Draft 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)
Adrienne Breidenstine
John Chessare, MD (phone)
Erin Dorrien
Kate Farinholt
Stacy Fruhling (phone)
Patricia Gainer (phone)
Ruth Ann Jones (phone)
Nicki McCann
Chris O'Brien
Joe Petrizzio (phone)
Renee Webster (phone)
Jennifer Wilkerson (phone)
Christine Wray
Marcel Wright (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 In Maryland, the methodology for determining the need for psychiatric beds is out of date, and MHCC staff has improvised when reviewing CON applications.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 re-purposing 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 Depart 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.