Draft Meeting Summary
Acute Psychiatric Services Workgroup Meeting
Tuesday March 17, 2020, 1pm-3pm
Maryland Health Care Commission (MHCC)
Virtual Meeting

Workgroup Attendees
John Chessare, M.D.
Kate Farinholt
Stephanie Knight, M.D.
Joe Petrizzio
Renee Webster
Spencer Wildonger (substitute for Nicki McCann)
Jennifer Wilkerson
Christine Wray

MHCC Staff Attendees
Eileen Fleck, Chief, Acute Care Policy and Planning
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Jessica Raisanen, Program Manager, Acute Care Policy and Planning
Suellen Wiedeman, Assistant Attorney General

Other Attendees
Pat Cameron, MedStar Health
Unannounced Attendees (4)

Eileen Fleck commenced the meeting and introduced the members of the workgroup. Ms. Fleck then discussed the Clinical Advisory Group (CAG) meetings and explained that MHCC staff created an executive summary. Full summaries are available online and were previously sent to the workgroup attendees. Ms. Fleck gave a brief synopsis of the CAG discussions; the CAG discussed placement challenges, discharge delays and specific reasons for them, caring for high acuity patients, involuntary patients, and reimbursement rates. The CAG emphasized that the whole care continuum is important when looking at need but it was challenging to get a direct answer from them on how they might recommend defining need. Ms. Fleck asked the group if there were any topics that were not discussed at the CAG meetings that are important to ask the CAG to consider. Workgroup members did not identify any.

Proposed Policies for State Health Plan Chapter for Psychiatric Services

MHCC staff proposed policies for the updated chapter and requested feedback from workgroup members. Jessica Raisanen stated that the policies will allow for a more detailed discussion of the issues that have been discussed in the workgroup and the CAG and provide a framework to guide the standards that will follow in the chapter. The proposed policies discussed are shown in italics.

Policy 1: People should be treated in the least restrictive setting appropriate to their medical conditions. *Treatment in the outpatient setting is preferable to hospital-based treatment for long-term management. Hospitalizations should be reserved for individuals with an acute psychiatric condition who cannot be safely managed in the community.*

Ms. Raisanen explained that this suggested policy is similar to three policies in the existing State Health Plan chapter. One of the existing policies states that the Commission supports a Statewide policy of deinstitutionalization. Another existing policy states that mentally and emotionally ill adults should be cared for in a discrete psychiatric unit rather than in a general medical surgical bed. Finally, the third policy states that patients should not be admitted to a State hospital for acute care unless necessary. Ms. Raisanen explained that these three existing policies are outdated.

Policy 2: An increase in funding and provision of mental health services by the private sector and the government is necessary to adequately meet the needs of Maryland's population. *The General Assembly, the governor, and the Department of Health, local government agencies, and health care facilities are encouraged to increase the capacity for mental health services in Maryland through funding community mental health resources.*

Ms. Raisanen explained the language in this policy was slightly similar to the language in existing Policy 7; this policy describes that the General Assembly, governor, and Department of Health should allocate funding to increase access to acute psychiatric care for uninsured and underinsured patients. MHCC staff's suggested update to the policy expands who is responsible for the provision of mental health services to include the private sector. The private sector should also contribute to funding for community-based mental health services.

Policy 3: Patients should be able to secure timely placement in a psychiatric bed when acute inpatient psychiatric services are required. *Boarding of acute psychiatric patients that results in decompensation is unacceptable.*

Ms. Raisanen explained that this suggested policy is not directly reflected in any of the existing policies. However, MHCC staff created this policy based on feedback from work group members that boarding psychiatric patients in emergency departments is detrimental.

Policy 4: Acute psychiatric services shall be financially and geographically accessible whether patients are voluntary or involuntary. *Facilities should increase their capacity to care for higher acuity patients and vulnerable patient populations. Acute general and private psychiatric hospitals with licensed inpatient psychiatric units should admit involuntary patients.*

Ms. Raisanen described existing Policy 6; it states that all acute general and private psychiatric hospitals should admit involuntary patients. MHCC staff suggested modifying this to reflect the discussion at the last meeting and allow for exceptions, so long as the status of the patient does not impact placement availability. Staff also included the language about high acuity patients and vulnerable patient populations to reflect the challenges with placing individuals with certain needs (e.g. individuals with developmental disabilities, geriatric populations).

> ***Policy 5: Patients shall be timely discharged from hospitals once acute psychiatric services or other acute care services are no longer needed.***
> *Discharge delays result in an inefficient use of resources and potentially negatively affect access for other patients.*

Ms. Raisanen explained that existing Policy 8 posits that hospitals must identify and coordinate outpatient mental health treatment and support services in preparing discharge, and if these are not available, the hospital must provide the services directly. MHCC staff suggested modifying this language to focus on discharge delays because most facilities already do significant discharge planning and it is regulated by other entities.

> ***Policy 6: A hospital with acute psychiatric services will continuously and systematically work to improve the quality and safety of patient care. This includes planning, implementing, and optimizing the use of electronic health record systems, electronic health information exchange, and telehealth to provide high quality, cost effective, and patient centered care.***

Ms. Raisanen explained that MHCC staff wanted to have a policy speaking to quality and patient care. The language in this policy is similar to what has been included in other chapters and colleagues at MHCC have helped to inform the language. It also highlights the importance of telehealth, which has been discussed in both the workgroup and CAG.

John Chessare, M.D., commented that the policies are excellent, but he asked that the statement about decompensation under Policy 3 be modified because boarding in emergency departments is unacceptable, not just boarding that results in decompensation. He did not think additional policies are needed. Ms. Fleck mentioned that the CAG had not been able to define an amount of boarding time that was unacceptable because it would vary patient to patient. Some people said that boarding for four hours is unacceptable, and others said that boarding over 24 hours is unacceptable. She explained that part of the reason why it was worded that way was because the amount of time could not be easily defined, and the main reason not to board the patients for too long is that it can result in decompensation.

Dr. Chessare responded that the generally accepted definition of boarding is a patient where there is no outflow to a better place. Although, organizations may argue about the amount of time that is too much, Dr. Chessare stated that he believes that all would agree that boarding is unacceptable. The deterioration part is unnecessary because boarding is blocking care to other patients. Jennifer Wilkerson agreed. Kate Farinholt also agreed. In her view, the point is not an

argument about the number of hours boarding that will lead to decompensation; boarding itself is unacceptable.

Ms. Farinholt suggested that Policy 5 could address discharge planning. Patients are sometimes discharged and not connected to the resources they need to avoid repeat hospitalization. Ms. Wilkerson stated that she believes that MHCC could certainly add something about discharge planning, but she asked for a clarification about the purpose of the policy statements because sometimes those types of things are out of the hospitals' control. Ms. Farinholt agreed that the hospitals cannot necessarily solve that problem alone, but by law there is supposed to be a discharge plan; MHCC should refer to this. Ms. Wilkerson commented that we could add something about a discharge plan. However, this may refer to a service (e.g. residential treatment, group home) that is unavailable, and the patient may end up staying longer in the hospital. It is not necessarily something that the hospital could affect.

Ms. Fleck clarified that the policies are to inform the standards and are a big picture view. Ms. Raisanen added that the policy section of the State Health Plan chapter serves to establish ideals. With that in mind, Ms. Farinholt reiterated that she would recommend adding a piece about discharge plans that link with appropriate services. Ms. Fleck suggested that discharge planning could be included as a standard, rather than in the policies. Ms. Raisanen suggested that it could be put both in the policies and the standards, if desired, and that we could consider the need to make a standard for it later. Ms. Wilkerson commented that we may be getting beyond the scope of the policies because discharge planning is already regulated by other agencies. Stephanie Knight, M.D. agreed with Ms. Wilkerson.

Health Planning Regions

MHCC staff explained that the existing SHP chapter for acute psychiatric services defines five health planning regions and referred workgroup members to materials sent out prior to the meeting (Agenda Item 3 Part 1). Ms. Raisanen discussed the number of programs in each of the health planning regions. In the Central Region, there are more psychiatric programs than in the other regions. Eastern Shore has the fewest acute psychiatric programs. Ms. Raisanen also noted an error in the handout; Montgomery Region has five adult psychiatric programs, not four, as listed. For children and adolescents, there are no programs in the Southern Region or in the Eastern Shore Region. For programs denoted as having geriatric beds, Ms. Raisanen clarified that these beds are specialized beds within an adult program. There are no geriatric designated beds in the Western Region, Southern Region, or Eastern Shore Region.

Ms. Raisanen explained that most hospitals with acute psychiatric services also have a partial hospitalization program or an intensive outpatient service program. She also reviewed other information in the handout, including the types of beds, the daily average census, and the number of staffed beds per region. Daily occupancy rates of staffed beds and the number of programs that accept involuntary admissions were used to determine the number of staffed beds that are available to involuntary patients. A vast majority of beds in the State are available to involuntary patients. Dr. Knight mentioned that there are State hospitals missing from the document; there are actually five in the State of Maryland. Ms. Raisanen clarified that the State hospitals are not included in

any of the data on the table but that she would update the information to include all of the State facilities that Dr. Knight mentioned.

Ms. Wilkerson mentioned that the occupancy rates do not contribute to understanding the bed need because there are needs for very specific kinds of beds. Renee Webster mentioned that there are 16 new beds added at a new facility in Anne Arundel County. Ms. Webster also stated that Adventist HealthCare at White Oak Medical Center opened up the beds last week, probably 16 beds. Ms. Fleck reiterated that these data are for fiscal year (FY) 2019. MHCC staff recognize that capacity has changed a bit in FY 2020.

The workgroup then reviewed the next handout (Agenda Item 3 Part 2). Ms. Raisanen explained that the tables show where patients from each of the existing health planning regions are hospitalized. The numbers that are bolded represent those who are able to be seen in their region of origin, and the data are separated by age group. Data are fairly similar for children and adolescents; a vast majority of discharges for patients from the Central Region and Western Region are from hospitals in the same region where the patient is from within these two age groups. There are no child or adolescent units in the Southern or Eastern Shore regions. Therefore, the numbers of children and adolescents hospitalized in the region where they reside is much lower. The pattern for adults and geriatric patients are also similar to each other but geriatric patients seem to be discharged from programs outside of their region of origin more frequently than other adults.

Ms. Wilkerson stated that she is not surprised by the patterns described because it just reflects the current location of psychiatric beds. Ms. Farinholt said that seeing these data is really helpful and that they fit with what she has heard. Ms. Fleck asked if it is a problem that people travel outside of their region for care, and whether it is a particular problem for any specific age group. Dr. Knight commented that regardless of the duration or age of a patient, anytime you put someone into a vehicle for a period of time, then it increases risk. These data are helpful to demonstrate what everyone in the workgroup already knows; it is consistent with what has been said.

Dr. Knight also stated that she believes that it is harder for older adults and children to travel a significant distance. There are fewer resources in the community for these age groups, and when they are hospitalized in acute settings outside of the regions where they reside, it is hard to connect them to local resources following discharge. The discharge planners may not be aware of resources in patients' home regions. This adds additional challenges to discharge planning. Also, if they are older adults and their caregivers or children, then travel for family members or guardians is more challenging.

Ms. Farinholt agreed with Dr. Knight and said that she believes this is true for all ages. Patients have issues with their support network visiting, especially people on the Eastern Shore or elsewhere, if it is so far for them to travel. Ms. Farinholt described that if a patient has been connected to any kind of community services in their own community, it can still be a problem to get them reconnected to those prior to discharge. Ms. Fleck asked if Ms. Farinholt could explain a bit more because she was surprised about the challenges with connecting patients back to resources if they have already been connected.

Ms. Farinholt responded that ideally, psychiatric patients would be able to connect before or upon discharge. Sometimes people are told that they need to be connected or even have an appointment, but that connection does not always happen; the patient could just disappear into the community with a prescription and being told to follow-up. Dr. Knight agreed that was an excellent point, and unfortunately, it happens with some frequency. If patients are treated in a different region, their mobile treatment teams are much less likely to come see them. Dr. Knight noted that this can happen sometimes even within the city limits, but it is a certainty for patients hospitalized in a different region from where they live.

Dr. Knight further explained that providers may not have access to information about the previous treatment in the community because of the increased level of privacy related to psychiatric records. Sometimes providers do not share information on mental health treatment in CRISP or with other providers. Dr. Knight stated that if a provider is working with a patient who they are not familiar with, the patient could have been seen many times in another region. If the person is too ill to communicate who past provider are, then a new provider may have no idea of the person's prior history. Dr. Knight also stated that Behavioral Health Systems Baltimore (BHSB) has been a failsafe because they often have insurance information about where the person may have received care, but that assumes that they have Maryland Medical Assistance.

Ms. Fleck commented that it was surprising to her to hear that privacy concerns are a barrier for psychiatric care in particular. Dr. Knight stated that it may vary by facility but at the University of Maryland, when they switched to EPIC, there was concern about protecting the privacy of employees and trainees who seek treatment for mental health concerns. Dr. Knight also commented that there are more HIPAA laws related to psychotherapy notes and substance use treatments. To her knowledge, there are not more restrictions for general psychiatric care that exclude those two sections. She states that it has been a conscious choice by the University to restrict sharing.

Ms. Farinholt agreed that protecting privacy is a huge issue. A lot of the issues are not HIPAA related but are really institutional decisions. She commented that MHCC staff could consider some standards related to this, as other states have done. Ms. Farinholt stated that NAMI tells families once they find their relatives to provide as much history as possible, and keep it themselves so that they can hand it over to the hospital system as well as at discharge. This is another reason why it is so important to have caregivers be present. Ms. Wilkerson mentioned that she would want to defer to the clinical folks, but her sense is that there could be a benefit to statewide guidance, but there may have to be exceptions for employees.

Ms. Wilkerson also expressed that the regions are somewhat arbitrary and may not necessarily account for travel patterns. Further, she noted that it may be appropriate for someone to leave their region for treatment. Ms. Wilkerson suggested that MHCC staff think about travel time as opposed to regional care. Ms. Fleck mentioned that she can look into that more by looking at the jurisdiction in addition to the regions. Ms. Wilkerson also added that it may be appropriate for someone to travel farther for a specialized service than for general psychiatric services.

Ms. Raisanen explained that Table 5 in the handouts shows the portion of psychiatric discharges in Maryland hospitals that come from out of state by age group. In the Western region, 46% of child psychiatric discharges were for out-of-state children, and for adolescents, 38% were from out-of-state. Ms. Raisanen emphasized that the hospitals in Maryland do not just serve Maryland patients.

Ms. Raisanen explained that the Tables 6a, 6b, and 6c highlight boarding in Maryland hospitals for psychiatric patients who may have been admitted to a Maryland hospital, but who were not admitted to the same hospital where boarding occurred in an emergency department. Ms. Raisanen pointed out that boarding for adults appeared to be highest in the Central region. For adolescents, boarding appears to be more frequent and for longer periods than for adults. In the Central Region, over 4% of adolescents boarded for over 72 hours. Boarding for children appeared to be a bit less frequent than for adolescents. In the Western Region, it appears that there is less boarding for children.

Ms. Raisanen asked if workgroup members had explanations for the data that she presented. Mr. Petrizzio commented that there are very limited units that accept adolescents and children, and so beds are particularly limited for those age groups. Ms. Wilkerson asked if there was any way to break the data down more. She added that the data and the occupancy rates do not make sense together. She also commented that from experience and anecdotal information, there are problems with access for specific patient populations. Ms. Fleck asked if she was interested in seeing a breakdown for discharges with a developmental disability or some other co-occurring diagnosis. Ms. Fleck asked if there are some other factors that should be investigated. Ms. Wilkerson responded that is what we have heard here and in the clinical group. Dr. Chessare commented that in the Central Region, the neurodevelopmental patients are more likely boarded because of less capacity of beds that will serve them. Ms. Fleck stated that she can work on breaking the data down further.

Ms. Fleck asked whether the data reveal anything useful. Ms. Wilkerson responded that her concern is that if we decide based on these data that we need more beds, and we go and open more general psychiatric units, which may or may not be full, we will still have the same issue with these populations waiting in the ED, no matter how many small general psychiatric units we open. Another workgroup member reiterated that there is only one neuropsych unit for kids at Sheppard Pratt Hospital, and the waitlist is three to six weeks. A patient has to be in the ED to be admitted, so the patient sits in the ED waiting. Ms. Wilkerson agreed and stated that opening general beds across the state is not going to solve that problem.

Ms. Fleck stated that MHCC staff have broken down the data a bit further, and MHCC staff presented some of this information to the CAG. She commented that it seemed that from 2010 to 2018, the total number of patients with developmental disabilities has not increased. It seems that boarding may have slightly increased. It may be that Maryland hospitals have been continuing to serve those patients poorly over time. Ms. Wilkerson said that she thinks that is true. It is more and more difficult to discharge them; with limited beds and patients who could be discharged, but who have nowhere to go, the funnel keeps getting backed up. She thinks that will account for more of the boarding that we are seeing, and it will help explain the differences between the boarding

and the overall occupancy to inform the policies about what kinds of beds we need to add and what programs we need to support.

Ms. Fleck asked about the potential need to collect more data on blocked beds. Ms. Farinholt responded that she thinks it is important to have as much accurate information as possible; there is too much of a disconnection. Dr. Knight commented that it is a very valuable idea, but it would be extremely difficult to execute for many reasons. There is a lot of variability between facilities about who gets to decide if a bed is blocked, and the majority of inpatient psych units do not have a formal way of determining acuity of a particular patient and whether a bed next to that patient needs to be blocked. More units do have a way to measure acuity of the entire unit but less so for the risk of having two particular patients in one room.

Dr. Knight explained that a lot of systems might be hesitant to provide information on bed blocking because of EMTALA. If a hospital is keeping an EMTALA compliant queue of next in line for admission, then the hospital would have to provide clinical justification for why a patient who is in the hospital's ED gets priority for a bed over a patient who was put on the waitlist hours ago. That is valuable information, and she would be thrilled to participate in efforts to collect those data in a way that could be analyzed to help arrive at a standardized process. However, Dr. Knight was uncertain if it is possible. Ms. Fleck commented that she had just had in mind asking about blocked bed numbers and not the specific reasons for the beds being blocked. Ms. Wilkerson commented that institutions may prioritize patients coming into their ED over other patients, and that is a real issue.

Ms. Webster confirmed that OHCQ has found issues where hospitals within systems will hold beds within their system even if patients have not had appropriate screenings. It is a problem, and it has been cited at Maryland hospitals. Dr. Knight commented that these are related issues because there are times when if the process for blocking beds lacks a standard process of authorization, then a facility that cannot find a clinical reason to refuse to admit a patient, may suddenly block a bed in a shared room because of the acuity of the patient who is already admitted.

Ms. Wilkerson commented that she does not know the status of the bill with everything that is going on, but the bed registry that has been proposed in legislation could help with this. If and when Maryland has a bed registry, if it is established correctly, it could provide information that would be helpful to this whole process. Ms. Wilkerson explained that the hope is that MHCC would have representation on that group to provide input into what a bed registry should look like. Mr. Petrizzio commented that his institution's experience with a bed registry is that it did not work because staff still had to call hospitals. Also, the registry required that ED staff seeking a bed put in the request as soon as possible, but the hospitals with psychiatric beds only updated availability twice a day, and all beds could be filled within five minutes of the updated information. Ms. Wilkerson responded that those issues were addressed in the workgroup, and it seemed like the Department of Health was looking for ways to automate things to maybe address some of those issues. She agreed with Mr. Petrizzio that a bed registry is not going to solve all of the problems.

Ms. Raisanen asked workgroup members if these existing health planning regions should be maintained in the updated SHP chapter. A workgroup member asked how the existing regions

were created. Ms. Fleck responded that the definitions of these regions go back years and that she thinks that it is based on population and what seems reasonable in terms of travel time for services. She stated that the regions should be ones that make sense to us in terms of planning for services and making decisions about the needs. Ms. Webster commented that she thinks of Prince George's and Montgomery counties as closely connected. Some of the hospitals in Prince George's County are near the border with Montgomery County, so patients may go back and forth between the two counties. As we go forward, we will have more hospitals closer to Montgomery in Prince George's County.

Ms. Fleck asked if there are enough services in those two counties for it to be its own region. Ms. Webster responded that it just seems like the populations would be more similar in Montgomery and Prince George's, and there might be shared community-based services. Ms. Farinholt also commented there is a lot of cross-over in the most populated areas in what she would call central Maryland. Specifically, a lot of people in Howard County might be closer to Montgomery County. People in Prince George's may be closer to one of three counties, Howard, Anne Arundel, or Montgomery.

Ms. Farinholt also commented that the Eastern Shore could be divided into multiple regions and that perhaps regions one and three could be discussed together. Ms. Fleck stated that there is no reason to have exactly five regions. In some cases, the Eastern Shore is separated into two regions, an Upper Shore and Lower Shore. Ms. Farinholt suggested a potential midshore region as well, noting that it depends on the purpose of the regions. Ms. Fleck responded that the regions are for planning for services and determining if there are enough services in a region. As someone pointed out, for people who live near the border of a region, perhaps MHCC should consider both if residents are going to another region and travel distance. Ms. Farinholt suggested that the workgroup also consider the travel time.

Ms. Fleck then asked if anyone want to propose a different approach to health planning regions for specific age groups. Ms. Webster stated that the region definitions do not matter much, so long as the Commission takes into consideration the service area of the facility. Ms. Fleck responded that MHCC definitely does consider market share for Certificate of Need applications. The idea here is that we are trying to make a statement about the need for acute psychiatric services for the population in an area. Ms. Fleck added that MHCC could also consider encouraging specific facilities to add services for specialized populations if they submit a Certificate of Need application for changes to other psychiatric services, and there is a need identified in their region. Ms. Farinholt asked for clarification.

Ms. Fleck responded that MHCC is just trying to understand what makes sense for defining the regions in terms of planning and evaluating proposed projects. Ms. Farinholt stated the planning needs to address whether there are adequate beds for the populations within a reasonable distance. She stated that she thinks it is important to do the planning based on the need and the distance; she is not sure how that fits with the map of existing regions. Ms. Fleck responded that it would be helpful to have an answer to the question about what distance is appropriate. Ms. Raisanen then asked what should be acceptable for different age groups as far as distance and time travelled. Christine Wray responded that patients should not be waiting more than an hour or two

to get to their next destination. She also commented that there is a delay in the ED because of insurance.

Another workgroup participant explained that the health planning regions historically were based on the way people use the facilities. For example, Prince George's was grouped with the southern counties because residents in those counties might migrate up, and the providers in the southern counties did not necessarily have all of the high-end services. Residents in those southern counties also tended to migrate to the locations where they work, such as the District of Columbia. However, people in Montgomery County tend to just use the services available in Montgomery County. Residents in Prince George's County are unlikely to go south for care, but the residents in southern Maryland counties will go north. That is also why you see more distances in other areas on the Eastern Shore. She finished by stating that in the less populated areas, we are accustomed to having to travel farther distances what we are not okay with are waiting.

Ms. Farinholt agreed that individuals in rural areas certainly expect to travel farther distances but that she does not think that people from the lower Eastern Shore are expecting to travel up to Kent County to get services. Ms. Wray stated that it is acceptable for people to travel from Saint Mary's County to lower Prince George's County. Ms. Farinholt mentioned there are also patients going into Delaware for services. Ms. Fleck asked, in terms of the acceptable travel time, are there numbers that people would suggest. A workgroup member asked for clarification on to whom travel time should be acceptable. If a family does not have transportation, that may be a moot point.

Ms. Fleck suggested that MHCC might say that 90% of the population should have access to acute psychiatric services within a certain travel time or distance. A workgroup member questioned if this travel time depended on the specialty. Ms. Fleck responded that it can vary. The current SHP chapter for acute psychiatric services uses 30 minutes or 45 minutes to define reasonable access. For other specialized services, it is acceptable for travel time to be longer. A workgroup member commented that there are services that are just not cost effective to put in every jurisdiction, and programs need to be large enough to be high quality. She states that she would defer back to the clinical group for guidance. Ms. Raisanen ask if there are specific subspecialties to ask about. A workgroup member responded that age is not the only thing to keep in mind.

Paul Parker explained that the health planning regions date back to the 1970s and a primary reason for the configuration is because the federal government wanted the United States divided up into regional health planning areas, and regional health planning agencies were created. The health planning regions were configured based on reasonable areas for service and reasonable population sizes for funding the agencies. Mr. Parker also explained that MHCC did bed need projections that ran effectively through the 1990s. However, these bed need projections are not meaningful anymore. For adult services, which are widely available, in his view it does not make sense to use these regions for psychiatric bed need projections. Acute psychiatric services for adults should be highly accessible throughout the State. He added that it is a reasonable goal to expect that a majority of hospitals to provide some type of psychiatric program. For adolescents and children, because the volumes are so much smaller, those should be evaluated differently, at a

regional level. Ideally, we should organize the regions in a way that makes sense for children and adolescents.

Mr. Parker commented that reconsidering the definitions of the current health planning regions is necessary. The idea of having the current Eastern Shore region divided into two regions makes sense, an upper region and a lower region. The regions near the District of Columbia should also be reconsidered. A workgroup member agreed with Mr. Parker's logic. She also commented that considering volume makes sense. Ms. Fleck asked if workgroup members still wanted MHCC to request feedback from the CAG regarding travel time.

Ms. Wilkerson commented that she did not know if the clinicians should weigh in on the travel time, but she would like to have the CAG weigh in on which specialized populations to consider. Someone else in the workgroup agreed, and another member asked if specifying specific travel times would have any clinical impact. Ms. Fleck stated that it is more about what is adequate in terms of the current system and for health planning regions. MHCC wants to make sure that hospitals are not just filling their beds but also meeting a specific need for the population in Maryland. Ms. Fleck asked again if there were any specific access measures that anyone would like to propose. No one in the workgroup responded.

Standard 10

Ms. Fleck asked for feedback on the proposed revision to Standard 10. She reiterated that one potential solution to the challenges with low occupancy levels is to lower the occupancy standard. The note about the number of private beds in large facilities is an attempt to control for the blocked beds issue. Dr. Chessare responded that he is not really sure what these statistics provide, and he would advocate for us to think a little bit more on this one before adopting lower occupancy rates. Dr. Chessare stated that the supply and demand curves need to take both demand and supply into account. He expressed concern that all beds are not the same, and consequently, the statistics are not meaningful.

Ms. Raisanen suggested looking at the number of private beds and looking at the occupancy rates according to semi-private vs private beds because she thinks that part of the challenge is that the occupancy rate could be a lot lower with more semi-private rooms. Another workgroup member commented that it is not just the age, occupancy, and type of room (semi-private/private); it is about the services needed. Ms. Fleck said that she views the standard as a general standard for someone that is wanting to add capacity; there can be other analysis and criteria and standards in terms of actually approving a proposed project if someone wants to expand bed capacity. She suggested that MHCC should try and lower the barrier to adding psychiatric beds, so that if someone wants to add more capacity, it is possible. The workgroup member stated that, if it is just one factor, then she agrees. She then asked for confirmation that the standard would not apply for a program that currently has a unit for adults and is seeking to add a unit for children. Ms. Fleck reiterated that the bed capacity standard would be specific for different age groups. For child units, they are probably going to be less than 20 beds so the occupancy would be at 70%.

Ms. Raisanen asked if the workgroup had feedback on using a two year period for the standard and whether a one year period would be preferable. Dr. Knight responded that at the

University of Maryland Midtown Hospital, 37 new private rooms for acute psychiatric patients opened about a year ago. The beds filled up almost immediately. However, because the census is no longer limited by acuity, the acuity of the unit was very high and staff turnover became a problem. The status of the rooms (semi-private vs private) just shifting the issues of occupancy rates; the underlying issue is not eliminated. There are weeks when insufficient staffing units is a barrier to fully utilizing the available capacity to care for high acuity patients.

Ms. Fleck asked for potential solutions to the issue raised by Dr. Knight. Dr. Knight responded that there are definitely some people where you cannot pay them enough to stay. However, psychiatry is really behind when it comes to differentials. At her facility, they have a small night time differential, but they do not have a weekend differential or an acuity differential. She stated that higher reimbursement should be provided for higher acuity patients, but health systems barriers make that difficult. Ms. Farinholt added NAMI is aware of the issues raised by Dr. Knight. It is not just if a hospital has private vs. semi-private rooms; it is also the services that patients need. Other members in the workgroup agreed.

Ms. Fleck wrapped up the meeting and described issues to be discussed at the next meeting. She also asked the workgroup if, now that we have taken a look at more data, individuals had ideas about how to measure bed need. Ms. Wray commented that she had expected that the purpose of the CAG was to get at a totally different way of doing bed need and to project the need based off of different kinds of diagnosis categories. The bed occupancy conversation still requires that there to be other bed need analyses. We have not addressed how we are going to look at bed need analysis. There is still work to be done. Ms. Wray stated that she understands this analysis, but in the absence of understanding how the bed need analyses will look. She also mentioned that if a program has semi-private rooms, then they will likely block beds and she still doesn't think we have done the thing that we had wanted the CAG to do.

Ms. Fleck responded that MHCC staff asked the CAG about the groups that need services or that have difficulty accessing services, and she did not think that the workgroup expected the CAG to figure out a new approach to need projections. She added that analyzing discharges by diagnoses has not been helpful. When the workgroup last met, there was a lot of uncertainty about whether MHCC should have a need projection for acute psychiatric beds. Staff had proposed that MHCC eliminate need projections and instead request that applicants address utilization data and have a determination of need based on other criterion.

Ms. Wray responded that was not her understanding, and she thought that we were intending to look at need from the clinical side. She reiterated that she still believes in doing need analyses. Ms. Fleck agreed that we definitely need to analyze need, but she thought that the question was if we should be doing need projections or should it be more just based on analyzing information. Ms. Wray responded that she does not agree that it should be up to an applicant to determine need; there has to be a set of criterion that you would determine as the State based on logical bed need methodology. Ms. Fleck agreed that MHCC definitely needs to have criteria.

Ms. Fleck thanked the workgroup for their participation. She also explained that MHCC staff originally planned to have only one more meeting but a final decision has not been made yet.

Lastly, Ms. Fleck mentioned that MHCC staff would develop draft regulations and post for informal public comment. There will be more opportunities for feedback before staff asks the Commission to consider adopting proposed regulations. The meeting adjourned at approximately 3:10 p.m.