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 (phone)
Stephanie Knight
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. Ms. 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 Ms. Knight had been advised by someone on that interpretation. She noted that in-person does not necessarily mean physically located in the same place. Ms. 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. Ms. 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. Ms. 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 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. Ms. 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. Wary 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.