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

Workgroup Member Attendees

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

MHCC Attendees

Eileen Fleck
Paul Parker
Mario Ramsey
Ben Steffen
Suellen Wideman

Other Attendees
Oksana Likhora

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

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

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

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

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

Certificate of Need Regulations and the State Health Plan

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

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

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

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

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

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

Workgroup Members' Questions Concerning CON Projects and Regulations

Nicki McCann asked about information on applications for acute psychiatric services which were denied and instances where psychiatric bed capacity decreased. Mr. Parker answered that among the applications that had not been approved as originally submitted, one was for a hospital which was a replacement project at UM Prince George's Hospital Center. That hospital currently allocates 32 of its total licensed acute beds to adult psychiatric services, and the replacement hospital is approved for 28 adult psychiatric beds, which is a net loss of four psychiatric beds. He stated that MHCC staff also reviewed a proposal from Sheppard Pratt, to relocate and replace their hospital in Howard County. The facility was licensed for 92 beds, but had a physical capacity for 78 beds. Sheppard Pratt proposed building a replacement hospital of 110 beds, and MHCC approved a replacement hospital of 100 beds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Problems with the Acute Psychiatric Care and Possible Solutions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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