO
Joe Petrizzo, M.S.W.	Holy Cross Health	Director, Behavioral Services at Holy Cross Hospital Inc.
Nancy Praglowski	Johns Hopkins Hospital	Nurse Manager
Nyree Price	Adventist Shady Grove Hospital	Needs Assessment/Admissions Manager at Adventist Behavioral Health and Wellness Services
Steve Rainone, N.P.	Sheppard Pratt Health System	Nurse Practitioner
Robert Roca, M.B.A, M.D., M.P.H.	Johns Hopkins Medicine	Associate Professor of Psychiatry and Behavioral Sciences
Corneliu Sanda, M.D.	MedStar Franklin Square	Chair of Department of Psychiatry and Director of Behavioral Health Service Line
Elias Shaya, M.D.	MedStar Health	MedStar North Regional Medical Director; Senior Associate Executive Director for Behavioral Health Services at MedStar
Jane Virden, B.S.N., M.S.N.	Johns Hopkins Hospital	Nurse Manager, Pediatric Emergency Department
Bob Wisner-Carlson, M.D.	Sheppard Pratt Health System	Service Chief, Intellectual Disabilities and Autism Unit; Medical Director, Neuropsychiatry Program; Chair, Ethics Committee

**Final Meeting Summary
Acute Psychiatric Services Workgroup Meeting
Friday, May 3, 2019
Maryland Health Care Commission
4160 Patterson Avenue, Baltimore, MD 21215**

Workgroup Member Attendees

Marian Bland (phone)	Thomas Merrick
Adrienne Breidenstine	Joe Petrizzo (phone)
Erin Dorrien	Dennis Phelps
Kate Farinholt (phone)	Steve Reed (phone)
Stacy C. Fruhling (phone)	Renee Webster
Patricia Gainer, J.D.	Jennifer Wilkerson
Ruth Ann Jones (phone)	Christine R. Wray (phone)
Stephanie Knight, M.D. (phone)	Marcel Wright
Nicki McCann	

MHCC Attendees

Eileen Fleck	Ben Steffen
Paul Parker	Suellen Wideman
Mario Ramsey	

Other Attendees

Oksana Likhora

Eileen Fleck began the meeting by having workgroup members introduce themselves and indicate whether they regard Certificate of Need (CON) regulations as having negative impact on the development of acute psychiatric bed capacity. Workgroup members were not asked to explain their answers, and Ms. Fleck let workgroup members know that declaring uncertainty about their position on the issue was fine too.

Ms. Fleck emphasized that Maryland Health Care Commission (MHCC) staff is very interested in stakeholder feedback from representatives for organizations along the continuum of care for mental health services. This feedback will be used to try and create a better more accessible health care system for those who need it. With respect to the timeline for the workgroup, she explained that the workgroup would likely meet three to four times over a period of a few months. Staff would like to develop draft regulations soon and then bring proposed regulations for consideration by the Commission in November. She explained that legislation was adopted that requires MHCC to produce a report regarding the development of new CON regulations for psychiatric services, if new regulations have not been adopted by December 31, 2019.

Ms. Fleck explained that the workgroup would discuss various issues, and then staff will develop draft regulations that will be released for informal public comment. Anyone is welcome

to submit comments. Usually staff allows a few weeks or 30 days for public comment. The feedback from the informal comment period will be used to develop revised draft regulations for consideration by the Commission. If the Commission adopts proposed regulations, then there is another formal opportunity to provide comments on the proposed regulations. Erin Dorrien asked for clarification on the timeline for the development of proposed regulations, specifically whether MHCC staff would ask the Commission to consider adopting proposed regulations prior to November. Ben Steffen indicated that the goal would be for the Commission to consider regulations prior to November.

Mr. Steffen noted that a CON Modernization Task Force that met over a period of 18 months provided recommendations supported by the Commission. He emphasized that feedback from the workgroup would be valuable because it will facilitate a faster review process by the Commission if consensus has already been reached by stakeholders on draft revised regulations for psychiatric services.

Certificate of Need Regulations and the State Health Plan

Paul Parker gave an overview of the CON process and history of CON. Mr. Parker explained that CON is essentially state government regulating the supply and distribution of certain types of health care facilities and services. He noted that Maryland was one of the first states in the country to establish CON. During the 1970s to 1980s, the federal government mandated CON and provided guidance on how CON programs should be structured. Even though the federal requirements are no longer in place, current CON regulations still echo some of the original federal requirements. In Maryland, the types of facilities regulated are all licensed facilities, which includes hospitals, nursing homes, ambulatory surgery centers, residential treatment centers, substance abuse intermediary care facilities, home health services, and hospice services. There are still 35 states with CON regulations. Approximately 24 other states have CON regulations that are similar to Maryland, covering a comprehensive set of facilities and services. The remaining states have limited CON programs and are generally focused on long-term care.

In Maryland, there is a CON application review process. Capital projects for regulated services or facilities are submitted to MHCC, and staff reviews them against six general criteria: compliance with the State Health Plan (SHP), need for the project, availability of cost-effective alternatives, viability of the project, impact of the project, and the applicant's track record on other CONs. Mr. Parker noted that the CON Modernization Task Force Report recommended that an evaluation of impact on providers be focused on costs and charges and not the potential negative financial impact on providers. He also noted that the criterion of compliance with the SHP encompasses the CON regulations for acute psychiatric services, and MHCC staff is seeking feedback from the workgroup on those regulations.

Mr. Parker noted that in the past ten years, the Commission has considered eight CON applications that involved acute psychiatric services and two projects that were consolidations that required an exemption from CON review. There was also one project that was approved previously, but then modified; due to the modification, reapproval was required. Only four of the 11 reviews involved changes in bed capacity. Some projects were replacement of capacity when

a hospital planned to relocate. Most projects were for special psychiatric hospitals rather than general hospitals with acute psychiatric units. The net change in psychiatric beds has been an additional 40 beds over the last ten years. Thirty-eight of those beds were added to special hospitals, only two were added to general hospitals.

There are currently four acute psychiatric care projects in review. Three are active and one is inactive at the request of the applicant. Those four CON projects, if approved would result in 43 additional psychiatric beds; 31 of the additional beds would be located in general acute hospitals. One of these projects is for a hospital system that wants to replace beds that are now in a general hospital setting, with a special hospital, which would result in a net increase of 12 beds. Another project would add adolescent psychiatric beds to a hospital that currently provide child and adult acute psychiatric services.

Mr. Parker stated that MHCC prioritizes updating regulations that are most frequently applied to CON projects. For the first ten years after the last update of the regulations for acute psychiatric services, MHCC did not receive any CON applications for acute psychiatric services. Despite the low number of CON applications for acute psychiatric services in the last ten years, updating the Chapter is now a priority. Mr. Parker noted that while some of the standards in the SHP chapter for acute psychiatric services are obsolete, most of the standards remain applicable. He noted that in many Chapters, standards may be maintained for ten or more years, even if the SHP chapter has been updated during that time span. For that reason, Mr. Parkers anticipated that the new draft set of standards would be similar to the current regulation in many ways.

Workgroup Members' Questions Concerning CON Projects and Regulations

Nicki McCann asked about information on applications for acute psychiatric services which were denied and instances where psychiatric bed capacity decreased. Mr. Parker answered that among the applications that had not been approved as originally submitted, one was for a hospital which was a replacement project at UM Prince George's Hospital Center. That hospital currently allocates 32 of its total licensed acute beds to adult psychiatric services, and the replacement hospital is approved for 28 adult psychiatric beds, which is a net loss of four psychiatric beds. He stated that MHCC staff also reviewed a proposal from Sheppard Pratt, to relocate and replace their hospital in Howard County. The facility was licensed for 92 beds, but had a physical capacity for 78 beds. Sheppard Pratt proposed building a replacement hospital of 100 beds, and MHCC approved a replacement hospital of 85 beds.

Jennifer Wilkerson asked for clarification on the third acute psychiatric services project currently under MHCC reviewed, and Mr. Parker explained that MHCC currently has a proposal from Peninsula Regional Medical Center to add child and adolescent programming. The proposal would add 15 child and adolescent beds. Thomas Merrick noted that only in describing the current projects under review had there been talk about the distinction between child, adolescent, and adult psychiatric services. He asked whether it could be assumed that in the years prior, applications all focused on adult psychiatric beds. Mr. Parker responded that one project at Franklin Square Hospital in Baltimore County involved dropping child psychiatric services and replacing it with adolescent psychiatric services so there was no change in the bed capacity for the facility. The

Sheppard Pratt facility project, previously described, provides services to all three age groups. All other projects were solely for adult psychiatric beds.

Mr. Parker next explained that general acute hospitals have a dynamic licensing process. Every year, each general hospital's patient census for the past twelve months, ending on March 31, is used to determine the number of licensed beds for the next fiscal year. A general hospital's total licensed bed capacity is set at 140 percent of its average daily census, and it then has the discretion to allocate beds to any acute care services that a hospital is authorized to provide. There are four services that a hospital may allocate licensed beds among: medical/surgical services; obstetric services; psychiatric services; and pediatric services.

Mr. Parker added that most general hospitals usually have more physical bed capacity than licensed bed capacity. Some of the physical capacity may be used for other purposes, but it is still considered in physical bed capacity if the space was designed for patient use and could be converted easily for patient use. A few hospitals have more licensed beds than physical capacity; this is usually seen among larger hospitals that may operate at higher occupancy rates more easily. Special hospitals do not have a dynamic licensing process that tracks with their average daily census; theoretically the licensed bed capacity and physical bed capacity of special hospitals should be equal. However, Mr. Parker noted that over time facility renovations sometimes produce mismatches between licensed and physical bed capacity.

Renee Webster asked if the 15 beds at Peninsula Regional Medical Center (PRMC), discussed earlier, were the same 15 beds from Chesapeake Treatment Center. Marcel Wright responded that Adventist used to provide services on the Eastern Shore, but those services were discontinued. PRMC submitted a CON request, but it is not a transfer of beds from Adventist to PRMC.

Joe Petrizzo asked if psychiatric bed capacity includes State beds as well. Mr. Parker explained that MHCC regulates all acute psychiatric beds in the State, including those at general hospitals, special hospitals, and State hospitals. Mr. Petrizzo noted that several State hospitals have closed over the last 17 years, resulting in a reduction of psychiatric bed capacity in State hospitals. Ms. Webster added that many of the State beds are no longer staffed for as many beds as could be physically accommodated, and a large number of State psychiatric beds are occupied by court-committed patients. Ms. Webster also noted that State hospitals have not been able to meet the courts' demands for evaluation, which limits the ability of State hospitals to admit hard to place patients.

Ms. Dorrien asked about MHCC's timeframe for reviewing current applications on acute psychiatric services. Mr. Steffen responded that the applications would be considered in the next several months, but the Commission meeting agenda items are not released with months of advance notice. Mr. Parker added that the two child and adolescent applications would be addressed by the Commission first. He explained that in Harford County a hospital is converting to a freestanding medical center. The facility currently has a psychiatric unit, and the applicant is proposing to preserve the bed capacity of the psychiatric unit in a special hospital that would be on the same campus as the freestanding medical center. The applicant for the inactive CON project

proposes adding psychiatric services for the first time at that hospital, and the project would add 16 psychiatric beds. This project has been put on hold at the request of the applicant.

Mr. Parker stated that in the scope of CON regulations, hospitals are regulated and acute psychiatric services are regulated services. The law allows the Commission to go beyond regulating acute psychiatric services. Historically, MHCC and its predecessors have been conservative in not expanding the scope of CON through regulation. From Mr. Parker's perspective, the requirement for a CON to serve different age cohorts (children, adolescents, and adults) could be regarded as an expansion of the scope of CON for acute psychiatric services because the law does not specify that a separate CON must be obtained in order for a hospital to provide acute psychiatric services to different age groups. This requirement is one that MHCC staff wants to discuss with the workgroup.

Ms. Dorrien asked if the Chapter for psychiatric services is the only chapter in the SHP where a distinction is made between age groups. Ms. Fleck stated that there are separate standards for pediatric and adult cardiac services. A workgroup member asked if MHCC has the authority to regulate psychiatric services outside of inpatient facilities. Mr. Parker responded that MHCC has the authority to do it, but it has not. A workgroup member asked if geriatric services are separately regulated, and MHCC staff responded that those services are considered adult services and do not require a separate CON.

Mr. Wright asked whether the workgroup must adhere to the recommendations of the CON Modernization Task Force and essentially functions as subgroup for the Task Force. Mr. Parker responded that the work of the Task Force should be given consideration because it includes recommendations on changes to the SHP that the Commission supports. The workgroup is not a subset of the Task Force. Ms. Fleck agreed that the recommendations should be considered and clarified that the workgroup is not bound by the recommendations of the Task Force; if the workgroup feels strongly that a Task Force recommendation should not be followed, then it can be addressed by the Commission.

Mr. Steffen added that the recommendations were submitted to the Commission and passed on to the State legislature. Some of the recommendations were adopted into law, and some recommendations are still awaiting the governor's signature. One recommendation from the Task Force that was not adopted into law was a recommendation to allow existing hospitals to expand psychiatric bed capacity without CON review. Mr. Steffen commented that the recommendation was not adopted in part because MHCC was expected to update the SHP Chapter for psychiatric services. Mr. Wright asked for a summary of the Task Force recommendations that were passed; Mr. Steffen responded that MHCC staff would provide workgroup members with a bulleted list of recommendations from the CON Modernization Task Force.

Mr. Steffen asked the representative for the Health Services Cost Review Commission (HSCRC) to explain the differences in payment for the different types of hospitals that provide psychiatric services. Mr. Phelps explained that the main difference is how these facilities are treated under the new payment model and the Medicare waiver. He explained that for acute general hospitals all payers pay the same rate. Special psychiatric hospitals, however, are not under that

same provision. At special hospitals, commercial payers and self-pay patients are obligated to pay the HSCRC rates, but government payers are not. He explained that private psychiatric hospitals and rehabilitation facilities have been excluded from HSCRC rate setting since the State's original Medicare waiver in the 1970s. In addition, if there is a hospital where two-thirds of its patient revenue is from governmental payers, then the hospital can be excluded from rate setting system for all payers.

Current Problems with the Acute Psychiatric Care and Possible Solutions

Mr. Parker asked for feedback from workgroup members regarding what they would like CON regulation to achieve. Ms. Fleck suggested that it may be useful for workgroup members to think about the problems with the system and how changes to CON regulations might be able to address those problems. Ms. Dorrien commented that boarding of psychiatric patients is a major problem in hospitals with EDs, although it may not be an issue that can be resolved through changes to CON regulations. She explained that patients in EDs need to be able to access the services they need, which may not always be a psychiatric bed. She added that sometimes a hospital puts a patient in a psychiatric bed simply because it saves time. Mr. Merrick agreed with Ms. Dorrien; he is notified daily that there is a minor that has been in the ED for one or multiple weeks. He added that whether or not the CON process is part of the solution is unclear.

Ms. McCann stated that she did not have a clear view on how problems in the mental health care system overlap with the CON process, but it is important to recognize that a bed cannot always be filled by any patient who needs one. There are times where a patient is so acute that additional beds must be shut down in order to treat a patient. This may occur when a patient requires a sitter, body guards, or other resources that impede the use of otherwise available beds. Ms. McCann noted that this is not captured in the bed capacity data; the data also does not capture whether the patient is dealing with an intellectual or development disability in addition to a mental health issue. Ms. Fleck inquired how data on blocked beds could be captured better. Ms. McCann did not know.

Ms. Wilkerson stated that starting with a baseline of what is available for a patient beyond the age categories would be a good start. Ms. Dorrien added that MHA hears from its members that the acuity of psychiatric patients is increasing. Hospitals are seeing sicker patients who are in the hospital longer and may have comorbidities. Mr. Wright stated that Adventist looked at occupancy data recently, and during a recent two-week period, approximately 25 percent of the hospital's psychiatric beds were blocked due to patient acuity. He stated that in addition to an acuity issue, a room may be blocked for other reasons that are not captured in the bed capacity data. Ms. Wilkerson commented that her concern is access to beds for high acuity patients, not access to beds in general. She expressed concern that if hospitals were allowed to expand their psychiatric bed capacity without a CON, it would not facilitate access for high acuity patients.

Although OHCQ is not a placement agency and does not have placement resources, Ms. Webster noted that OHCQ receives calls from hospitals that have patients in their EDs who cannot get placed in acute psychiatric beds. Many times the patients are adolescents, and parents do not know how to help their children get the care that they need. When a patient is finally placed, the patient may be located in a part of the State that is not easily accessible to the family; OHCQ

receives complaints from families about this too. Ms. Webster added that the most frequent calls that OHCQ receives are for patients with borderline intellectual or development disorders (IDD) and a psychiatric issue. OHCQ also receives calls concerning geriatric patients with dementia and a psychiatric problem, and psychiatric patients with a physical disability or hearing impairment. She stated that as the workgroup moves forward, those special populations should be given consideration. Ruth Ann Jones agreed with Ms. Webster's comments.

Kate Farinholt inquired about opportunities for better data collection to address the issues raised by Ms. Webster. Ms. Fleck asked Mr. Wright, who mentioned reviewing and analyzing data on patient acuity for Adventist HealthCare, how difficult it was to collect that information. Mr. Wright responded that the information on blocked beds is relatively easy for Adventist HealthCare to collect. He noted that for general acute care hospitals, there is a flexibility in allotting psychiatric beds on a yearly basis that allows general acute hospitals to be more responsive to the needs of the community. He suggested that it may be helpful to consider allowing that type of flexibility for special hospitals. He suggested having a system where the Commission approves the facility to serve a specific age group, and then allows a hospital flexibility in the number of psychiatric beds, based on the dynamic needs of the community.

Stephanie Knight stated that there is a general lack of crisis beds in the state, and inpatient psychiatric beds should be considered the intensive care unit (ICU) of behavioral health care. If a patient does not need ICU-level care, the patient should not be admitted to an inpatient psychiatric bed. She explained that patients may be admitted to an inpatient psychiatric bed because no appropriate alternative is available. The lack of crisis services, a potential alternative to an inpatient psychiatric bed for some patients, puts additional pressure on the supply of inpatient psychiatric beds. Her facility switched from 28 semi-private rooms to 37 private rooms. As a result, the occupancy rates increased from 70-75 percent to 90-95 percent. Patient acuity has drastically increased too because the hospital no longer has to close beds to account for patient's acuity level. Acts of patient aggression have doubled with 83 events in the first three months of the calendar year. Her hospital is able to make sure that staff are safe, and the quality of care is appropriate. The consequences of shifting to private rooms should be considered in the discussion of updating the CON regulations for acute psychiatric services.

Kate Farinholt stated that there are instances where someone comes to a hospital voluntarily for a psychiatric issue and ends up out in the community and then comes back in as an involuntary psychiatric patient or not. She stated that such patients may or may not be appropriate for inpatient acute bed, but they are contributing to the crowding of EDs.

Mr. Phelps asked whether information on the number of patients in need of crisis beds is currently captured. Mr. Wright clarified that crisis beds are a level of acuity lower than inpatient psychiatric beds, not a higher level acuity; access to crisis beds assists in keeping behavioral health patients out of an inpatient psychiatric bed. Adrienne Briedenstine noted that Baltimore City has 21 crisis beds that are highly utilized, generally 90 percent. The beds are grant funded.

Mr. Phelps requested additional clarification on the tracking of bed closures when highly acute patients require additional resources. Ms. McCann commented that The Johns Hopkins

Hospital tracks when beds are closed due to the need for sitters, body guards, or other patient acuity issues, but it is not required. Ms. Wilkerson stated that because Sheppard Pratt deals with high acuity patients on a daily basis, they do not have worry about closing beds as often. So, tracking such instances is not an issue for them.

Ms. Webster stated that she recently participated in a hospital survey for a 35 bed psychiatric unit in an acute care hospital and six or seven of the beds could not be used due to patient acuity. In addition to discussing how many beds are available, she suggested that the workgroup discuss how many beds are available to serve involuntary patients and how many are available to serve voluntary patients. For example, The Johns Hopkins Hospital accepts involuntary patients, but John Hopkins Bayview Medical Center only accepts voluntary patients. She added that this is important, because the more difficult patients are involuntary patients. A workgroup member stated that there is no designation for voluntary or involuntary beds, such a determination is made by the hospital. The designation, however, makes a difference in the use of psychiatric beds. Ms. Webster added that treating involuntary patients means that you have to ensure the patient's rights by affording them a hearing before an administrative law judge. A hospital that only serves voluntary patients does not have the mechanisms in place to take patients against their will.

Mr. Wright commented that the use of the term behavioral health to refer to psychiatric issues conveys that psychiatric services are needed to address behavioral health problems. A behavioral problem, however, is different than a psychiatric issue. For example, he explained that a person with dementia or a traumatic brain injury that is exhibiting behavioral challenges does not need a psychiatric bed. However, staff in the ED want to get a patient with a behavioral problem out of the ED, and the patient tends to end up in a psychiatric bed. He commented that it is important to understand who the community the mental healthcare system is trying to serve, and to consider from a CON perspective, how the availability of beds affects meeting the needs of patients. Ms. McCann and Mr. Merrick agreed. Mr. Merrick added that the autism spectrum is an essential component of the child and adolescent aspect of this issue. Approximately 20 years ago, there was a massive increase in the number of children identified with autism spectrum disorders.

Ms. Farinholt stated that there needs to be more community services, crisis beds, step-down beds, and stabilization centers. However, the National Alliance on Mental Illness is also hearing from providers, families, and individuals that they cannot access inpatient beds when needed. Part of the problem is educating people about when a patient should be placed in a psychiatric bed, but another part is that forensic patients are taking up beds in State hospitals, and patients are waiting a long time for psychiatric care when they present at an ED. As a result, a small group of people who present at the ED voluntarily may decide to leave rather than continue to wait for a bed. Anecdotally, there is a need for additional psychiatric beds.

Ms. Wilkerson stated that patients who are hard to place into an inpatient psychiatric bed are also hard to place when it is time for them to be discharged. She added that the limited number of beds to care for psychiatric patients is part of the reason why you both cannot get people into beds and cannot get patients out of beds; it is a compounding issue, especially with child and geriatric populations. For example, Mr. Merrick noted that a child or adolescent would be expected

to be able to step down into a residential treatment center bed after leaving an inpatient psychiatric facility, but residential treatment centers lack capacity too.

Mr. Phelps mentioned that an HSCRC workgroup has formed to look at long admissions for all patients, including psychiatric patients. Ms. McCann stated that psychiatric patients in medical beds are not being accurately captured in data. Mr. Wright commented that some hospitals have space in their emergency departments for psychiatric patients in order to diffuse their impact on other patients in the ED. Ms. Webster agreed with Mr. Wright. Mr. Wright also commented that because priority is given to patients in a hospital ED, when the patient needs to be transferred to another facility, a hospital may find it difficult to decide whether to move a psychiatric patient to a medical bed, which could then make it harder to get a patient admitted to a psychiatric bed in another facility.

Another workgroup member commented that there are other disadvantages to admitting a psychiatric patient to a medical bed, such as further stigmatizing patients with mental illness because staff do not understand how to meet the needs of such patients. Mr. Phelps expressed confusion as to why the use of a medical bed for a psychiatric patient would be a problem. He explained that services are not charged based on the type of bed for patient; charges are based on the services provided. Psychiatric patients would be billed for those services, regardless of what type of hospital bed they occupy, as far as discharge data. Ms. McCann commented that Medicaid will not pay for a psychiatric patient in a medical bed; she does not know why, but the more important point is that patients should be provided appropriate care.

A workgroup member commented that a psychiatric patient in a medical bed will miss out on key aspects of mental health treatment, which includes interaction in a community environment, recreational therapy, and other therapies. A patient in a medical bed may have a sitter that may not have much training in handling psychiatric patients, and the patients interaction with others will be brief and limited. Mr. Phelps agreed that psychiatric patients receive better treatment in a psychiatric unit, but he noted that psychiatric patients may still receive some psychiatric care in a medical bed. Another workgroup member commented that there are legal consequences if a patient is put in a medical bed rather than a psychiatric bed.

Ms. Fleck commented that the discussion addressed access issues, as MHCC staff had planned. She also asked the representative for Sheppard Pratt, Ms. Wilkerson, about its ability to track patient acuity that results in fewer available beds. Ms. Wilkerson responded that the population treated by Sheppard Pratt has higher acuity than other general hospitals with acute psychiatric units, and it has more capacity, so the patient acuity issue raised by some general hospitals has not been a problem for Sheppard Pratt.

Ms. Fleck commented that the discussion had given her ideas to think about in terms of updating the regulations for psychiatric services, such as whether more single psychiatric rooms are needed and the types of information that should be collected or presented to demonstrate the need for additional psychiatric bed capacity. Mr. Steffen noted that the workgroup had talked a lot about patient acuity and inquired whether HSCRC has case-mix data for psychiatric patients that shows an increasing level of acuity over time. Mr. Phelps agreed to investigate the issue.

A workgroup member stated that the Office of Administrative Hearings collects data on how patients are involuntarily committed, and that data may be useful to review. Ms. Fleck commented that the HSCRC discharge data may capture whether a psychiatric patient was voluntary or involuntary. Mr. Wright suggested that the financial incentive structure should recognize different levels of patient acuity and whether a hospital treats patients who are involuntary. One workgroup member commented that it is a challenge for administrative law judges to get to hospitals and rule on petitions for involuntary patients. Ms. Breidenstine cautioned against the use of incentives for involuntary placements. Another workgroup member cautioned that involuntary status for a patient should not be used as a proxy for high acuity, and Mr. Wright agreed. Ms. Webster noted that only a few hospitals do not take involuntary patients, less than six.

Mr. Steffen asked if Medicare distinguishes between crisis beds and observation beds and has limits on the length of stay for these beds. A workgroup member explained that Mr. Steffen was mixing up terminology. The beds in hospitals for psychiatric patients in hospital EDs are not considered crisis beds. Those beds are not considered an observation bed by Medicare. Mr. Phelps explained that the definition of observation care is very narrow and only includes the time period up to a decision to admit a patient. He also noted that HSCRC recognizes extended care costs and is evaluating those now; those are costs incurred after a decision has been made to transfer a patient.

Ms. Farinholt asked if anyone has done a survey of hospitals and EDs to find out more about how they handle crowding of EDs. Ms. Dorrien responded that MHA conducted one study of discharge delays for psychiatric patients in hospitals' inpatient units (medical or psychiatric) and mentioned some of the findings. The average discharge delay was 13 days. She also noted that MHA is currently studying all psychiatric patients in hospital EDs. Data collection will take place between April 15 and May 31. The results of the study should be available by August 2019. Ms. Farinholt mentioned that NAMI has conducted national and statewide surveys of patient and family experiences in EDs; a lot of the feedback mentioned delays in EDs.

Ms. Fleck commented that the discussion had been very good and suggested to her an explanation as to why MHCC staff did not see high occupancy rates despite complaints about the difficulty of finding beds for patients. Ms. Fleck said that she would send out a poll with potential dates for the next meeting, likely in mid-June. The meeting was adjourned at 12:01p.m.

**Final Meeting Summary
Acute Psychiatric Services Workgroup Meeting
Monday, June 17, 2019
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue, Baltimore, MD 21215**

Workgroup Attendees

Marian Bland (phone)	Nicki McCann
Adrienne Breidenstine	Chris O'Brien
John Chessare, M.D. (phone)	Joe Petrizzio (phone)
Erin Dorrien	Renee Webster (phone)
Kate Farinholt	Jennifer Wilkerson (phone)
Stacy Fruhling (phone)	Christine Wray
Patricia Gainer, J.D. (phone)	Marcel Wright (phone)
Ruth Ann Jones (phone)	

MHCC Staff Attendees

Ose Emasealu, Program Manager, Acute Care Policy and Planning
Eileen Fleck, Chief, Acute Care Policy and Planning
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Ben Steffen, Executive Director
Suellen Wideman, Assistant Attorney General

Eileen Fleck welcomed members of the group, and attendees introduced themselves both around the table and on the phone. She reviewed corrections to the meeting minutes for the last workgroup meeting held on May 3, 2019. An attendee that was initially omitted was added, and on page three of the meeting summary, the description of the Certificate of Need project for Sheppard Pratt was corrected. Shepard Pratt proposed 100 beds, and MHCC approved a replacement of 85 beds. On page eight, the phrase “children born with autism” was replaced by “children identified with autism.” Workgroup members did not propose any additional changes and approved the revised meeting minutes.

Evaluation of the Need for Additional Acute Psychiatric Bed Capacity

Ms. Fleck referred to the White Paper distributed to members of the workgroup and described different approaches taken by other states for evaluating the need for additional psychiatric beds through their Certificate of Need (CON) processes. She explained that the approaches used by other states typically account for population growth rates, historic levels of utilization, and target occupancy rates. The thresholds for occupancy rate differ among states; however, a target occupancy rate of 75% was the most common. Some states, such as Georgia, have different target occupancy rates for psychiatric facilities in rural area and psychiatric facilities in urban areas, while other states have different occupancy rates for adolescents, children, and

adults. In Maryland, the methodology for determining the need for psychiatric beds is out of date, and MHCC staff has improvised when reviewing CON applications. Typically, staff evaluates market share information, current utilization trends, and utilization projections by separate age groups. MHCC staff assumes historic trends in the use of psychiatric beds will continue in future projections.

Ms. Fleck explained that MHCC staff would like to know from the workgroup which factors are relevant to determining the need for psychiatric beds. She also suggested that the workgroup should discuss the appropriate level of occupancy for psychiatric beds. She noted that the 90% bed occupancy threshold for psychiatric beds included in the current State Health Plan (SHP) is too high. Erin Dorrien asked whether the occupancy rate is based on total licensed beds or staffed beds. Paul Parker responded that in the current SHP, there is not an occupancy standard that part of the need methodology. There is a standard that requires a hospital to meet a specific occupancy threshold for consecutive two years before expanding psychiatric bed capacity. The threshold standard for a facility with 40 beds is an occupancy rate of at least 90%. For a facility with between 20 and 39 beds, the threshold occupancy rate is 85%. For a facility with less than 20 psychiatric beds, the threshold occupancy rate is 80%. MHCC staff considers these occupancy thresholds too high. Mr. Parker explained that staff looks at use-rate trends, average daily census, and market share. For medical surgical beds, the occupancy thresholds range from 70 to 83% depending on the number of beds; 83% for 300 beds or more, 80% for 150-299 beds, 75% for 50-149 beds, and 70% for less than 50 beds.

Christine Wray commented that the current bed need methodology is the same approach that was used 40 years ago. She suggested that data analytics be used to improve the need methodology, for example by analyzing psychiatric disease subgroups, case-mix, or other indices. She asked who was innovative in their approach to evaluating the need for psychiatric beds. Ms. Fleck responded that most states use similar methods that rely on factors such as population growth, average daily census, and historic utilization rates. She noted that at the last workgroup meeting, members explained that patient acuity makes a difference in the level of occupancy that can be achieved. A hospital may not be able to use all of its beds if patient acuity is high.

Ose Emasealu explained that he analyzed the frequencies of different psychiatric diseases grouped by Diagnosis Related Group (DRG) codes and the relative magnitude of disease acuity could not be deduced from DRG codes. MHCC staff also compiled information on the number of private and semi-private rooms for psychiatric patients. Most hospitals have a mix of both types of rooms. Ms. Wray commented that she has blocked psychiatric beds every day in semi-private rooms because a second patient cannot safely be in the same room. Ms. Fleck noted that the issue was raised at the last workgroup meeting. Mr. Emasealu noted that although a variable for continuous patient observation is included in the Health Services Cost Review Commission (HSCRC) discharge database, the field for continuous patient observation is currently often incomplete and cannot be utilized to assess the need for continuous patient observation. Ms. Fleck added that since the data for the continuous patient observation is incomplete, it will be helpful if members of the group talk to responsible staff at their facility and find out if and why attention is not given to capturing this information in the HSCRC database.

Jennifer Wilkerson proposed jumping ahead to another question on the agenda, whether a bed need forecast is a good idea for psychiatric services. She suggested that it may not be useful to focus on the details of what is relevant to determining bed need, if no one thinks that a bed need forecast is a good idea. Ms. Fleck responded that the relevant factors for evaluating the need for psychiatric beds still need to be considered because even if there is not a forecast, the need for additional psychiatric bed capacity has to be evaluated for CON reviews of those services based on standards and criteria.

Jennifer Wilkerson asked if there are some types of beds subject to CON approval, but with no applicable bed need forecast. Ms. Fleck responded that sometimes a need forecast is not applied to some services. She mentioned that for organ transplant service, there had been a need projection, but the projections were too volatile and seen as invalid for that reason. There is a lot of flexibility and opportunity for an applicant to justify a new organ transplant program. She also noted that for cardiac surgery, there is a utilization projection, and an applicant is expected to present specific analysis and information. Mr. Parker added that there are no bed need projections for CON reviews of obstetric beds, residential treatment centers, and hospice inpatient beds.

Mr. Parker explained that MHCC staff is seeking to understand whether the workgroup thinks a bed need methodology is a necessary feature for the SHP chapter for acute psychiatric services. In his view, there need to be regional projections of the need for psychiatric beds in order for the Commission to be effective in making good decisions. However, the SHP chapter for acute psychiatric services could lay out the analysis required rather than having a need projection for psychiatric beds. For example, applicants could be asked to present a service area analysis of those historically serviced by the applicant. The applicant could also project a different pattern and explain the rationale for it. That information would be used in combination with some assumptions about what is a reasonable occupancy rate to decide whether approval is recommended for a CON project. This type of approach is reflected in the recently revised SHP chapter for cardiac surgery services. There is a projection of the utilization of cardiac surgery, but not a forecast of need. An applicant for a new cardiac surgery program is required to present certain analysis in order to justify the need for a proposed project. MHCC staff asked if a forecast is needed that creates a limit on the capacity that can be developed. Ms. Wray asked if it bed capacity or services more broadly, not just inpatient psychiatric services. Mr. Parker explained that CON review is required for psychiatric bed capacity, not psychiatric services broadly.

Ms. Fleck asked for feedback on what key factors matter for evaluating the need for acute psychiatric services. Based on the discussion at the previous workgroup meeting, MHCC is not capturing the number of acute psychiatric beds needed through its need methodology and neither are other states. Ms. Wray suggested that analyzing factors such as socioeconomic status, disease acuity based on DRGs, and the lengths of stay associated with those DRGs could be better indices to use. In her view, the number of psychiatric beds is not relevant. Mr. Parker responded that MHCC focuses on the number of beds because of the way the law is written.

Ben Steffen asked if there was evidence that behavioral health services continue to have an associated stigma. There is a portion of the population that will not seek help. Estimates on behavioral health services should account for this. Ms. Fleck stated that statistics on prevalence

rates are available, but determining who needs but does not get services is very difficult. Those who do not get services in some cases are more likely to need acute care. Mr. Steffen asked if anyone had tried to calculate the proportion of the population that needs services but does not get them. That information could be useful for improving the delivery of behavioral health services. Ms. Fleck commented that a small group of people can get intensive services. Typically, states target people who are frequently using inpatient services with extra services and support that ultimately results in cost savings. Adrienne Breidenstine agreed with Ms. Fleck, noting that there are such programs in Baltimore City. However, she cautioned that care management provided locally may not be relevant to the question posed by Mr. Steffen. Ms. Fleck responded that in some cases psychiatric hospitalization can be avoided through providing more intensive community services, but it is difficult to quantify. It is only a subset of the population in need of services that are targeted for intensive case management, and the results for this subset of the population may not apply to those with less intensive needs.

Ms. Fleck again asked workgroup members what factors to consider in making a determination on the need for psychiatric beds. She noted that the higher acuity of patients and their higher resource use is not captured by occupancy rates. Mr. Steffen added that other states, at least those referenced in the White Paper, do not provide a model to follow. Ms. McCann asked why restrictions are needed for acute psychiatric services given that it is not highly profitable, and few providers are seeking to establish or expand acute psychiatric services. Ms. Fleck explained that potentially, if too many providers enter the market, then it may be more difficult for all providers to maintain optimal occupancy rates.

Ms. Dorrien commented that her understanding is that the SHP is set up to keep people out; only once a need is identified and occupancy rates reach a certain threshold can someone propose to meet it. Ms. Fleck responded that while CON is usually seen as restrictive, it could also be seen as showing an opportunity to fill a need that has been identified. Ms. Dorrien then suggested taking a different approach and considering disease burden or emergency department visits for behavioral health rather than the number of beds. Ms. Fleck responded that disease prevalence is part of the need methodology for psychiatric beds, but the methodology references a publication that is very old. In addition, there has been a shift towards keeping people out of hospitals. A workgroup member asked how the Commission allows for the establishment of new acute psychiatric services and whether it is based on a CON review schedule. Mr. Parker responded that there is currently no bed need projection that controls when MHCC will consider applications. There is a schedule for general hospitals, and most providers of psychiatric services are general hospitals.

Ms. Wilkerson suggested that the regulations should distinguish between adding a new program and expanding beds. Ms. Fleck asked whether she was proposing that it should be easier to add psychiatric beds compared to establishing a new program. Ms. Wilkerson noted that it would be more expensive to add a new program, and barriers should not be the same for both. Mr. Parker explained that for acute care general hospitals, every year hospitals can allocate among services. If a hospital has the physical ability to expand psychiatric beds, then the hospital can reconfigure its beds, and allocate more of its licensed beds to psychiatric beds and less to medical

surgical beds or obstetric beds. There is potentially lots of flexibility in the number of beds allocated for psychiatric services.

Kate Farinholt asked if there are any disincentives to reallocate psychiatric beds to other acute care services. Ms. McCann responded that the hospital's case-mix will be lower and that will affect revenue. Mr. Parker agreed that financial incentives play a role. He noted that a hospital's medical surgical beds may be full too.

Ms. Farinholt asked for an explanation of the process for changing the total number of beds at a hospital. Mr. Parker responded that if a hospital is changing physical bed capacity, then it would have to get CON approval. Many hospitals have more physical capacity than licensed capacity, but lack the ability to configure the space for psychiatric beds. There is a cost to repurposing space. Mr. Steffen interjected that allowing existing programs to add beds was proposed in the last legislative session and then rejected. The SHP chapter for psychiatric services must be updated first.

Ms. McCann noted that her hospital is always at capacity for both medical surgical beds and psychiatric beds. Mr. Parker added that statewide over the past nine years, the total number of beds has been declining. Ms. Wilkerson commented that if a hospital's beds are full, then the total number of beds will grow because the licensed number of beds is set at 140% of average daily census. Mr. Parker again noted that the total number of licensed beds has not been growing for most hospitals. Also, while a hospital may be full with respect to psychiatric beds, the average daily census may be falling for medical surgical beds, resulting in the total number of beds shrinking. The total number of licensed beds for a hospital is based on the total census. Ms. Dorrien asked whether it is possible to track the changes made by hospitals in the allocation of their beds. Ms. Fleck responded that the information is tracked through conducting an annual survey.

Ms. Fleck asked for comments on if there should be a bed need methodology included in the CON regulations. There were no comments. Ms. Fleck proposed returning to the issue later.

Evaluation of the Need for Separate CON Approval and Standards by Age Group

Ms. Fleck explained that currently a hospital needs a separate CON to serve each of three age groups: children, adolescents, and adults. She referred workgroup members to the handout that is a copy of an appendix from the White Paper. She also noted that MHCC received a petition from one provider that suggested hospitals that provide acute psychiatric services to children and adults should be allowed to treat adolescents without obtaining CON approval for that additional age group. Four organizations commented on the petition, and three expressed reservations about the proposed change. MHCC staff responded to the petition by stating that the workgroup formed for updating the SHP chapter for acute psychiatric services should consider the issue.

Ms. Wilkerson commented that the standard should be retained because there are key programmatic differences in serving children and adolescents. Ms. Fleck noted that the Joint Commission has standards that require a provider to meet the needs of patients and to keep both

patients and staff safe. She asked whether Joint Commission standards could substitute for some of the CON standards. A workgroup member commented that not every hospital has to meet the Joint Commission standards. Ms. Fleck explained that MHCC staff would like to try and streamline the CON regulations, if possible. Marcel Wright suggested that if a facility already has psychiatric beds for multiple age groups, then the facility should have flexibility to shift the number of beds used for each age group, as needed; he did not propose that age groups be mixed together. Another workgroup member asked whether there is currently flexibility. Ms. McCann responded that a hospital may go over the licensed number of beds, but it has to be reported to a State agency. It usually happens for medical surgical beds, but not for behavioral health because there is not another unit available for expansion. Renee Webster also responded to the question, noting that a hospital can request changes to its licensed number of beds; there is some flexibility to move patients around. There is not a formal process in place; if there is appropriate space, then it can be done.

Ms. Fleck emphasized that she wants to know whether MHCC needs to be the one that holds applicants to a standard that requires separation of age groups or whether Joint Commission standards address it or some other entity. Ms. Dorrien asked if the goal is to reduce the number of standards for CON applications to make the process easier. Ms. Fleck agreed that it is a goal based on the Commission's preferences. However, if there is a clear rationale for keeping a standard, and the workgroup recommends keeping a standard, then it probably makes sense to keep that standard. Ms. McCann commented that the separation of age groups is a fundamental safety issue, but facilities are governed by so many other regulations and rules that it may not be needed.

Mr. Parker described two CON projects for psychiatric capacity recently reviewed by the Commission. One project was for Peninsular Regional Medical Center (PRMC) to add 15 psychiatric beds for children and adolescents; the hospital only had been providing acute psychiatric services for adults. The other project was for the University of Maryland Medical Center (UMMC) to add psychiatric beds to serve adolescents. UMMC had been providing acute psychiatric services only for adults and children. UMMC previously proposed changing the SHP chapter to allow for a hospital already serving adults and children to also serve adolescents without obtaining CON approval for it.

Mr. Parker commented that in his view the SHP chapter for psychiatric services does not impede flexible use of beds, such as adjusting the number of beds for different age groups when a hospital serves multiple age groups. It would not make sense to require CON approval in order to increase the number of beds for adolescents by two beds by reducing the number of beds for another age group by two beds. Ms. Dorrien asked whether PRMC could add beds for children and adolescents by converting adult psychiatric beds to serve those two age groups without CON approval, if a specific standard was eliminated. Mr. Parker responded that Ms. Dorrien is correct. However, he noted that the petition from UMMC did not propose eliminating CON approval any time a facility proposes to serve another age group without expanding the total number of psychiatric beds.

Ms. Fleck asked for feedback from the workgroup on the issue. Ms. Wilkerson responded that the standard requiring CON approval to establish psychiatric services for specific age groups

should be retained. Another workgroup member suggested that it could be a slippery slope for other services, allowing a provider to do one thing just because they are already doing another. Ms. Farinholt proposed that it could be acceptable for MHCC to eliminate the requirement, if there was another entity that was enforcing clear standards. Ms. Wilkerson questioned how standards could be enforced without the CON requirement. Ms. McCann agreed with Ms. Wilkerson on maintaining the CON requirement. She added that flexibility with reallocating beds at a facility that serves multiple age groups should be acceptable.

Ms. Fleck asked if it makes a difference to workgroup members if there is no one that objects to a proposed project to establish new psychiatric services for additional age groups. Ms. Wilkerson commented that she thought a streamlined CON process was approved that allows for faster approval when there are no interested parties; the change would apply to most types of CON projects, not just acute psychiatric services. Mr. Steffen explained that the Commission adopted a timeframe for rendering CON decisions, except for organ transplant and cardiac surgery programs or establishment of a new health care facility. Ms. Fleck asked for clarification on whether establishing a new service, like psychiatric services is covered by the new process. Mr. Parker noted that it is included. If there are not interested parties, then the application will be considered by the Commission. An application will be automatically approved if the Commission does not act on it.

Ms. McCann asked whether MHCC staff viewed the CON process as valuable in its review of recent CON applications to add psychiatric beds, for example UMMC's application. Mr. Parker commented that UMMC had a strong case for creating a program for adolescents based on documentation of the demand for it and difficulty finding beds locally. Most adolescents were referred to the Psychiatric Institute of Washington. He noted that if UMMC had started an adolescent program without any CON oversight, some stakeholders may have concerns. The CON process requires an applicant to address how a facility is changing and why it is changing. The CON process has value if you think that it is useful to have projects go through a public vetting process that verifies a project is needed, sustainable, and cost-effective. Ms. Fleck added that it is a useful process for evaluating quality and considering the impact on other providers.

Mr. Parker emphasized that the purpose of the SHP chapter for psychiatric services is to give the Commission guidance on how to evaluate the need for additional psychiatric beds. CON approval is only needed for establishing a new psychiatric hospital, expanding psychiatric bed capacity, or adding acute psychiatric services for a new age group. CON approval is not required for intensive outpatient services or crisis services. The CON Modernization Task Force proposed that existing psychiatric hospitals be allowed to add beds without CON approval, but the law would have to be changed. The legislature did not approve that change. Ms. McCann asked for further explanation on why the legislature did not favor the recommendation. Ms. Fleck noted that the recommendation was not discussed much by the CON Modernization Task Force. Mr. Steffen noted that the Maryland Hospital Association did not take a stand on the specific bill. The industry was divided. Mr. Steffen emphasized that the workgroup should focus on making recommendations to the update of the SHP chapter for psychiatric services.

Ms. Fairinholt asked if there is model where the continuum of services is considered in evaluating the need for beds. Patient flow in and out of hospitals is affected by the availability of other services. Ms. Fleck responded that it has been difficult to operationalize how the availability of other services affects the demand for acute psychiatric beds. Ms. Wray commented that highlighting the need for access to a continuum of services could be helpful for emphasizing the tradeoffs required when a continuum of services is not available. She also proposed that access could be defined in part by the number of miles traveled to access services, even though insurance coverage often dictates access to services.

Based on the earlier discussion, Ms. Fleck concluded that workgroup members support retaining standard 4a. This standard requires physical separation of different age group receiving acute psychiatric services at the same facility.

Consideration of Specific Standards in the Current COMAR 10.24.07.

Ms. Fleck asked workgroup members to refer to the standards listed in Appendix A of the White Paper for a discussion of select standards. She started with standard 2a, shown below in italics.

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 limitations for weekends or late night shifts (Unless otherwise exempted by DHMH as provided by Maryland law Health General Article Sec. 10-620(d)(2)).

Ms. Fleck asked if this standard was necessary and whether anyone was currently getting an exemption from the standard. Ms. Wray stated that hospitals with psychiatric services have to follow the standard, and it should not be included. Ms. Wilkerson commented that the standard expresses an operational expectation, and it should not be part of the regulations. Ms. Farinholt commented that the standard needs to be clear. Workgroup members agreed that the standard refers to patients who have already been admitted who need emergency treatment; the standard is not referring to patients who show up in an emergency room or to the need to generally provide inpatient treatment for psychiatric patients 24 hours a day and 7 days a week. Workgroup members agreed that the standard is not needed. Ms. Fleck next asked workgroup members to consider standard 2b, shown below in italics.

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

Ms. Fleck noted that approximately seven hospitals do not accept involuntary psychiatric admissions. She suggested that the standard seemed reasonable and could be maintained. Ms. McCann commented that the standard was controversial. Ms. Wilkerson suggested that more

should be done to make sure that the burden of accepting involuntary patients is spread fairly among hospitals. Ms. Fleck noted that a state agency must approve exceptions, so it seems like there is an opportunity to control when exemptions are granted. She also mentioned that at the last workgroup meeting it was noted that judges have to show up at psychiatric facilities to decide on petitions. It is a burden for the court system, not just hospitals, which may be part of the justification for some exemptions.

Mr. Wright asked what can be done to make hospitals accept involuntary patients equitably across the state. Ms. McCann stated that from her understanding, by virtue of a hospital having an emergency department, it has to take psychiatric patients under an emergency petition. Joe Patrizzo stated that at his facility, Holy Cross Hospital in Silver Spring, there is not a psychiatric unit, but the emergency department handles patients brought there under an emergency petition. Mr. Wright stated that there is a difference between the hospital having to evaluate a person brought to an emergency department under an emergency petition and the inpatient psychiatric unit accepting involuntary patients. Inpatient psychiatric units do not all accept involuntary patients. Ms. Webster also stated that hospitals are required to evaluate patients and arrange for safe transfer due to a federal law. Ms. Fleck next asked workgroup members to consider standard 2c, shown below in italics.

Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room. (Unless otherwise exempted by DHMH as provided by Maryland law Health General Article Sec. 10-620(d)(2)).

A workgroup member suggested that the standard could be deleted probably because it is standard operating procedure. However, she suggested that other workgroup members verify that is the case. Another workgroup member agreed with her assessment. Ms. Fleck next asked workgroup members to consider standard 3a, shown below in italics.

Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Ms. Fleck stated that the Joint Commission or other accreditation agencies may have covered this already. For this reason, MHCC staff recommended that the standard be deleted. Ms. Farinholt agreed that the standard is unnecessary. Another workgroup member commented that it is not the role of a psychiatric unit to deal with family therapy. Ms. Wilkerson commented that getting into the level of detail included in the standard is unnecessary. Workgroup members agreed that the standard should be deleted. Ms. Fleck next asked workgroup members to consider standard 3b, shown below in italics.

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.

MHCC staff recommended that this standard be deleted, and the workgroup agreed with deleting most of the language in this standard. Workgroup members agree that physical separation of age groups served in a hospital's psychiatric unit is important and want to maintain this requirement. However, they also concluded that the level of detail included in the standard is unnecessary because the standard reflects standard operating procedures for inpatient psychiatric treatment. Ms. Fleck next asked workgroup members to consider standard 3c, shown below in italics.

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

There was some confusion regarding the interpretation of this standard. A workgroup member asked if a hospital without a psychiatric unit still has to have psychiatric consultation services available and whether services needed to be available in a hospital's emergency department. Ms. Fleck responded that the standard is referring to all hospitals. For a hospital without inpatient psychiatric services, it was stated that a psychiatric patient would be transferred or referred out. Workgroup members agreed that this standard should be clarified, or even deleted, if the standard was intended to refer to hospitals with psychiatric units. Ms. Farinholt noted that if all hospitals, even those without psychiatric units need to be able to evaluate patients brought to a hospital's emergency department on an emergency petition, then someone with psychiatric expertise needs to be available to provide those evaluations. She noted that the standard does not state that though, which is why clarification is needed. Ms. Fleck next asked workgroup members to consider standard 5, shown below in italics.

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*

Ms. Fleck commented that based on the workgroup feedback on other standards, she would expect the workgroup to recommend deleting the standard. The workgroup agreed that the standard should be deleted. Ms. Fleck next asked workgroup members to consider standard 6, shown below in italics.

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.

Ms. Fleck stated that this standard may be addressed by accreditation agencies. The workgroup recommended deleting the standard for this reason. The level of detail covered by the standard is unnecessary. Ms. Fleck next asked workgroup members to consider standard 7, shown below in italics below.

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.

Ms. Fleck mentioned that MHCC staff recommends modifying this standard. One workgroup member asked for clarification on the reference to legal status. Ms. Wilkerson proposed that there needs to be a separate conversation about hospitals' obligation to accept involuntary patients. Another workgroup member asked if legal status referred to people in the United States without legal permission (undocumented). Ms. Fleck asked about a specific proposed change to the wording of the standard, but a workgroup member commented that the proposed change did not clarify whether hospitals must accept involuntary patients. Mr. Steffen agreed. Ms. Fleck next asked workgroup members to consider standard 12a, shown below in italics.

Acute inpatient psychiatric service must be under the clinical supervision of a qualified psychiatrist.

A workgroup member noted that the Joint Commission and other accreditation agencies cover staff credentials. The workgroup agreed that the standard should be deleted. A workgroup member commented that accreditation could replace many standards included in the psychiatric regulations. Ms. Fleck agreed that requiring accreditation makes sense. Ms. Fleck next asked workgroup members to consider standard 12b shown below in italics.

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.

The workgroup agreed that this standard should be deleted, based on the same logic applied to other standards the workgroup recommended for deletion.

Next Steps

Mr. Steffen asked Ms. Fleck to describe the topics to be covered at the next meeting. She stated that the workgroup will likely revisit the evaluation of need for psychiatric beds and the evaluation of impact on other programs. The workgroup will also discuss how to evaluate access as part of CON reviews. Access was discussed at the first meeting, but not as it pertained to CON standards.

Mr. Parker noted that there is a set of policy statements in the SHP chapter for psychiatric services, and one of these policies states that acute general and private psychiatric hospitals with

licensed inpatient psychiatric units should admit involuntary patients. There is a clear policy preference for all hospitals with acute psychiatric services to accept involuntary patients. Ms. Fleck stated that the next meeting may be in late July, but with summer vacations it can be more difficult to schedule meetings. She thanked workgroup members for their participation and closed the meeting.

**Revised Draft Meeting Summary
Acute Psychiatric Services Workgroup Meeting
Monday, August 19, 2019
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue, Baltimore, MD 21215**

Workgroup Attendees

Marian Bland (phone)
John Chessare, M.D.
Erin Dorrien
Patricia Gainer, J.D. (phone)
Stephanie Knight, M.D.
Nicki McCann
Thomas Merrick (phone)

Chris O'Brien
Joe Petrizzo (phone)
Dennis Phelps
Renee Webster
Jennifer Wilkerson
Christine Wray

MHCC Staff Attendees

Ose Emasealu, Program Manager, Acute Care Policy and Planning
Eileen Fleck, Chief, Acute Care Policy and Planning
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Ben Steffen, Executive Director
Suellen Wideman, Assistant Attorney General

Eileen Fleck commenced the meeting, and members of the group introduced themselves. Ms. Fleck stated that no one submitted changes to the draft meeting summary for the meeting held on June 16, 2019. Work group members approved the meeting minutes.

Ms. Fleck then referred work group members to a handout with a summary of standards in the State Health Plan chapter for psychiatric services. For many standards, it is noted that the standard still needs to be discussed. She asked if there were comments on the status of any standards. There were no comments.

Standards that Pertain to Program Operation

Ms. Fleck noted at the last meeting the work group suggested that CON regulations should not include excessive detailed information in standards that is covered by other regulatory bodies or accreditation agencies. She then asked work group members to consider whether Standard 12C should be maintained, modified, or deleted. She read the standard, which is also shown below in italics.

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

Jennifer Wilkerson commented that this standard was already covered by the Joint Commission and would be duplicative, if it is retained. Thomas Merritt asked if other pediatric hospitals distinguish between patients who are between zero and 21 years of age. If yes, then there could be a parity issue. Ms. Wilkerson noted that the Joint Commission has competencies for every age group handled by a hospital. Ben Steffen agreed that the concern raised by Mr. Merrick would not be an issue. Ms. Fleck next asked work group members to consider Standard 13, which is shown below in italics.

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.

Ms. Christine Wray stated that this standard is operational and addresses the requirements covered by other agencies as well. The work group recommended that the standard be removed.

Access to Acute Psychiatric Services

Ms. Fleck next asked work group members to consider Standard 7, which is shown below in italics.

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.

Ms. Fleck noted that at the previous work group meeting, members suggested that the standard be clarified. Ms. Fleck read the current standard and suggested an approach to clarifying the standard. She explained that the reference to a patient's "legal status" in this context refers to whether a patient is voluntary or involuntary. MHCC staff proposed that the term "legal status" be removed and replaced with a reference to involuntary patients. She explained that while the revised standard does not directly require all hospitals to take involuntary patients, if that was the only reason a hospital did not want to take a patient, then the standard could in effect be requiring that hospitals take involuntary patients.

She asked for the work group members' opinions on whether new psychiatric facilities should be required to accept involuntary patients. Renee Webster responded that for hospitals that currently take only voluntary patients, there may not be adequate facility and resources to accept and provide services for involuntary patients. She suggested that if a hospital has the capability or capacity to care for involuntary patients then they should admit such patients, instead of making arbitrary decisions on who to accept. Ms. Wray agreed, adding that the administrative legal authorities may not be able to support every hospital.

Suellen Wideman commented that some bond hearings are done through teleconferences, and she suggested that approach may be feasible for psychiatric patients too. Dr. Knight responded that teleconferences are not an option. When she tried to arrange those for psychiatrists located in western Maryland, and coordinate with the Office of Administrative Hearings, it was not permitted. The COMAR regulations do not account for recent technology and testimony must be in person. Ms. Wideman asked whether Dr. Knight had been advised by someone on that interpretation. She noted that in-person does not necessarily mean physically located in the same place. Dr. Knight responded that the Office of the Public Defender (OPD) said that if teleconferencing was used, then it would protest that the testimony was not in person. Ms. Widman advised that an opinion from the Office of the Attorney General could be sought. OPD does not like that bail hearings can be done that way because they are unfavorable to the accused, but it is an option. Dr. Knight noted that her request may have been made over a year and a half ago, and she was not sure if an opinion from the State's Attorney General was sought.

Ms. Wray emphasized that more data on the number of involuntary patients is required, and the need methodology should account for voluntary and involuntary patients. She also expressed uncertainty about whether hospitals should be encouraged to accept involuntary patients. Ms. Fleck responded that the number of involuntary patients in captured in the Health Services Cost Review Commission (HSCRC) discharge data, but there is still a question about how many patients are waiting in emergency departments because of their involuntary status. That information is not available in the discharge data.

Ms. Wray clarified that she understands having a requirement for a new provider to take involuntary patients. She asked whether a hospitals that does not take involuntary patients would have to take them in order to add a couple beds. That would be discouraging for an applicant. Ms. Wilkerson agreed that it would be reasonable to require a new program to take involuntary patients, but not an existing program. Ms. Fleck asked if others agreed.

John Chessare commented that the work group is struggling to make policy decisions in the absence of data. He also noted that for his hospital the primary bottleneck is not whether hospitals take involuntary patients, but the availability of specialized beds. He emphasized the value of data-driven decision making in writing policies. Nikki McCann agreed with Dr. Chessare. She also would not want a hospital to be deterred from opening a neurobehavioral unit because of regulations. Mr. Joe Petrizzo agreed that data on trends is needed.

Ms. Fleck asked whether knowing the percentage of patients who are involuntary for a specific age group would be useful. Dr. Knight responded that the information would be helpful theoretically, but there is enough discretion that different hospitals may categorize the same patient as voluntary or involuntary. Some patients may also convert from involuntary to voluntary before a hearing occurs. Ms. Webster agreed that it is not possible to get great data on the number of involuntary patients. Ms. Fleck was skeptical that data from the HSCRC discharge abstract on the number of involuntary patients would be helpful. Instead, it would be useful to understand the reasons that some hospitals do not take involuntary patients and under what circumstances it should be acceptable for a hospital to have a policy of not accepting involuntary patients.

Mr. Steffen asked why it would be a problem for a new program to take involuntary admissions. Ms. Dorrien responded that it may not be a problem, but she was not sure. She asked about whether recently approved CON projects for new facilities take involuntary patients. Mr. Parker responded that both facilities do take involuntary patients, and his understanding is that the standard requires hospitals to take involuntary patients.

Ms. Wray commented that psychiatric beds, like the other beds in the hospital, can be increased or reduced based on demand without a CON. Mr. Steffen responded that it is unlikely that psychiatric beds would expand without connection to the psychiatric unit, so a CON project is likely to be a larger expansion. Ms. Wray asked why a hospital would be denied the opportunity to add new psychiatric beds because it currently does not take involuntary patients. Mr. Parker responded that there could be an equity issue if it is required for every new program but not required for existing program that wants to increase capacity. Ms. Wray suggested that the requirement be triggered by a certain percentage of change in capacity.

Ms. Webster noted that usually the reason why a patient cannot be admitted and is boarded in the emergency room for an extended period is not because the patient is involuntary. The patient may be difficult to place because of other special co-occurring conditions, such as a developmental disability, or the unit may seem too dangerous for the patients, or the patient seems too dangerous for the unit. Ms. Fleck responded that the way the standard is phrased allows for those considerations; a hospital just cannot solely refuse to admit a patient based on the patient's status as an involuntary patient. If the reason for refusing to admit a patient is clinical criteria, that is acceptable.

Ms. Wilkerson noted that some hospitals currently do not take involuntary patients and that does not fit with the standard. Ms. Fleck responded that some hospitals may have already had programs and did not go through the CON process. Ms. Dorrien commented that the intent is good, but she cautioned that the group needs to think through the unintended consequences as well.

Mr. Parker asked whether the voluntary or involuntary status of patients is a bottleneck issue or not. Ms. Wray responded that it is not an issue. It is patient specialty issues and insurance policies that may require a patient to go to a different location. Dr. Knight noted that there are gradations of delay. A delay may just be due to a patient's involuntary status, which creates a relatively mild bottleneck.

Ms. Webster suggested that the standard should say that legal status should not be the sole criterion for determining whether to admit a patient to a hospital. Ms. Fleck responded that it is the current standard, and MHCC staff suggested that the standard refer to the involuntary status of a patient because it was suggested that the standard should be clarified. However, there seem to be concerns about requiring hospitals to take involuntary patients. A work group member commented that there needs to be data to support the need for better access for involuntary patients that supports a policy change.

Ms. Fleck asked Ms. Dorrien about the conclusions of the study done by the Maryland Hospital Association (MHA) that examined delays in emergency departments for psychiatric patients. Ms. Dorrien responded that the MHA did not include a patient's status as voluntary or

involuntary in their study. Ms. Fleck stated that MHCC staff would follow up with hospitals that do not take involuntary patients to find out the perspectives of those hospitals. Ms. McCann explained that hospitals that do not take involuntary patients still see sufficient patients to operate at full capacity. There is not excess capacity that cannot be accessed by involuntary patients. She also noted that hospitals that do not take involuntary patients would have to re-design their space and change their staffing model if they were required to take involuntary patients. Those changes could be viewed as a barrier to expansion in the future.

Ms. Fleck next read Standard 8, which is shown below in italics.

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.

Dennis Phelps explained that hospitals are required to have financial assistance policies, and there are minimum standards in the HSCRC regulations. Each hospital is assessed differently for the uncompensated care that it provides. Rates are partly based on the amount of uncompensated care and partly based on a prediction for the amount of uncompensated care. Ms. Fleck asked if the policies are the same for acute care general hospitals and private psychiatric hospitals.

Mr. Steffen stated that the current standard seems to set the same percentage of uncompensated care that applies to general acute hospitals with psychiatric units and special needs psychiatric hospitals. It does not make sense to take that approach. Other work group members agreed. Mr. Phelps responded that different criteria are used for private psychiatric hospitals, and HSCRC does not have jurisdiction over governmental payers for private psychiatric hospitals. It was noted that there are only currently two private psychiatric hospitals.

Ms. Fleck asked the work group if the revised regulations should not include anything about the level of charity care expected. Mr. Phelps noted that since 2010, hospitals must provide a copy of their financial assistance policies. Ms. Dorrien commented that the standard is duplicative and already covered by HSCRC. Ms. Fleck agreed that the standard does not make sense. However, she noted that in the SHP plan chapter for general acute care hospitals include requirements related to providing notice about financial assistance policies, which is distinct from the standard. The goal is to make sure that patients are aware that financial assistance may be available and have a preliminary decision on their eligibility for financial assistance. Ms. Dorrien asked if MHCC staff was proposing that both acute care general hospitals and private psychiatric hospitals be required to provide notice of charity care policies. Mr. Phelps referred to COMAR 37.10.26 and noted that it is already in regulation to provide each patient with an information sheet on charity care policies.

Ms. Fleck read Standard 9, which is shown below in italics. She then asked whether the access stand with a drive time of 30 minutes for 90 percent of the population reasonable, and similarly

whether a drive time standard of 45 for 90 percent of the population of children and adolescents is reasonable.

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 care 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 1a and 1b.)

Dr. Chessare stated that this standard is outdated because it is impossible to provide appropriate treatment. There are no specialized staff to do it. A child is kept physically safe, until a place is found. Drive time has no bearing. He also noted that a child is not officially admitted but may be held on the pediatric unit. Most hospitals no longer have pediatric units though. In most cases, the child will be kept in the emergency department and kept safe, but no treatment is provided and that is upsetting for everyone. The standard is not helpful. Other group members agreed.

Ms. Fleck asked if there is a better approach to addressing the situation that should be incorporated. A work group member responded that we should figure out a way to encourage more hospitals to open up more pediatric psychiatric units. It is not necessary to tell hospitals what is needed to keep a child safe. The Joint Commission has requirements for keeping patients safe in an emergency department, until they can be transferred to a more appropriate location.

Cost Effectiveness

Ms. Fleck read Standard 11, which is also shown below in italics, and then asked for feedback on the standard.

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.

Mr. Phelps commented that the standard is too prescriptive. HSCRC evaluates the financial feasibility of CON projects and sets rates. Ms. Wilkerson, Ms. Wray, and other work group members agreed. Ms. Fleck noted that the consensus is to eliminate this standard.

Evaluation of Need for Psychiatric Bed Capacity

Ms. Fleck stated that MHCC staff proposes to eliminate the use of a bed need projection to determine whether to approve CON applications for the establishment of a special psychiatric hospital, inpatient psychiatric bed services at a general hospital, or inpatient psychiatric services for an age group not currently served by a hospital. Instead, MHCC staff suggests that an applicant present specific information and analysis that will be evaluated to determine whether the need for the proposed project has been demonstrated, as described in a meeting handout.

Ms. Fleck briefly reviewed the types of analysis described on the handout, which includes reviewing trends in average length of stay, occupancy rates, and emergency department visits, as well as market share information and information on boarding in emergency departments. She noted that the suggested occupancy level standards are lower, which should make it easier for an applicant to demonstrate the need for additional psychiatric capacity. The suggested changes are consistent with the standards used in other states. They also account for the configuration of many psychiatric units, which may physically allow for two patients in one room, but may only be used for one patient, based on the acuity level of the patient.

Dr. Chessare stated that the emergency department boarding statistics should not be an afterthought. It is a primary marker for measuring need. Additionally, the occupancy levels in the handout suggest that all beds are the same, and that is not the case. He recommended a more sophisticated evidence based mapping of beds. At Greater Baltimore Medical Center (GBMC), the number of psychiatric patient visits has been relatively unchanged over the past 10 years. However, the capacity for specialty treatment declined in the State, and boarding at GBMC went up dramatically. The placement of specialty patients is a problem that needs to be addressed. Policies and regulations need to fix that problem. Mr. Chessare also suggested that there should be some outcome measure for a region for health status outcomes.

Ms. Dorrien commented that there has not been a comprehensive look at what is needed for this population throughout the whole treatment spectrum. Ms. Fleck responded that because the State does not have a good handle on the need for psychiatric services it may be better not to have need projections. Ms. Wray stated that she opposes the approach described by Ms. Fleck. She suggested that nothing be done until a comprehensive need analysis is developed. Otherwise, there may be unintended consequences. She added that this cannot be considered in isolation by assessing only acute care. It is not fair to have politically-driven decisions instead of decisions based on what is good for the State. She emphasized that the service should not be looked at in isolation. Even though MHCC only governs only part of the continuum, a comprehensive need analysis is needed. Dr. Chessare stated that an imperfect analysis may result in some progress. His belief is that more beds are probably needed only in certain areas. If the system was better, then may be the number of beds could be reduced.

Ms. Wilkerson stated that the group has talked about the current usage and the need by major age and diagnosis categories. Mr. Steffen commented that looking at diagnoses presumes a lot of specificity in care delivery. A lot of beds may be used across diagnoses. A work group member commented that the beds are flexible, but the staffing is not. Ms. Fleck stated that the applicants are required to submit information on trends in discharges, average length of stay, and

other information. She also explained that the lower occupancy rate standards will result in a lower barriers to adding new psychiatric beds. A work group member commented that an applicant could add psychiatric bed and not take care of the problem of access to beds for some patients. Typically, lower acuity psychiatric patients are not the ones stuck in emergency departments.

Ms. Dorrien stated that it is not possible to answer the question of whether a bed need projection should be used or another approach. It is only known that the population is not being served well because of patient boarding in emergency departments. Ms. Fleck responded that one option is to put a higher burden on the applicant to demonstrate the need for additional beds. She also asked whether an applicant for psychiatric beds be turned down because community services are what is really needed. Ms. Dorrien stated that there needs to be more coordination with all the other groups that are looking at pieces of the behavioral health system.

Mr. Steffen commented that he heard that there is a need for more neuropsychiatric beds, and he asked how the regulations should be changed in order to incentivize establishment of neuropsychiatric beds. Ms. Dorrien responded that there could be a more streamlined CON process for an applicant proposing to serve one of the patient groups that is currently poorly served. Mr. Chessare commented that the board for his hospital asked why the hospital does not just build neuropsychiatric beds if those are needed. Mr. Chessare noted that the hospital concluded that the hospital's rates would not cover it, so there is a financial disincentive to do it. Honing in on the true issue and payment reform, it could be beneficial. There needs to be health planning. Ms. McCann commented that she is concerned that if only the task at hand is accomplished then the perception may be that a problem is fixed. Ms. Fleck responded that she does not see MHCC's process as one that fixes the problem. MHCC is addressing one small piece of the system.

Ms. Wilkerson commented that while she would ideally prefer a closer look at the continuum of services, she accepts that it may not be feasible. However, the hospital part of the continuum should be reviewed closely. She does not want to develop regulations that allow for approval of beds that do not address the problems with access for some patients. The regulations should make approval easier for someone that wants to add psychiatric beds that will help address problems identified. Once the group agrees on what the real need is, then it can focus on how to revise the regulations. Ms. Wray agreed.

Mr. Parker asked if anyone views the State Health Plan chapter as a barrier to approval of CON projects for acute psychiatric services. Ms. Wilkerson commented that Sheppard Pratt was not allowed to add a geriatric psychiatric unit that it requested. Fewer beds than requested were approved; the planned geriatric beds were not approved. Mr. Parker commented that CON is a reactive regulatory program. An applicant proposes a project, and MHCC decides whether to approve it. He commented that the CON process likely cannot address problems identified because CON is reactionary. Dr. Chessare agreed. However, he would like there to be a health planning function. No one is doing it. He does not want to just check a box. He sees this as an opportunity to try to accomplish health planning. Mr. Parker again expressed skepticism that a revision of the CON regulations could address the issues raised by some work group members. In his view, the only opportunity is to have a new SHP chapter that when psychiatric projects are reviewed, the process is streamlined and faster. That is his only expectation.

Ms. Wray responded that she really believes in the process, and she thinks the State should take a look at what is needed. There is nothing wrong with that. Hospitals can then respond and develop their plans. She agreed that CON is not stopping people, but she sees value in a comprehensive look at the need for services. The fundamental question about need should be addressed better, instead of asking applicants to justify the need for the proposed project.

Mr. Parker stated that a health planning group should handle the questions that Ms. Wray wants to address. He commented that even a sophisticated need formula will not address any of the problems being discussed today. Mr. Chessare commented that it would be a useful starting point. Mr. Parker again emphasized the limitations of the CON process and stated that CON is not a barrier for those who want to add acute psychiatric beds. Mr. Chessare agreed that there are barriers to those projects beyond the scope of the regulations. He suggested that people should not be allowed to close beds without permission. The closure of beds has created the current situation with a big increase in patient boarding. The field is reacting to the financial reality of specialty beds. That is not the only problem though. Other aspects of the health care system have a role.

Ms. Wray asked how MHCC would handle competing applications. Ms. Fleck noted that in one of the handouts she had suggested how to handle competing applications. She stated that preference will be given to programs that demonstrate minimized delays, increased access, and reduced burdens in hospital EDs.

Ms. Fleck commented that it appears that a lot of hospitals do not want to serve certain groups of psychiatric patients. Mr. Parker commented that certain types of patients are hard to place, and it is because the adult psychiatric programs do not have the capacity to address the treatment needed. In his view, the SHP chapter cannot be used to address that problem. The other problem is that more child and adolescent beds are probably needed and maybe a better distribution of them, but again he does not believe that the SHP chapter can address that problem. Ms. Fleck responded that there are ways to influence things, even in a limited way.

Mr. Steffen commented that he is hearing that hospitals want better incentives and that is HSCRC's role. In order to make the process work, there should be incentives from HSCRC. MHCC could try to identify significant needs, but then it would be up to others.

Ms. Wilkerson commented that the information on needs could help guide discussions in other settings. There are more than ten other groups focused on the behavioral health system. She sees MHCC's role as guiding policy and health planning, and the update of the State Health Plan chapter for psychiatric services is an opportunity to do health policy and planning. The work group should help frame the problem. There is not a good understanding of the problem.

Mr. Chessare commented the State should be very proud of all the initiatives to tackle somatic chronic disease. There is no such thing for mental health. Maryland is a progressive State. It would be great if there were some State leadership to align the incentives. The resources are already being spent, but the use of them is not cost-effective.

Ms. Webster commented that many patients have insurance, geriatric and developmentally disabled patients typically have insurance coverage through Medicaid or Medicare. There must be other road blocks and that may have nothing to do with the State Health Plan chapter.

Ms. Wray commented that her understanding is that the work group is to address health planning. There is another group for streamlining the CON process. She suggested that the work group address the broader problem. Mr. Parker stated that the State Health Plan is not a plan. Ms. Wray agreed, but she added that she wants to have a conversation about the need for psychiatric services. Another work group member commented that the work group should be suggesting standards to add, rather than just standards to remove.

Ms. Fleck asked whether the Commission should turn a project for more beds if the real issue is a lack of community services. Mr. Steffen commented that the standards should address the problems identified, but it is difficult to better define the need for psychiatric services. He is not convinced that there is that much more data that can be pulled together to address the questions raised.

Mr. Steffen commented that the Cardiac Services Advisory Committee is more clinically focused, and that approach could be considered. It would take a lot more time. The legislature wants the regulations finished by the end of the year, which is not compatible with that idea. Ms. Fleck commented that a greater burden could be put on a CON applicant to address the continuum of mental health services and the need for those services. Ms. Wray commented that she understands that approach could be taken for the CON process, but she wants there to be health planning at the state-level, apart from the CON process.

Mr. Steffen commented that he did not think an applicant should be trusted to present information on the broader need for psychiatric services across a continuum of care. Ms. Fleck responded that MHCC staff normally tries to validate information presented by an applicant. Mr. Steffen commented that some important points have been raised. However, the intent was not to identify problems. MHCC staff needs to pause and consider what that would mean. It would be a mistake to rush forward. Ms. Dorrien commented that MHCC is not expected to identify problems alone. There need to some clinical expertise and others included in the process too. Mr. Phelps asked if anyone had participated in transformational grants for psychiatric services. Ms. Wray commented that her hospital has used one of those grants from HSCRC for an initiative and appreciates the seed money for the project.

Mr. Chessare suggested a two-step process. Update the State Health Plan chapter and note further work is needed and continue that work in the future. Ms. Fleck responded that sometimes it is possible to quickly update a SHP chapter or have a two-step process. However, there seems to be a big fundamental issue that is unresolved, the approach to evaluating the need for psychiatric services. Given the issue and expectations, it could be difficult to have a two-step process, but it is worth thinking about. Ms. Dorrien commented that some people are ready to answer the question of whether there should be a need projection, and some people are not ready to answer it.

Mr. Phelps asked about specialty beds and whether it is known that there is a shortage of those beds. Mr. Chessare commented that it is not known. Getting something imperfect from

experts and then starting to take action is acceptable, but without any data on the need, then not much can be done. Mr. Phelps commented that the HSCRC discharge data will not capture that type of detailed information. Mr. Steffen suggested that relying on DRGs in the HSCRC discharge abstract data could be useful.

Ms. Fleck commented that one issue that came up is high-intensity one-on-one staffing that is not captured in the discharge abstract data. MHCC staff thought that a field in the HSCRC discharge abstract could capture that information, but then it did not seem like it was being used because HSCRC was not using it for setting rates. Ms. Fleck added that she thought that HSCRC was trying to capture more information on psychiatric patients, based on a memorandum in the last couple years. She said that she would check on it again.

Ms. Dorrien asked if there was a way to use the all-payer claims database to capture information, at least knowing the volume of services outside the hospital could be useful. It could capture some gaps in services. Mr. Steffen commented that it would be better to stick to an analysis of hospital services.

Mr. Steffen also noted that defining a problem, but keeping the same structure would not be a lot more work and is feasible, but defining a whole health system is not. Re-engineering the behavioral health system is more appropriate for the Lieutenant Governor's Commission to study mental and behavioral health. MHCC has provided some information to this task force and may in the future too.

He suggested that further definition of the problem would be helpful. He also suggested that having more psychologists and psychiatrists would be helpful. It might be a subgroup that would then inform the work group. He stated that MHCC staff would further discuss the matter internally. Community issues are definitely beyond the scope of the work group. Ms. Dorrien suggested including nurses, social workers, and discharge planners.

Mr. Steffen asked for other comments. Mr. Parker again reiterated that the problems being discussed would not be fixed by having a better CON review process for capital projects. Instead of getting sidetracked on problems that cannot be solved by MHCC, the work group can focus on developing better project review standards. It is very inefficient to talk about the real issues and real problems with the behavioral health system. His frustration is that discussing those things will not result in better project review standards in a reasonable time frame. He wants to first revise the project review standards. He would like to have a health planning group that does not look at CON, but the gap between the current behavioral health system and what is desired. Mr. Phelps commented that HSCRC does not want to incentivize adding beds. Mr. Parker commented that the SHP chapter could state what is needed in terms of the types of beds needed, and everyone could agree, but it would not matter because MHCC cannot then give people money to add those services.

Ms. Dorrien proposed having a streamlined process for people that are adding certain types of beds. To a large extent those gaps and how to apply those resources is outside the realm of CON. It would be great to have a more integrated set of community services that reduce the need for inpatient hospital services, but that is not regulated by MHCC. Mr. Steffen commented that there are ways to incentivize certain projects though.

Ms. Webster commented that for a lot of special populations, the traditional psychiatric program model does not work. Many of those individuals may not be able to participate in group therapeutic services or some of the other typical services. There needs to be more of a behavioral model. Mr. Steffen commented that it will not be possible to delineate those needs.

Mr. Steffen suggested that he would welcome written comments. MHCC staff will consider what can be said about the problems that exist in the system today and pause work on the SHP chapter for psychiatric services. He has learned that if the industry is not happy with a proposed plan, then the regulatory review process will be painful. He would like to have more consensus. The meeting adjourned shortly after 3:00 p.m.

Final Meeting Summary
Psychiatric Services Clinical Advisory Group Meeting
Wednesday, November 6, 2019
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue, Baltimore, MD 21215

Workgroup Attendees

Jeffrey Bracken (phone)	Joe Petrizzo, M.S.W. (phone)
Anthony Chico, D.O. (phone)	Nancy Praglowski
Sarah Edwards, D.O. (phone)	Corneliu Sanda, M.D. (phone)
Elias Shaya, M.D.	Steve Rainone, N.P. (phone)
Todd Peters, M.D. (phone)	Bob Wisner-Carlson, M.D.

MHCC Staff Attendees

Ose Emasealu, Program Manager, Acute Care Policy and Planning
Eileen Fleck, Chief, Acute Care Policy and Planning
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Ben Steffen, Executive Director
Suellen Wideman, Assistant Attorney General

Other Attendees

Pat Cameron, MedStar Health

Eileen Fleck commenced the meeting, and members of the clinical advisory group (CAG) introduced themselves. Ms. Fleck then explained that MHCC staff are in the process of updating Certificate of Need regulations for acute psychiatric services and thought additional clinical expertise could be helpful. She explained that a Certificate of Need (CON) is required in order to establish a psychiatric unit within a general hospital or a psychiatric hospital. As part of the CON review process, the Commission considers whether a project is needed, financial feasible, cost-effective, consistent with the applicable State Health Plan chapter, and meets other criteria. Ms. Fleck also noted that CON regulations for acute psychiatric services have not been updated in over two decades. As a result, even though there is a need projection methodology for CON reviews, it is not applied.

A work group was convened by MHCC staff to facilitate updating the CON regulations for acute psychiatric services, and two members of the CAG are members of that work group too (Stephanie Knight, M.D. and Joe Petrizzo). The work group includes some clinicians, but MHCC staff concluded that it would be beneficial to have more clinical expertise and broader representation of some of the other staff that serve acute psychiatric patients. Ms. Fleck noted that

the CAG may be able to provide guidance on additional analysis that should be undertaken by MHCC as well as feedback on specific issues raised by the work group.

Ms. Fleck stated that before this meeting, MHCC staff asked for feedback on populations who need acute psychiatric services that are difficult to serve. Some types of patients were already identified by the work group, and MHCC staff asked about additional types of patients that may be difficult to serve, either placing them for treatment or discharging after treatment. Ms. Fleck next explained that the tables in the handout include additional information and analysis of some of the types of patients identified by CAG members and work group members. Table 1 has the breakdown by categories of primary psychiatric diagnoses over time. The categories are based on the ICD-9 coding system and mapping the corresponding ICD-10 codes to these categories, in order to keep the number of categories manageable.

Ms. Fleck noted that boarding in emergency departments is a concern that has been raised, and this is seen as an indication that acute psychiatric bed capacity is lacking. Ms. Fleck then explained the way that data is captured by the Health Services Cost Review Commission (HSCRC) for administrative purposes. If a patient has an emergency department visit that does not result in admission or that results in admission to a different hospital than the one where the initial ED visit occurred, then the ED visit is captured in the HSCRC outpatient data set. When a patient has an ED visit and is admitted to the same hospital, then the visit is captured in the HSCRC discharge abstract data, as part of the same record for the inpatient admission. MHCC staff relied on the HSCRC data sets for its analysis of acute psychiatric service utilization in Maryland hospitals.

Ms. Fleck explained that Table 2 includes the estimated time that psychiatric patients spent in emergency departments over time. Table 2 shows that it is a relatively small number of patients who are boarding over 20 days, but it is still concerning that any patients are boarding for that period of time. The number of patients with longer boarding times has increased over time. For example, she noted that the number of ED visits with an estimated boarding time of four to eight days increased from 139 in 2010 to 870 in 2018. Ms. Fleck also clarified that the data in Table 2 is for patients who are not admitted to a hospital or admitted to a different hospital. The estimated boarding times for psychiatric patients admitted to the same hospital from an ED is not captured in the HSCRC discharge abstract data. Ms. Fleck estimated that 75% of psychiatric ED visits are captured in Table 2. The next set of tables shows the same type of information for specific age groups (children, adolescents, and adults). Ms. Fleck quickly reviewed these tables and noted that the same trend appears across these age groups, with more psychiatric patients having longer boarding times over the period calendar year 2010 through calendar year 2018.

In Table 6, the trends in the volume of psychiatric ED visits that resulted in admission and length of stay are shown. Elias Shaya, M.D. asked for clarification on Table 6, specifically whether the length of stay reflected time boarding in an ED. Ms. Fleck responded that the length of stay information in Table 6 refers to time in the hospital as an admitted patient. Dr. Shaya asked if there information on the length of stay in an ED apart from the length of the hospital stay. Ms. Fleck explained that the information is available for patients who are not admitted to the same hospital where they initially showed up in the ED. Ms. Fleck estimated that about 75% of psychiatric patients who are admitted to a hospital are admitted to different hospitals than the

hospitals for their initial ED visits. This may occur because a hospital does not have acute psychiatric services or because a bed is not available.

Bob Wisner-Carlson, M.D. commented that a lack of capability and not just capacity is an issue. Some patients need a specialized psychiatric program. He runs the inpatient adult neuropsychiatry unit that is primarily for patients with severe intellectual disabilities and autism. The patients may wait days or weeks in emergency departments until space is available in his program.

Ms. Fleck noted that work group members had mentioned that placing psychiatric patients with intellectual disabilities and autism is a concern. For this reason, MHCC staff created some tables with statistics for this population, including estimated boarding times in EDs and length of stay in hospitals. Dr. Wisner-Carlson noted that discharge delays are part of the problem because patients need to then get into residential services following discharge, and these services are usually funded by the Maryland Department for Developmental Disabilities. He noted that there are also problems with discharging children who have developmental disabilities because multiple agencies are involved, including education boards.

Ms. Fleck noted that another person from Sheppard Pratt Health System contacted her prior to the meeting and mentioned the same issue. She followed up with the Maryland Developmental Disabilities Administration, and it mentioned working together with Sheppard Pratt to try and address the problem for adults.

Dr. Wisner-Carlson commented that for families of children with developmental disabilities and an acute psychiatric problem it is very challenging to get the right care. A family may be forced to keep their child in an emergency department in order to maintain their child's priority position for a specialized bed, even though it is a challenging environment. MHCC staff responded that the same concern has previously been raised by others. Ms. Fleck asked for feedback on how to address the issue. She asked whether emergency departments should be designed differently to accommodate those particular patients.

Ben Steffen commented that MHCC is limited in what it can do to address some aspects of the problem. Mr. Steffen noted that operational concerns have been raised that are not within the scope of MHCC's authority. MHCC regulates the establishment of services. He asked what can be done in terms of MHCC's regulations and planning for those acute psychiatric patients with developmental disabilities. Nancy Praglowski commented that Johns Hopkins Hospital does not have beds for that population. Sheppard Pratt has 12 beds for this population, and those are the only beds for them in the State.

Dr. Wisner-Carlson commented that Maryland is unique in having a neurodevelopmental unit available. There are very few in the country. There is an opportunity for Maryland to be a leader for serving those with autism and developmental disabilities. Todd Peters, M.D. agreed with Dr. Wisner-Carlson. There are only seven or eight programs in the country, and Maryland has two programs. However, he also noted that other programs have better reimbursement for the costs. There may be children with staffing that is a two to one ratio. There is also specialized equipment and training. There needs to be more recognition of the costs. Often patients can be

stabilized within a couple of weeks or months, but the average length of stay is longer because of discharge barriers when patients will not be returning home. Often multiple agencies have to coordinate their efforts, and the waiting can result in decompensation of patients.

Dr. Wisner-Carlson commented that keeping patients boarded in an ED is not consistent with Maryland statute. A patient may be non-verbal and have a guardian and have to be involuntary patients. These patients may have spent an excessive amount of time in an ED, and then may be released on technicalities by a judge, even though it is not consistent with what the family wants. Dr. Shaya commented that because of how challenging the process is, a patient may be kept several days in an emergency department which results in further deterioration of the patient's condition. It is a disservice to the population. Ms. Fleck asked if the technical violations can be addressed or is the law written in a way that is necessary to cover a broad range of patients and changing the law is not part of the solution. Dr. Wisner-Carlson responded that he wants the Commission to be educated about the severity of the problem and how it hits many different areas, as solutions are considered.

Ms. Praglowski explained that being boarded in an ED means sitting in a small empty room for days without anything to do. Mr. Steffen asked about moving patients to observation space instead. Dr. Shaya explained that observation space is more of a status for patients and not a dedicated physical space. There is not another safe space for the psychiatric patients who are boarding in an ED to wait.

Anthony Chico, M.D. commented that once a patient is not seen as an emergency patient, then it becomes less urgent to get them into a psychiatric bed. Ms. Fleck asked for feedback on how the Commission can be part of the solution. Should there be another neurobehavioral unit for children, even though it seems like it is not financially appealing and discharge barriers often exist. Ms. Praglowski responded that both more acute care beds and long term care beds for children and adults would be helpful. Ms. Fleck asked for clarification on the long term care setting referenced. Ms. Praglowski stated that usually patients are released to residential treatment facilities. There are few in the state of Maryland though.

Dr. Peters commented that preventative measure should be taken, especially for those patients that do not qualify for Medicare or Medicaid. Private insurance often may not cover some services that would be very helpful. There need to be wrap around services to allow physicians to feel comfortable releasing some patients. Having more of those services available regardless of insurance coverage would be helpful. Mr. Steffen asked what wrap around services are essential.

Dr. Peters noted that Maryland has 14 non-public school settings that often cater to autism specter disorders. Those services really help. Without them, problem would be much worse. Many children might be hospitalized regularly without those program. Other services that would helpful are day hospital services. Some of those services are provided in schools, but for those people over age 21, it would be helpful to have more high fidelity programs that are not just day care or a respite provider. Applied behavioral analysis (ABA) services may be helpful, especially in-home ABA services. Getting out of the house can be hard for families. Telepsychiatry services would be helpful, but regulations are prohibitive in Maryland. Other states have revised their regulations to allow for more telepsychiatry.

Dr. Chico agreed with Dr. Peters. If there were more options for a back door, then inpatient hospitalization may be avoided. Often focus on symptoms. If day programs were available, that would be helpful. Sarah Edwards, D.O. commented that she strongly agreed with the importance of telepsychiatry as a tool to address the needs of both children and adults. Using innovative technology would help to reduce ED visits.

Dr. Edwards asked if a representative from the Kennedy Krieger Institute (KKI) was a part of the meeting, and staff responded that it was not represented at the meeting. Dr. Edwards emphasized that KKI plays an important role in the region that should be included. She mentioned that some states have specific crisis programs for individuals with neurodevelopmental conditions. There is a program called START, which is intended to reduce the need for emergency departments for individuals with developmental disabilities. If there was an opportunity to partner with KKI and State funding for an initiative that would be significant. Dr. Wisner-Carlson noted that the Maryland Developmental Disabilities Administration and Bernie Simons, Deputy Secretary for the Administration, already have a contract with START. A pilot project is planned in the Southern Region that will cover Montgomery County and Prince George's County. He also agreed with other comments; more flexibility for other services provided to those with developmental disabilities would be very helpful.

Mr. Steffen asked if limitations on telepsychiatry are in the COMAR regulations for Medicaid. Dr. Peters confirm that is correct. The regulations only allow for point of service brick and mortar. He mentioned that New York relaxed its regulations to allow for telepsychiatry. Issues may fester that otherwise could be addressed more quickly.

Dr. Chico commented that when Rosewood closed many patients went to small unstructured group homes. Staff at group homes cannot provide medication periodically, as-needed basis. Staff cannot do any hands on de-escalation. State should consider that training and those requirements. Staff seem unaware of what they can do and how they can help. Dr. Wisner-Carlson agreed with Dr. Peters. Ms. Fleck commented that she spoke with staff at Maryland Developmental Disabilities Administration and asked about staff training. The Developmental Disabilities Administration indicated that training is adequate. There seemed to be a disconnect between its perception of staff training at group homes and the perception of physicians who treat psychiatric patients with developmental disabilities in hospitals.

Dr. Wisner-Carlson noted that the regulations are intended to protect the rights of individuals. He said that family could administer medication as needed, but staff for group homes cannot administer medication as needed, so the only alternative is an emergency room. It is a level of complication that may be beyond that charge of the CAG, but it highlights the complexity of the issue, and it becomes very cumbersome for EDs. Ms. Fleck asked if a clinician could come to the group home to administer medication, instead of a taking an individual to an ED. Dr. Wisner-Carlson commented that regulations probably do not allow this type of intervention. Dr. Peters commented that it is too late at that point. A patient may try to run out of a group home. He also added that it would be helpful to have more tools to de-escalate a situation instead of needing to go to a crisis center.

Ms. Fleck asked if it would be beneficial to change the configuration of an ED to better meet the needs of psychiatric patients with a developmental disability. Dr. Shaya responded that each hospital can decide, but it could put them at risk for not meeting certain requirements. Dr. Shaya also pointed out that the problems for the population of patients with a developmental disability are problems that other populations face as well. He suggested that it would be helpful to have tables for the population over age 60 with psychiatric issues that show estimated boarding times and lengths of stay for hospital admissions.

Dr. Shaya asked for more description on what is within the Commission's control. Mr. Steffen asked Paul Parker to review the services that are subject to CON regulations. Mr. Parker stated that psychiatric hospitals, psychiatric units at general hospitals, bed capacity, and residential treatment centers. Outpatient programs for behavioral health are not regulated. Sometimes a hospital may be developing a range of psychiatric services and facilities, including acute psychiatric services. The whole project is reviewed, even though only acute psychiatric services may be subject to CON review. Mr. Parker also noted that intermediate care facilities, which are for drug treatment, are subject to CON regulations.

Dr. Shaya asked if post acute hospitals are subject to CON regulations. He asked specifically about Levindale Hospital, as an example. Mr. Parker responded that Levindale has three separate licenses for services that are all subject to CON regulations. It has a chronic unit, a rehabilitation unit, and a nursing home (comprehensive care facility). Establishing any of those special facilities requires a CON. Dr. Shaya asked about whether intensive day programs are subject to CON regulations. Mr. Parker responded that those services are not subject to CON regulations. The program would only be reviewed if it was part of a larger project that is subject to CON regulations.

Ms. Fleck commented that it would be helpful to have feedback on how the need for acute psychiatric services should be evaluated. She asked, what the signs are that there is a need for a service or a particular population; should the State encourage the development of programs for a particular population; and is there data that should be collected that would be helpful to evaluate the need for acute psychiatric services. For example, she asked whether capturing the intensity of staffing would be valuable. Although MHCC does not control rates for psychiatric services, it could potentially highlight an issue, like a lack of financial reimbursement, and make recommendations to the HSCRC.

Dr. Shaya commented that for non-psychiatric hospital patients, there are more levels of care with different staffing requirements. For psychiatry, it is one rate. It would be helpful to have recognition in the rates with stratification for the intensity of resources required. It would better reflect the reality and create greater parity among services. Dr. Peters agreed with Dr. Shaya's point. There needs to be rate reimbursement commiserate with the level of care. He also suggested that more geriatric psychiatric beds could be helpful and identified this population as one that requires greater resources. Mr. Steffen asked if anyone was aware of a state that has tried to tackle offering different levels of reimbursement for psychiatric patients. No one knew of another state tackling this issue.

Ms. Fleck commented that the lack of recognition of the intensity of resources required for some patients has previously been raised. She noted that often MHCC staff evaluates the occupancy rates for psychiatric beds to determine if there is a need for more beds. Very high occupancy rates may be an indication that more psychiatric beds are needed. She noted that occupancy rates are not currently extremely high, despite reported problems with a lack of beds and boarding of patients. MHCC staff was told that for semi-private rooms with two beds, it may only be possible to have only one patient in the room, due to the level of staffing required. If that is the case, then occupancy rates may not be a good indicator of need.

Dr. Peters commented that everyone to some extent may be treating psychiatric patients with developmental disabilities. Everyone to some extent works with children and adults who are psychiatric patients with developmental disabilities. He noted that treating this population can result in less efficient use of resources, if there is not a program in place for them, which can then impact the resources available for other patients. Ms. Fleck mentioned that the idea of encouraging more private rooms came up. Dr. Shaya responded that it is both rooms and staffing. If there is two to one staffing, which may be required occasionally or even three staff members, then fewer patients may be accepted to a psychiatric unit. Ms. Fleck responded that she understood, but she wanted to know if encouraging the development of more private rooms would be helpful. Dr. Shaya responded that it would be helpful.

Dr. Shaya stated that another challenge is patients who are not helped by treatment. The result may be prolonged time in an acute psychiatric bed for two or three months. Ideally, these patients would be in a long term facility, but State beds are not available anymore. There should be a better solution. Ms. Fleck asked if there is a way to identify those patients specifically. She noted that there is a code for homelessness, but other subpopulations of psychiatric patients may be harder to identify.

Dr. Shaya stated that the patient population that may need a long term care facility are those with severe psychoses that have not been helped by treatment in the hospital or who have not been adherent to medication treatment. Many of those patients wind up back on the streets. There is not a good alternative. The patients are too dysfunctional, and the process for getting guardianship and civil commitment cannot be carried out. These patients are often then discharged with a relatively safe plan, but not a good plan. State hospital beds are not available. We need to recognize that for the small percentage of patients who are not helped by treatment in an acute hospital setting, it may be more appropriate to place the patient in a long term facility.

Ms. Fleck asked whether more specialized programs are needed and whether a critical number of patients is needed for them or whether spreading the burden around makes sense and raising expectations for staff, in terms of their ability to treat a range of patients. Dr. Wisner-Carlson commented that it would be better to concentrate patients. If staff has the skills for handling patients with developmental disabilities, then the time that it takes to stabilize a patient may be much quicker. Dr. Chico commented that sometimes there is too much emphasis on getting into a specialized unit, when one is not needed or it is preferable to have treatment sooner rather than boarding in an ED. He provided the example of a patient with opioid dependence and a psychiatric problem. He stated that management of opioid withdrawal is part of standard general psychiatry training. Mr. Steffen suggested that it may be more equitable to spread high cost

patients among hospitals, if the HSCRC rates do not account for the full range of costs for treating some patients.

Dr. Shaya commented that the way patients are handled who are not responding to treatments is to increase the staffing ratio in order to keep all patients safe. It may be more efficient to have all units to have some baseline ability to respond to high intensity needs for some patients, similar to the expectations for medical surgical units.

Ms. Fleck asked whether travel time should be a consideration in defining reasonable access to acute psychiatric services. She noted that it could be a different standard for different age groups. Dr. Wisner-Carlson commented that his program gets inquiries from all over the state and many would come from outside the state, if they had the opportunity. Dr. Shaya commented that facilitating access for families and community based providers would be helpful. Ms. Fleck explained that sometimes travel outside of a health planning region is regarded as an indication of a lack of access. She asked for feedback on what the criteria should be for adequate access.

Dr. Peters commented that there are behavioral health ‘deserts’ outside of the Baltimore and District of Columbia regions, such as on the Eastern Shore and out on the panhandle. Although the focus of MHCC is on the acute level of psychiatric care, having more services along the continuum of care would help with inpatient diversion and better utilization of acute psychiatric beds. It will continue to be hard to assess the number of beds needed, until better use is made of the existing beds. Both are needed, but helping the throughput is important. Dr. Shaya pointed out that in Table 9, the percentage of patients with a developmental disability that stayed over 20 days was 2.3% in 2010 compared to six percent in 2018. He also noted that the number of psychiatric patients admitted who are homeless doubled between 2010 and 2018. Clearly, there has been a change over time.

Dr. Wisner-Carlson commented that the units at Sheppard Pratt are for those with autism and extreme challenges due to a developmental disability. He noted that the autism codes do not capture very well those with severe problems. The more severe group really needs specialty services. It is hard to imagine putting another program in other parts of the State if there was not a real financial commitment to it. He mentioned that he is board certified psychiatrist and board certified neuropsychiatrist. There are few of the latter in the country. He specializes in developmental neuropsychiatry. He seemed skeptical about putting a unit on the Eastern Shore for those with the most severe problem because he did not think an organization would have the expertise or interest to create such a unit. However, he agreed that better access to services for those with less severe problems makes sense. There is boarding in hospitals on the Eastern Shore due to the lack of available inpatient psychiatric specialty beds.

Ms. Praglowski commented that when children are in an emergency department waiting for a psychiatric bed, the family does not want to go more than ten miles away and would prefer to wait. Sometimes this has to do with transportation concerns, time away from work, and the ability to be part of the treatment team. Ms. Fleck commented that she understood the family preferences, and she asked how often that situation arises. She also asked for feedback on solutions. Ms. Praglowski commented that it often arises, and a family would rather wait a day instead of going to a hospital in the District of Columbia.

Dr. Shaya noted that acute psychiatric services are not that different from other kinds of medical services, like bone marrow transplants and heart surgery. These services are not available in every hospital and not every hospital needs to provide those services. The majority of patients, they can be served in community hospitals, but for those who need highly specialized services the right balance is needed. Ms. Fleck asked if there is a way to define the need. She noted how challenging it is to address that when access to other services on the continuum affect the need for acute psychiatric services, and access to some of those other services may not improve, even if a need has been identified.

Dr. Shaya suggested that a pragmatic approach be taken. The focus should be on what MHCC can do, and the goal should be to take one step forward. It would be better not to be overly ambitious and try to improve the system just a little bit. In his view, a graduated reimbursement rate could help improve capacity and improve care.

Ms. Fleck noted that the HSCRC discharge data has a field for capturing one-on-one staffing, but HSCRC does not do anything with the information, and the field is often blank. However, if it is important to capture that information and use it, then maybe there needs to be a change. She also noted that the existing fields may be inadequate, if sometimes staffing must be even higher, at two to one or three to one.

Dr. Shaya commented that every unit in a hospital has a budget and must be mindful of it. The psychiatric unit tries to do the best for patients, but that can mean that a patient is left waiting in an emergency room because the acuity on the unit is too high to accept another patient. Dr. Peters commented that even if staffing is not specifically two to one for a given patient, the staffing on the unit may be higher due to patient acuity. Even if nurse staffing is not high for patients, routine additional staffing may be required for certain programs.

Dr. Peters commented that better compensation for care will be helpful, but it should not just be based on nursing staff. Ms. Fleck responded that she expects that it may be easier to account for costs for a psychiatric hospital as compared to a psychiatric unit within an acute care general hospital which has a global budget that covers multiple types of hospital services.

Mr. Steffen commented that MHCC has been a participant in multiple meetings of different bodies, and the boarding issue has been raised in all of them. He asked about tracking of ED boarding and whether hospitals compare themselves to each other. Mr. Steffen commented that people wanting to be close to home makes sense, but in some cases, it seems like families will only accept placement in one hospital and do not want to leave ED until that hospital has an opening. He asked about how much education is done for families to discourage that approach. Dr. Shaya agreed that education should be done. However, he noted that apart from that issue, there is boarding and will continue to be boarding.

Dr. Shaya then also commented that he did not think it was common for boarding to occur because a family only wanted to go to Sheppard Pratt Hospital. Dr. Wisner-Carlson commented that his perspective is skewed, but based on his perspective, it happens all the time. Families recognize specialty care is needed. Dr. Shaya clarified that he had in mind patients with less

specialized needs and did not think those patients spent excessive time boarding because of family preferences for a specific hospital. Dr. Chico commented that they do not let families board in the ED due to hospital preferences. Families are informed upfront and asked to sign a form. Unless there is a specific reason that specialized care is needed, patients cannot board due to a hospital preference. Dr. Chico also commented that boarding times have doubled in the past five years.

Joe Petrizzo commented that parents' preferences do not dictate where children and adolescents go for acute psychiatric treatment. However, for patients with a developmental disability, when the hospital tries to get the patient into a psychiatric unit at another hospital, the hospital is told that the other hospital cannot treat the patient, and then the patient may be boarded for several weeks until placement at Sheppard Pratt Hospital is possible. Dr. Chico commented that is also what happens at Greater Baltimore Medical Center. Mr. Petrizzo commented that the focus is on finding a bed and patients will be sent anywhere in the region where one can be found. Mr. Steffen commented that at other meetings concerns have been raised by some families about the placement options presented.

Mr. Steffen returned to the topic of telehealth. He asked what should be done to make the diffusion of telepsychiatry more effective. Although it is not a CON issue, MHCC has some credibility on it. Dr. Shaya commented that revising the regulations, as proposed earlier in the meeting would be helpful. Dr. Shaya also commented that there is data validating the benefits of telepsychiatry in North Carolina. Dr. Peters agreed that data supports the use of telepsychiatry. He noted that he works on the Committee of Telepsychiatry for the American Academy of Child and Adolescent Psychiatry. The data shows that treatment through telepsychiatry is just as good as psychiatry services provided in-person. States that have revised their regulations have benefited from those changes. Dr. Peters offered to provide more data if it would be helpful. Mr. Steffen responded that MHCC staff would reach out directly for it.

Ms. Fleck asked if anyone had any final comments. No one did. Ms. Fleck mentioned that a tentative meeting was scheduled for November 20, 2019 at 1:00 p.m. Dr. Shaya suggested synthesizing the discussion and having an action plan for this meeting. Ms. Fleck asked if the date and time would be acceptable for CAG members. No one objected. Mr. Steffen asked if anyone remembered when HSCRC last reviewed facility reimbursement for behavioral health services, but no one did. Mr. Steffen indicated that he would reach out to HSCRC directly to find out. Ms. Fleck let everyone know that the meeting had been recorded and she would be providing a detailed meeting summary.

**Draft Meeting Summary
Psychiatric Services Clinical Advisory Group Meeting
Wednesday, November 20, 2019
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue, Baltimore, MD 21215**

Attendees

Anthony Chico, M.D.
Stephanie Knight (phone)
Todd Peters, M.D.
Joe Petrizzo (phone)

Corneliu Sanda, M.D. (phone)
Jane Virden (phone)
Robert Wisner-Carlson, M.D. (phone)
Nancy Praglowski (phone)

MHCC Attendees

Eileen Fleck
Paul Parker
Ben Steffen
Suellen Wideman, AAG

Other Attendees

Patricia Cameron, MedStar Health
Nancy Jones, Capital News Service

Eileen Fleck convened the meeting and asked attendees to introduce themselves. She indicated that no one suggested any changes to the draft meeting summary distributed. The members of the Psychiatric Services Clinical Advisory Group (CAG) agreed to finalize the meeting summary without changes. (Following the meeting, Ms. Fleck realized that she had overlooked feedback on the November 6, 2019 meeting, and a revised meeting summary was distributed.)

Ms. Fleck next explained that one of the goals of the meeting is to discuss changes to Certificate of Need (CON) regulations especially how to evaluate the need for acute inpatient psychiatric services. At the last meeting the discussion was more generally focused on problems with the behavioral health system and specific populations. Ms. Fleck asked members to consider the first question in the discussion guide. She asked whether there is an outcome measure or multiple outcomes measures that would be useful for evaluating the need for acute inpatient psychiatric services and determining whether the need is being met in a given region in Maryland.

Jane Virden suggested length of stay in the emergency department (ED) as one measure. She noted that over four hours is considered boarding. Ms. Fleck asked if others agreed with using ED boarding as an indicator of need for additional acute inpatient psychiatric services. Several

members agreed with that approach. Ms. Virden also suggested considering the number of people served outside their region. Ms. Fleck asked if that approach should be for adults only or other age groups too. Ms. Virden commented that children and adolescents are often placed outside the region where they reside. Ms. Fleck explained that there are fewer locations with inpatient psychiatric beds for children and adolescents, and she wanted to know if there should be a different standard for those age groups. Mr. Petrizzo and another member commented that the standard should be the same.

Ms. Fleck asked whether a four hour delay should be the threshold for adding new acute inpatient psychiatric beds or a longer period. Stephanie Knight, M.D. commented that most patients wait more than four hours to be placed in a psychiatric bed. She was not sure how boarding should be defined. Ms. Virden explained that for both psychiatric and non-psychiatric patients, time beyond the first four hours after arrival is considered boarding. Mr. Petrizzo commented that for his hospital four hours is about average for medical patients, and if patients are in the ED for longer periods then it backs up the ED.

Ms. Fleck noted that it was brought up at previous meetings that some psychiatric patients are worse off as a result of spending excessive time in an ED because of the environment. She asked what amount of time should be considered acceptable, based on protecting the well-being of patients. She acknowledged that it may be different for different patients.

A member commented that the only time requirements for psychiatric patients pertain to those on an emergency petition; those patients are required to be evaluated within six hours. There are not other regulations that provide a guideline for time. Most facilities have a policy that the mental health assessment has to wait until a patient is clinically sober or has a blood alcohol level lower than a specific value. If a patient's blood alcohol level is high, then it may take four hours for the patient's blood alcohol level to be reduced to a level that is acceptable for conducting a mental health assessment. Mr. Petrizzo agreed that is a problem. He added that boarding hours should begin once a hospital has determined that the patient should be placed in an inpatient psychiatric bed. Ms. Virden also suggested that if the psychiatric patient census in the ED is higher than the number of available beds at a hospital, then that should be considered a problem. There needs to be throughput in the ED. If there were 13 psychiatric patients boarding at her hospital's ED that would be 50% of capacity.

Ms. Virden commented that some children may wait as long as 41 days for a bed. Ms. Fleck agreed that she had seen in the HSCRC data that a small number of patients may wait weeks in an ED. More often, the wait may be five to eight days, which is not ideal. Anthony Chico asked whether the question posed by Ms. Fleck is one that is asked of other patients. For example, what is an acceptable time for a patient with chest pain to wait in an emergency department or a patient with sepsis. Patients should be stabilized as soon as possible. Dr. Chico noted that at Greater Baltimore Medical Center, the volume of psychiatric patients has remained the same, but the time these patients spend in the ED has doubled. Something in the system is causing a problem. Fifteen years ago patients were placed the same day. Now the average time is days. In his opinion more than one day in an ED is not acceptable.

Dr. Knight commented that if regulations were to require an individualized treatment plan when a patient stays over 24 hours that would be a way to acknowledge that care must be progressed. She also suggested that it is relevant whether the ED has a dedicated area for behavioral health patients and staff with specialized training for those patients. She commented that the acceptable amount of time for boarding a psychiatric patient is highly variable and based on many factors, so she cannot pick one number as the acceptable length of time for boarding.

Ms. Fleck asked whether some level of overall crowding in an ED could be used to define the need of acute psychiatric beds. Mr. Petrizzo commented that there is still a law or regulations that require a hospital ED to contact the State for help in finding a bed for a patient, if the hospital has not been able to do it within six hours. For that reason, he suggested that six hours be the standard. He noted that Holy Cross Silver Spring has seen an increase in psychiatric referrals in the ED, almost double. Ms. Fleck asked if anyone else wanted to comment on the issue. There were no additional comments.

Ms. Fleck next asked members whether the CON application review process should be used as an opportunity to identify and document shortcomings in the continuum of mental health care in a health planning region or jurisdictions where the population to be served resides. Traditionally, Staff evaluates CON applications based on specific criteria and the need for the proposed service. However, the whole continuum of mental health services affects the need for acute inpatient psychiatric services, even though a hospital has limited control over those other aspects of the system. Nancy Praglowski commented that she agreed with that approach, if access to residential treatment services would be considered. Patients who need that type of care often face long waits. She added that she is aware of a patient who currently is waiting for a bed, and the patient has been waiting over five weeks.

Dr. Knight asked what would be done with information regarding needs for behavioral health services in a region, as part of the CON process. In addition, she noted that other groups have been identifying problems with the behavioral health system, and it could be seen as a duplication of effort. Ms. Fleck responded that an applicant would probably see that requirement as a large burden, but hopefully the applicant would draw on existing work already done. Staff could also be expected to do some analysis. There is a question as to what to do with the information. Ms. Fleck asked to what extent the shortcomings of the health care system should be accepted and whether less capacity should be approved, if ideally other changes should take place instead.

Todd Peters, M.D. commented that not all beds are the same. The types of beds proposed should be considered. Whether the proposed beds are general inpatient psychiatric beds or specialty beds should be taken into account. The infrastructure outside of acute inpatient psychiatric beds should also be considered. In his view, even though the infrastructure outside of acute inpatient psychiatric beds should be considered, it should not limit the development of additional beds that are identified as needed. He also noted that catchment areas are different for residential beds and acute inpatient psychiatric beds, and the travel time used to define access should not be the same.

Ms. Virden commented that Maryland Hospital Association (MHA) did a study last year of discharge delays for the psychiatric patients, and she suggested that it may be useful to the work of MHCC. Ms. Fleck agreed that providing the study to CAG members would be helpful. She also noted that MHA has done a study to examine the reasons for boarding in emergency departments, and those results may be helpful too. A final report has not been issued yet though.

Mr. Petrizzo commented that there need to be more beds for involuntary patients. His experience is that the patients who board the longest in the ED are those who are involuntary. Ms. Fleck responded that she did not think beds were designated for involuntary patients specifically, but some hospitals do not accept involuntary patients. A CAG member confirmed that is correct. Ms. Fleck noted that the issue of whether hospitals should have to take involuntary patients was raised by the work group at a prior meeting. She asked whether anyone wanted to offer feedback on that issue.

Mr. Petrizzo commented that psychiatric units for voluntary and involuntary patients are very different and subject to different regulations. Ms. Fleck commented that she understood that it may not be appropriate to impose new expectations on existing programs that do not take involuntary patients, but she would like to know whether it is reasonable to expect any new inpatient psychiatric program to accept involuntary patients. Ms. Fleck asked what a better approach would be, if involuntary patients have more difficulty accessing a bed.

Dr. Peters suggested that a compromise might be to prioritize approval of programs that meet the needs of patients that are not being met well, whether involuntary patients or other patients with specialized needs. Dr. Knight commented that acute inpatient psychiatric programs should be required to accept involuntary patients. There is a stigma for people with severe and chronic mental illness that is worsened by allowing some hospitals to refuse to accept those patients. Usually people who are involuntary do not have insight into their illness. She agreed that there is a general lack of beds for involuntary patients.

Mr. Petrizzo asked to find out the number of CON projects in the past ten years for new inpatient psychiatric capacity that were approved, even though the applicant would not accept involuntary psychiatric patients. Ms. Fleck responded that staff will review its records for CON projects and find out the answer.

Dr. Peters noted that the majority of patients who come in to his hospital on an emergency petition convert to being voluntary patients. There is a lot of infrastructure for handling involuntary patients. One case took six hours and tied up a whole team of people. It is more challenging to have a program that takes involuntary patients, which may be the reason that some hospitals have avoided it, but the burden is then not equally shared.

Mr. Petrizzo agreed with Dr. Peters. He also noted that there is virtually no access to State beds. The State hospitals used to accept some of the chronic involuntary psychiatric patients. Ms. Fleck asked if anyone had tried to address the issue with the State. Dr. Knight noted that the courts and jails have more people that are waiting for forensic assessments, and with facilities aging, and challenges with staffing, multiple factors contribute to the lack of access to State hospital beds. Salaries have increased for psychiatrists at State hospitals in order to recruit them. She agreed that

the State is not a resource. Ms. Fleck agreed that the State hospitals are used almost exclusively for forensic patients. She asked again if anyone had reached out to try to address the lack of access to State hospital psychiatric beds. No one knew of outreach by their respective organizations.

Ms. Fleck asked if anyone wanted to comment on what the expectations should be regarding the acceptance of involuntary and involuntary patients. She noted that her impression is that most people feel that there should be more sharing of that burden. Dr. Chico commented that he does not see a difference in the wait times for involuntary and voluntary patients at Greater Baltimore Medical Center. He also noted that previously when he worked at St. Joseph Hospital, which does not take involuntary patients, it was still operating at full capacity. His impression is that all beds are full. There is a need for beds for all patients.

Ms. Praglowski commented that the adult psychiatry program at Johns Hopkins Hospital takes voluntary and involuntary patients, and the child psychiatry program only takes voluntary patients. She would say the hospital is 98% full from September through June. During the summer months, occupancy is a bit lower for children and adolescents. Another member asked about whether lengths of stay are different for involuntary and voluntary patients. It was noted that length of stay is affected by discharge barriers, such as waiting for a residential treatment bed. Mr. Petrizzo commented that he thought there are 27 involuntary units, and 13 units that only take voluntary patients.

Ms. Fleck next asked question 5 from the discussion guide: Should a CON applicant be required to address the cost-effectiveness of providing additional resources along the continuum of mental health care that would likely directly reduce the need for additional acute psychiatric beds in the health planning region for the proposed project?

Ms. Fleck commented that this could be a way to highlight the cost of having expensive services versus less expensive services. She asked for feedback on whether members agreed with this approach. Ms. Fleck added that usually a CON applicant is asked to address the cost-effectiveness of a project and to consider alternatives to the proposed project. She has proposed something different. It is not alternative approaches to meeting the need for acute inpatient psychiatric services, but rather considering alternative services that could reduce the need for acute inpatient psychiatric services.

Dr. Peters commented that it a tough issue because the problem is multi-factorial. The strategies for addressing discharge delays are important and financial reimbursement is a factor. If expansion is limited based on the need to do other things, then the immediate problem may not be addressed. Ms. Fleck responded that the purpose is not necessarily to limit the addition of psychiatric beds, but to highlight the tradeoffs that are being made. Dr. Peters commented that if the information was used to augment a case, then it could be helpful for making sure everyone is trying to be part of the solution, but he recommends fixing the system at a more macro-level first. No one else had comments on the issue. Ms. Fleck suggested that members contact her if they had additional feedback following the meeting.

Ms. Fleck read the next discussion question: Should providers be required to engage in outreach or develop partnerships with community providers to address the mental health needs of

the population instead of only providing acute psychiatric services? A member commented that finding good follow-up services is a plan. A partnership might help address that issue. Dr. Knight commented that it depends on how formal the relationship is expected to be. In a secondary way, there are strong incentives that reinforce the importance of having partnerships.

Dr. Knight also asked whether it is a problem for other systems. Ms. Fleck responded that she agrees that there are other sources of pressure on systems in terms of population health, and MHCC sometime expects hospitals to do more to promote prevention of disease, such as heart disease, through community outreach or other measures. Dr. Knight agreed that adding a requirement to the CON process would reinforce that point, and it would not be that onerous because most systems probably have something in place. However, she was not sure if that would also be true in rural or less urban areas. Dr. Peters commented that there are already regulatory requirements for follow-up within seven days. He sees the issue as one that may already be adequately addressed, but he also wants to be sensitive to programs that may find it harder to meet such a requirement. Ms. Fleck asked if anyone else wanted to comment on the issue, and there were no additional comments.

Ms. Fleck read the next discussion question: Should the establishment of a new psychiatric hospital or unit for adults (not just expansion) be tied to also providing beds to another special population that is underserved in a region, if that need is identified? Ms. Fleck explained that in earlier meetings of the workgroup, there was a concern expressed about certain special populations not having adequate access to acute psychiatric beds and a concern that a provider might choose to only serve those perceived to be easier and less expensive to serve, such as adult voluntary patients. She again noted that a requirement to serve a special population would only apply to a CON applicant if a need has been identified in a health planning region.

A member asked why only adults were referenced in the question. Ms. Fleck responded that she considers adolescents and children to be special populations. Mr. Petrizzo asked how the need for beds for a special population would be identified. Ms. Fleck responded that she would appreciate input on how to identify the need for acute psychiatric beds for special populations. Ms. Fleck stated that MHCC staff is open to considering other criteria for defining the need. Dr. Peters commented that he likes some aspects of that approach. It has been permissible for a while for someone to declare that they do not serve specific population. He asked how much weight would be given to a need identified in making CON decisions. He stated that it would be a helpful approach for meeting the most critical needs, such as kids with autism, adults with co-occurring disorders, involuntary patients, or others.

Dr. Wisner-Carlson provided an update on the START services project in Maryland. START services are directed at individuals with developmental disabilities who also need psychiatric services. When START did its assessment of services in Maryland, it identified a dearth of the middle range of services. Ms. Fleck asked if a copy of the assessment could be provided to MHCC staff. Dr. Wisner-Carlson offered to look into it. Ms. Fleck commented that it may be helpful to know their methodology for identifying needs.

Ms. Fleck then returned to the issue initially raised, identifying critical needs for special populations. She suggested that having a threshold of need for a population is important because

if the need is too small, only one or two beds, then it may not be reasonable to require a CON applicant to address the need because it would not be cost-effective and sustainable. Dr. Knight agreed with Ms. Fleck.

Dr. Knight asked about why a distinction was made by MHCC staff between CON applicants developing new acute inpatient psychiatric services and an applicant expanding existing acute inpatient psychiatric services with respect to the potential requirement to serve special populations when a need is identified in a health planning region. Ms. Fleck responded that if someone already has a psychiatric unit, then it would be more of a burden for a CON applicant and unfair. She asked if anyone viewed the issue differently. Dr. Knight agreed with Ms. Fleck. Dr. Knight also agreed with the approach suggested by MHCC staff.

Jane Virden asked if there is a way to document capacity. She commented that kids with specialty needs can only be admitted to the twelve beds at Sheppard Pratt Hospital from the hospital's ED. Kennedy Krieger is not an option for acute inpatient psychiatric care. It is licensed as an acute rehabilitation hospital. With respect to capacity, Ms. Fleck noted that MHCC conducts an annual survey of bed capacity and tracks who is serving adults, adolescents, and children.

Ms. Virden commented that beds are full and that is what results in long waits for beds. Ms. Fleck responded that occupancy rates have been calculated by MHCC staff and included in the White Paper previously distributed. It did not appear that occupancy rates are extremely high everywhere all the time, but MHCC staff were told that due to patient acuity sometimes only one acute psychiatric patient may be in a semi-private room with two beds. That makes it tricky to rely on occupancy as an indicator of need for additional acute psychiatric beds. Consequently, it may be important to capture more information on how often that happens or to consider changing some of the assumptions about when additional beds are needed.

Ms. Virden summarized some of the information from the White Paper, noting that from 2008-2018, the adolescent discharge rate increased 26.4% in Table on page 18. Demand is seasonal for that group. There are beds needed year-round for children with autism though. Over the past five years, there has been a dramatic increase in demand during the school year. Ms. Fleck agreed that demand has increased.

Ms. Fleck asked for additional feedback on the idea of requiring CON applicants to meet the need for specialized psychiatric beds, when needed in a health planning region. She also asked about how the minimum threshold of need should be defined.

Dr. Knight responded that she does not have the expertise to answer the right threshold of beds. With respect to occupancy rates, she noted that at her hospital, for October, occupancy was 95% on average for adult beds, which are all single rooms.

Mr. Petrizzo commented that he is not sure about how to identify the level of need for specialized populations, but he agrees with the concept and trying to develop more specialized beds for children with autism, children, adolescents, and the geriatric population. Dr. Knight commented that she is not sure why there are not more specialty beds, and it is important to know why that is the case, before making the suggested policy change. Dr. Peters responded that one

reason is the lack of differentiation in payment. The staffing needed for a specialized bed may be twice as much. There could be other reasons, such as that it is harder to staff and additional training required. In his view, with better reimbursement more people would do it. Dr. Petrizzo agreed with Dr. Peters. He added that behavioral health patients are lumped together, unlike with other medical patients. Some patients require intense staffing. Better reimbursement would attract more people.

Ms. Fleck asked if anyone from HSCRC was on the call, and no one responded. Ms. Fleck next explained that MHCC staff followed up with HSCRC on some of the issues raised at previous meetings. She noted that HSCRC has not looked at parity between acute psych services and other medical services, and further discussion with HSCRC staff is needed.

Dr. Peters commented that payment is based on outdated regulations. Ms. Fleck responded that HSCRC staff would probably say that they are looking at the actual costs to determine the appropriate reimbursement level. It sounds reasonable, but maybe part of the problem is that a hospital makes plans based on a budget that is not ideal, and next year's budget is based on the prior year, which was not an optimal budget, so the same conditions are perpetuated year after year. MHCC staff needs to get a better understanding of the situation. Dr. Peters commented that many hospitals with general units may be barely breaking even, and staff are becoming more costly, so the idea of a specialty unit that requires doubling some costs may not be appealing. He has just heard some of that from others. It may seem like too much financial risk for many hospitals.

Ms. Fleck moved on to the next topic on the discussion guide, drive-time standards that define geographic access. She read the current standard and asked whether the current standard should be revised in some way. Dr. Peters commented that when he practiced in Tennessee the drive-time standard was three hours. He suggested that different standards may be appropriate for specialized beds. Ms. Virden commented that for children and adolescents, it is important to consider the family's ability to travel. In the Baltimore area, some families do not have access to a vehicle and really want their children to stay local, even 30 minutes away would be too much. That is the majority of patients.

Dr. Peters asked about providing transportation to family or telehealth, even though that is not ideal. He suggested that in other states, those solutions have been used because only so many hospitals can be built. He commented that it would be helpful not just for inpatients, but across the whole care continuum. Ms. Virden agreed, but she also emphasized that physical presence is really important and much better for children and adolescents. Dr. Peters agreed. Ms. Fleck summarized the discussion by noting that no one had objected to the standards. However, it was suggested that it could be useful to have different standards for general psychiatric beds and specialized psychiatric beds. It may be reasonable to have a longer travel time for specialized beds, which is the case for many patients now.

Ms. Fleck stated that the question of how to identify need is an important one. ED boarding was mentioned as one indicator of need and occupancy levels. Ms. Fleck encouraged members to provide additional feedback on the issue, as well as information on how to better identify sub-populations with a need for better access to specialized services. That information would be

helpful to MHCC staff. Dr. Knight commented that distance traveled by patients was mentioned as another possible indicator of need.

Ms. Fleck noted that MHCC staff would speak again with HSCRC staff. She also noted that MHCC staff reviewed the regulations in New York state regarding telepsychiatry. The changes were fairly recent, and may not be a factor in the update of the Maryland regulations for acute psychiatric services.

Ms. Fleck noted that there would probably be a longer break before the next meeting of the CAG, and MHCC staff would probably first convene the other work group. She told members that she would send out a poll for potential meeting dates before picking a date. She asked if anyone wanted to make any comments before adjourning the meeting. No one had comments, but Ms. Nancy Jones asked whether MHCC had plans for submitting any legislation related to the update of the Maryland regulations for acute psychiatric services. Mr. Steffen responded that there were no plans at this time. Ms. Fleck adjourned the meeting.