Report to the Legislature

Small Rural Hospital – Psychiatric Bed Conversion

Third Engrossed Substitute Senate Bill 5034, Sec. 204 (4)(f)
Chapter 4, Laws of 2013

December 31, 2014

Behavioral Health and Service Integration Administration
Division of Behavioral Health and Recovery
PO Box 45330
Olympia, WA 98504-5330
(360) 725-3700
Fax: (360) 725-2280

Washington State Department of Social & Health Services

BHSIA Behavioral Health and Service Integration Administration

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Small Rural Hospital – Psychiatric Bed Conversion

REPORT REQUIREMENT

The 2013 Second Special Session of the Legislature charged the Department of Social and Health Services (DSHS) with the cooperation of the Health Care Authority (HCA) to explore opportunities for small, rural hospitals to convert some of their hospital beds to psychiatric treatment beds.

3ESSB 5034, Sec. 204 (4)(f): The department shall work cooperatively with the health care authority to explore the feasibility of incentivizing small, rural hospitals to convert, in part or fully, some of their beds to psychiatric treatment beds. No later than December 31, 2014, the department shall report to the appropriate fiscal committees of the legislature on the feasibility of such conversion. The report shall consider rate enhancements and the ability to claim federal Medicaid matching funds on converted beds.

EXECUTIVE SUMMARY

The Small Rural Hospital Psychiatric Bed Conversion Workgroup first met in May 2014. Participants included representatives from DSHS Behavioral Health and Service Integration Administration, HCA, Department of Health, Research and Data Analysis Division, Washington State Hospital Association, Washington Community Mental Health Council, Greater Columbia Regional Support Network, and hospital administrators from Three Rivers Hospital and Othello Community Hospital. The primary purpose and outcome of the workgroup was to identity incentives and develop recommendations for small, rural hospitals that would find it beneficial and economically feasible to convert hospital beds to psychiatric beds in rural communities. After consideration, the workgroup identified the following categories of incentives that support small, rural hospitals converting hospital beds to psychiatric beds.

Incentives

- Consistent and viable rates, revenue, funding streams, and streamlined payments
- Payment that covers the cost of care
- Opportunity for capital funding to ease the renovation or new building costs
- Increase utilization of empty beds (dependent on payment rate)
- Compliment other medical services in rural areas or regions
- Increase local jobs in rural communities

- Streamline certification and licensing requirements
- Safety for patients
- Transition resources after being admitted to a hospital to create a gradual flow back into the community (via community services.)
- Rapid response to help patients – response teams, telemedicine, transportation

Survey of Rural Hospitals

The Washington State Hospital Association surveyed rural hospitals, including all Critical Access Hospitals (CAHs) and sole community hospitals in the state. Overall, given the specialized nature and complexity required to provide high-quality of care for psychiatric patients, most rural hospitals that responded to the survey did not see themselves as able to provide psychiatric services even if the recommendations in this report were followed. For additional concerns, please see the discussion about identified barriers on page 11.

The top concerns of the hospitals included:

- Fee-for-service payment rates are not sufficient to cover the cost of care.
- The numbers of patients needing inpatient psychiatric services in their community are very small and would not support a unit.
- Recruiting and attracting the professional staff, psychiatrists, and nurses would be a significant challenge.
- Significant remodeling and adding of new construction would be required to open new services. Due to lack of physical space, many of the hospitals indicate their current buildings are inoperable for psychiatric patients.

Below is a summary of the workgroup's recommendations based upon discussion and consideration of incentives that support small, rural hospitals converting hospital beds to psychiatric beds.

Recommendations

Based on the legislature's interest in incentivizing small, rural hospitals to convert, in part or fully, some of their beds to psychiatric treatment beds, the workgroup made the following recommendations:

1. **Rates and Revenue (Discussion begins on page 11)**

    - While many significant concerns remain for hospitals in the operation of psychiatric units, one incentive would be to increase the Medicaid fee-for-service payment rate to an

amount that reflects the actual cost of providing care for psychiatric services. Currently, Medicaid pays on average about 80% of the cost of care for psychiatric services for Medicaid enrollees in general acute care hospitals with units.

- Update the HCA's current payment methodology for rural hospitals opening new psychiatric services so they can be treated the same as hospitals currently with units or significant services as soon as it is feasible[1].
- The interim Medicaid payment rate should include additional funding to help offset startup operational costs.
- While inpatient rates are constrained by the Prospective Payment System (PPS) methodology used by the fee-for-service Medicaid program, hospitals could negotiate cost-based rates directly with Regional Support Networks (RSN) as they are managed care entities and they have the ability to set rates necessary to provide network coverage/adequacy.

2. **Staffing (Discussion begins on page 14)**

The workgroup recommends addressing the shortages in behavioral health professionals in rural areas to incentivize rural hospitals to convert existing beds to psychiatric beds. Strategies include:

- Staffing: Increase the number of providers able to care for clients with mental health needs in rural areas by allowing for expanded roles for current providers.
- Training: Increase availability and access to training for hospital staff caring for psychiatric and medical needs of patients, as well as others in the community involved such as primary care, long term care, emergency medical services personnel, and law enforcement. Training should be available via telehealth and in-person in rural communities. Address high stress and turnover for designated mental health professionals (DMHPs).
- Telepsychiatry: Seek full reimbursement by public and commercial payers (Medicare, Medicaid/RSN, commercial insurers) for psychiatric services delivered via telemedicine (telepsychiatry), including the originating site and provider. Consider legislation requiring insurers to cover telepsychiatry (e.g., House Bill 1448). Several states have mandatory telemedicine requirements. Explore options for simplified (universal) professional staff credentialing to support telepsychiatry.

[1] The payment methodology for new psychiatric services applies to all hospitals opening services. This report specifically focused on rural hospitals.

- Capital funds: Assist with obtaining secure connectivity where needed to enable use of HIPAA-compliant telecommunications and videoconferencing equipment, remodeling to accommodate telepsychiatry services and patient privacy, health information technology to allow secure sharing of clinical data to support providers, and team-based care and behavioral and physical health services integration.
- Workforce development: Enhance workforce development and recruitment in rural areas, and include behavioral health professions in state healthcare workforce development and recruitment initiatives.

3. **Certification and Licensing (Discussion begins on page 16)**

   The workgroup recommends hospitals interested in providing psychiatric services follow the certification and licensing procedure described in this report. Certification and licensing procedures ensure hospital psychiatric services meet regulatory requirements and are recognized for payment based upon the type of psychiatric service selected.

4. **Security and Safety (Discussion begins on page 18)**

   Converting existing hospital medical or surgical space to a hospital inpatient psychiatric care area requires attention in the following areas: individual security, building safety, and operational space. The workgroup recommends hospitals seek on-site technical assistance from the Department of Health Construction Review Services to facility security and safety features.

5. **Court Process and Transitions (Discussion begins on page 19)**

   Small rural hospitals that add mental health treatment services can address court processes and consumer transitions back into the community after hospitalization through developing working relationships with its local RSN, Community Mental Health Agency (CMHA), emergency medical response teams, county government, and local health care providers.

   The workgroup recommends hospitals, local RSNs, and courts consider conducting involuntary treatment hearings at the hospital which will decrease transportation time and costs as well as support efficient use of hospital staff time. To support consumer transitions from hospitalization to communities, the workgroup recommends hospitals work a variety of resources including CMHAs, emergency medical response teams, county government, RSNs, housing

resources and linkages for patients discharging from hospitals, and other providers to consider rapid response to help consumers – response teams, telemedicine, and transportation.

BACKGROUND

The first task of the workgroup was to begin understanding the complexities faced by small rural hospitals that would like to expand medical services in rural communities. Rural health care providers face significant regulatory, payment and funding, and professional staff challenges. The workgroup prioritized its work, based upon discussion and consideration of incentives that support small, rural hospitals converting hospital beds to psychiatric beds.

Issues / Opportunities

The Washington State Legislature as well as a number of state agencies have recognized and determined that there is a significant shortage of community psychiatric beds in our state. In recent years, a number of articles and studies indicate Washington State ranks between 47th and 51st nationally in the number of community psychiatric beds.

In October 2011, the Washington State Institute for Public Policy (WSIPP) reported that in general, Washington State has a relatively low rate of total inpatient hospital beds per capita, lower rates of admissions, and shorter lengths of stay in comparison to other states.[2] While Washington's hospitals had occupancy rates of 70% for acute bed services in a 2009 study period, psychiatric service bed occupancy rates were 93% indicating little excess capacity.[3]

In 2013, a number of news organizations in Washington State published articles about the state of inadequate resources for inpatient community psychiatric beds with concerns about psychiatric single bed certifications and psychiatric patient "boarding" in hospital emergency departments. As a result, the 2013 Washington State Legislature charged the Department to explore opportunities to support small rural hospitals to convert unoccupied beds to psychiatric beds.

Subsequently, on August 7, 2014, the Washington State Supreme Court ruled against detaining mental health patients in local hospitals. Mental health patients can no longer be held in emergency rooms or general

[2] Washington State Institute for Public Policy, *Inpatient Psychiatric Capacity in Washington State* (Part 2), October 2011
[3] Navigant Consulting, Inc. (2011). *Analysis of the Washington inpatient and outpatient hospital Medicaid payment methodology. P. 15.*

hospitals simply because there are no appropriate settings available to serve them and meet their needs. On September 4, 2014, the Supreme Court granted a motion to stay the timeline for implementation 120 days or until December 26, 2014, to end the practice of issuing single-bed certifications for overcrowding.

Recent Legislative Action

Legislative highlights and initiatives designed to address mental health issues and psychiatric inpatient bed capacity include the following.

2010: The State Legislature amended the legal guidelines for Involuntary Treatment Act (ITA) commitments to allow a DMHP to more fully consider reasonably available information about individuals from credible witnesses and historical records (RCW 71.05.212). The 2010 Legislature directed WSIPP to estimate the number of additional psychiatric admissions that will occur as a result of this law and examine how many inpatient psychiatric beds may be necessary to accommodate this increase. These statutory changes were set to take effect in 2012, but were delayed until July 1, 2014 by the State Legislature.

2013: The State Legislature passed Section 1071 of the 2013-2015 Capital Budget (SSB 5035) funding the Department of Commerce $5,000,000, for grants to hospitals or other entities to establish new community hospital inpatient psychiatric beds, free-standing evaluation and treatment facilities, enhanced services facilities, triage facilities, or crisis stabilization facilities with sixteen or fewer beds for the purpose of providing short term detention services through the publicly funded mental health system.

The State Legislature passed HB1777 and SB5480 which set aside $23 million to create specialized crisis services. Six RSNs were funded to increase crisis beds including one evaluation and treatment (E&T), and ten (10) new non-facility based services consisting of intensive case management, hospital transition services, and mobile crisis outreach response and other diversion services, were operationalized.

2014: The 2014 Legislature's supplemental budget funded mental health enhancements, including three (3) evaluation and treatment facilities, three (3) PACT teams, and supported housing at $14,940,000.

In August 2014, the Supreme Court of Washington held that the practice of using single bed certifications to avoid overcrowding certified evaluation and treatment facilities was unlawful. The Governor approved $30 million in General Funds - State to acquire up to 145 additional psychiatric treatment beds.

Small Rural Hospital – Psychiatric Bed Conversion Workgroup: Participants and Discussion

Participating members of the Small Rural Hospital-Psychiatric Bed Conversion Workgroup follows.

- DSHS Behavioral Health and Service Integration Administration, Division of Behavioral Health and Recovery – Dennis Malmer, Michael Paulson, Melena Thompson, David Reed, David Johnson, David Daniels, Judy Holman, Nancy Murphy
- Health Care Authority: Dylan Oxford, Andrew Steers, Scott Miloscia
- Department of Health: Kim E. Kelley, John Hilger, Bart Eggen
- DSHS Research and Data Analysis Division: Beverly Court
- Washington State Hospital Association: Chelene Whiteaker and Zosia Stanley
- Greater Columbia Regional Support Network: Ken Roughton and Troy Wilson
- Washington Community Mental Health Council: Ann Christian
- Othello Community Hospital, Connie Agenbroad
- Three Rivers Hospital, Scott Graham

The workgroup initially focused on identifying incentives for small, rural hospitals to convert available beds to psychiatric beds. The workgroup evaluated and searched for similar projects and work done since 2010 to look at options to increase psychiatric bed capacity and reviewed work done by WSIPP, Washington State Department of Health-Rural Health Section, and others.

The workgroup considered current community psychiatric bed inpatient capacity, loss of capacity at hospitals that closed psychiatric units and reduced inpatient beds, while reviewing options for new community psychiatric bed expansion.

Incentives

The workgroup identified incentives to convert hospital beds to inpatient psychiatric beds that included the following:

- Consistent and viable rates, revenue, funding streams, and streamlined payments.
- Payment that covers the cost of care.
- Opportunity for capital funding to ease the renovation or building costs.
- Increase utilization of empty beds (dependent on payment rate).
- Complement other medical services in rural areas or regions.

- Increase local jobs in rural communities.
- Streamline certification and licensing requirements.
- Safety for patients.
- Transition resources after being admitted to a hospital to create a gradual flow back into the community (via community services).
- Rapid response to help patients – response teams, telemedicine, transportation.

Barriers

The workgroup identified barriers to convert hospital beds to inpatient psychiatric beds that included the following:

- The Medicaid fee-for-service payment rates are too low to cover the cost of providing care.
- Significant federal regulatory laws prevent Critical Access Hospitals from taking advantage of cost-based payment for psychiatric services.
- The payer mix of psychiatric units is such that cost-shifting to commercial payers is limited. Rural areas face a significantly higher proportion of government payments – Medicaid and Medicare patients.
- Finding professional staff to work in the hospitals in rural communities is difficult and the state faces a significant shortage of psychiatrists.
- Training issues come up with staff that are unfamiliar about how to manage patients with mental health issues. Psychiatric care is a specialized service line and hiring trained staff in rural areas is problematic.
- Facility requirements such as special construction and secured doors of the unit.
- Patients need access to court services and transportation. If involuntary treatment cases could be held at the hospital, this would eliminate a constraint. Transporting patients to outside court services in rural areas is challenging given the long distances to travel. In some communities the Emergency Medical Technicians and response teams are the rural transportation system and cannot be taken offline to transport patients to court.

DISCUSSION

The workgroup discussed many issues regarding recommendations that would support small, rural hospitals so each would find it beneficial and economically feasible to convert hospital beds to psychiatric beds in rural communities.

1. Rates and Revenue

This section provides recommendations and outlines how a Critical Access Hospital (CAH) would be paid if it opened a psychiatric unit. This section describes the following areas of payment and regulatory considerations:

- Current Medicaid psychiatric payment methods and barriers to opening new psychiatric services;
- How a CAH could work within the Centers for Medicare and Medicaid Services regulatory requirements to open a 10 bed unit;
- Why operating a psychiatric unit under CAHs traditional 25-bed license is not feasible.

A. Current Medicaid Psychiatric Payment for Hospitals and Barriers to Opening New Psychiatric Services

Medicaid currently pays hospitals providing inpatient psychiatric services on a per-day basis for hospitalizations. For hospitals with existing psychiatric services that have more than 200 Medicaid days per year, Medicaid pays the higher rate of 1) 80% of the average aggregate statewide rate for all psychiatric services or; 2) an individual hospital's allowable costs for providing care reduced to about 80% of actual costs. The statewide average is a combination of the rate at psychiatric hospitals as well as community hospitals, where patients often have multiple conditions. As of the most recent Medicaid re-calculation of hospital rates in 2014, all community hospitals that meet the volume criteria and are licensed under RCW 70.41 as general acute care hospitals are paid based on their individual hospital costs.

The current payment rules used by the Health Care Authority place a disadvantage on hospitals wanting to open new psychiatric services. For any hospital opening a new psychiatric unit, including a CAH, Medicaid would pay based on the average statewide rate rather than a hospital specific rate, until the next Medicaid rate rebasing, which has historically occurred about every seven years. Medicaid pays hospitals currently operating psychiatric services based on either the average aggregate floor or a percent of the hospital's own costs, as described above. Since costs at community hospitals exceed the statewide average, this places a disadvantage on hospitals opening new units.

To combat this problem, the workgroup recommends that once a rural hospital can produce a complete annual cost report for its new psychiatric unit, HCA should calculate a hospital-specific rate for the hospital, similar to what it has done currently for the community hospitals with existing psychiatric services. As with other hospitals, the hospital would then be

paid based on the higher of its own costs or the average statewide per diem. This change will reduce the losses for new psychiatric units. Even with this change, psychiatric services will be a financial challenge. Losses are concerning to the workgroup because community hospitals providing services to involuntarily detained patients lose about $200,000 to $1 million a year according to a 2013 survey of financial data by the Washington State Hospital Association.

B. Critical Access Hospitals and Psychiatric Services and How CMS Could Allow CAHs to Open Psychiatric Services under a 10 Bed Model

For policy development, it is important to understand the regulatory environment CAHs must operate within when providing all clinical services, including psychiatric services. Washington State has 39 CAHs. These hospitals face many regulatory compliance policies that they must comply with in order to continue providing services under the CAH program. The two most comprehensive and overarching areas of regulation are the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation and Conditions of Payment. Hospitals must meet these in order to continue operating and serving patients. One of the most critical regulatory rules requires CAHs to limit its inpatient admissions for acute care and skilled nursing type care.

Recognizing the regulatory structure of 25 beds significantly limits a CAHs ability to provide certain services in its community, CMS allowed CAHs to add certain types of beds to its 25-bed license. In the mid-2000s, CMS relaxed its stance on rehabilitation and psychiatric services, allowing CAHs to operate services under a separate-type of 10 bed structure. This flexibility allowed CAHs the option of adding additional beds to their license:

- A total of 10 beds for psychiatric services; and/or
- A total of 10 beds for rehabilitation services.

As described above, CAHs operating psychiatric beds under this model would be paid on a per diem rate from Medicaid, receiving the statewide average rate until the next Medicaid rebasing unless this is corrected.

Important Takeaway: Providing psychiatric services under this 10 bed structured unit also allows CAHs to bypass certain regulatory rules that make operating a psychiatric unit unfeasible under a single 25-bed license.

While the 10 bed option allows CAHs not to be held to certain regulatory requirements, the current Medicaid per diem payment rate may be too low

for CAHs and would cause them to face significant losses from operating a unit. These 10 bed units are not eligible for the traditional method of payment for CAHs – cost based reimbursement. While cost-based reimbursement could theoretically be maintained if a hospital operated its psychiatric unit under a 25-bed model, that route is not feasible at this time.

C. Providing Services under 25 Bed License: Not Viable

After much research on CMS regulations, the workgroup concluded that providing psychiatric services under a CAHs 25 bed license is not a viable option for CAHs. While providing psychiatric services under this licensure would maintain the hospital's cost-based payments, the regulatory barriers on the federal level are insurmountable at this time.

The two rules that make operating a psychiatric unit for a CAH under a hospital's 25 bed license not feasible include (these two rules do not apply to the 10 bed described above):

- ***96 hour average length of stay rule:*** For CAHs wanting to provide psychiatric services, they must continue to meet a 25 bed limit for acute care and swing bed patients. In addition, the hospital must also maintain its average length of stay for all patients under 96 hours or four days. Involuntarily detained psychiatric patients have long lengths of stay, much closer to 10-15 days. As a result, a hospital would not be able to continue to meet the CMS Conditions of Participation if it provided psychiatric services.
- ***96 hour limit on Medicare patients:*** Lastly, for Medicare patients only, in order to be paid for services, a physician must certify upon admission that the patient will not be hospitalized for more than 96 hours. Given these regulations and payment barriers, we do not see a way to pay CAHs for providing care to Medicare enrollees.

D. Recommendations

- While many significant concerns remain for hospitals in the operation of psychiatric units, one major incentive would be to increase the Medicaid payment rate to an amount that reflects the actual cost of providing care for psychiatric services. Currently, Medicaid pays on average about 80% of the cost of care for psychiatric services for Medicaid enrollees.
- Update HCA's current payment methodology for rural hospitals opening new psychiatric services so they can be treated the same as hospitals currently with units or significant services as soon as it is feasible.

- The interim Medicaid payment rate should include additional funding to help offset startup operational costs.
- While inpatient rates are constrained by the PPS methodology used by the fee-for-service Medicaid program, hospitals could negotiate cost-based rates directly with RSNs as they are managed care entities and they have the ability to set rates necessary to provide network coverage/adequacy.

2. Staffing

The workgroup identified a number of challenges related to staffing and workforce that would need to be addressed before converting rural hospital beds for psychiatric patients. These challenges and strategies are informed by the findings presented by the Rural Health Work Group (RHWG) in "The New Blue H Report." The RHWG met simultaneous to the Psychiatric Bed Conversion Work Group. Its purpose was to examine barriers and opportunities to maintaining and improving access to health care services in rural communities, including behavioral health care.

The challenges are presented here, followed by strategies to address shortages in behavioral health care professionals in rural areas. Discussion focused on staffing, training, telepsychiatry, capital funding for telepsychiatry, and workforce development.

Four principal factors contribute to the challenge of caring for persons with mental illness in rural settings: (1) limited access to mental health providers, particularly psychiatrists; (2) lack of coordination and information sharing among continuum of providers often due to lack of information technology/data systems, regulations/statutes, or trust among providers; (3) a shift to increased public financing of treatment, accompanied by declining private coverage, budgetary constraints in publicly funded systems, managed care policies and practices, and the large number of uninsured individuals; and (4) limited utilization of available mental health services because of stigma or limited awareness of mental disorders.

Additional workforce challenges:

1. Difficulties in recruiting and retaining staff often due to concerns over compensation and difficulty in recruiting to rural areas; moreover, the significant demands and stress related to crisis work leads to turnover and burnout.
2. Rural agencies are challenged by clinicians who complete their training/licensing in rural areas and then move to urban areas to practice.

3. Limited access to relevant and effective training; trainings in Evidence Based Practices are often offered infrequently and only in one location.
4. Financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.
5. Lack of familiarity with resilience- and recovery-oriented practices.
6. Insufficient numbers in the behavioral health workforce to respond adequately to the changing needs of the rural population; moreover, rural communities lack the population needed to sustain specialists, requiring local providers to train for a wide variety conditions and patient populations.
7. Insufficient array of skills needed to assess and treat persons with co-occurring or co-morbid conditions.

Strategies include:

- Staffing: Increase the number of providers able to care for clients with mental health needs in rural areas by allowing for expanded roles for current providers.
- Training: Increase availability and access to training for hospital staff caring for psychiatric and medical needs of patients, as well as others in the community involved such as primary care, long term care, emergency medical services personnel, and law enforcement. Training should be available via telehealth and in-person in rural communities. Address high stress and turnover for DMHPs.
- Telepsychiatry: Seek full reimbursement by public and commercial payers (Medicare, Medicaid/RSN, commercial insurers) for psychiatric services delivered via telemedicine (telepsychiatry), including the originating site and provider. Consider legislation requiring insurers to cover telepsychiatry (e.g., House Bill 1448). Several states have mandatory telemedicine requirements. Explore options for simplified (universal) professional staff credentialing to support telepsychiatry.
- Capital funds: Assist with obtaining secure connectivity where needed to enable use of HIPAA-compliant telecommunications and videoconferencing equipment, remodeling to accommodate telepsychiatry services and patient privacy, health information technology to allow secure sharing of clinical data to support providers, and team-based care and behavioral and physical health services integration.
- Workforce development: Enhance workforce development and recruitment in rural areas, and include behavioral health professions in state healthcare workforce development and recruitment initiatives.

3. Certification and Licensing

Washington State hospitals that are interested in providing psychiatric services will be encouraged to consider the following steps. These certification and licensing procedures ensure that hospital psychiatric services meet regulatory requirements and are recognized for payment based upon the type of psychiatric service selected by hospitals that best meet community needs. The five steps include:

- a. Regional Support Network

  Contact the local Regional Support Network for an agreement on the psychiatric services to be provided. Submit Division of Behavioral Health and Recovery certification application to RSN for authorization.

  b. Department of Health

  Licensing

  Amend Hospital License to include distinct psychiatric services:
  http://www.doh.wa.gov/portals/1/Documents/Pubs/505069.pdf
  Contact: Julie Tomaro 360-236-2937

  Certificate of Need

  $40,470; May take 6 months; Temporary Exemption for 2014/15 for hospitals converting existing beds into psychiatric beds. Requests submitted during the 2014/15 period will be honored during the 2014/2016 period.

  Applying for Certificate of Need:
  http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/CertificateofNeed.aspx
  Contact: Janis Sigman 360 236-2956

  Construction Review Services

  Request Technical Assistance:
  http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/ConstructionReviewServicesCRS.aspx
  Contact: John Williams 360-236-2950

Inspection

State licensing initial:
http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/HospitalsAcuteCare.aspx
CMS inspection worksheet
Contact: Elizabeth Gordon 360-236-2925

c. Division of Behavioral Health and Recovery

Certification

Determine which type of certification best meets community needs such as inpatient evaluation and treatment facility, voluntary or involuntary triage facility, etc. Applications are located at:
http://www.dshs.wa.gov/dbhr/CertLicensing.shtml#dbhr.
Contact: Darrel Streets, 360-725-3819.

d. Questions and Issues Related to the Centers for Medicare and Medicaid Services

Consultation with the Department of Health

Conditions of Participation Applicable and PPS Exempt Psychiatric Units under CMS
Contact: Shannon Walker, DOH, 360-236-2933

e. Health Care Authority

Financial Models and Payment Rates
- Distinct Part Units
- Hospital Rates

http://www.hca.wa.gov/Pages/index.aspx
Contact: Gail Krieger 360-725-1681

Points of contact to coordinate licensing and certification

Julie Tomaro, Department of Health, 360-236-2937
Judy Holman, Division of Behavioral Health and Recovery, 360-725-1493

4. Security & Safety

Converting an existing hospital medical or surgical space to a hospital inpatient psychiatric care area would require attention in the following areas:

A. Security. The psychiatric patients must be physically separated from the rest of the patient population. This may require the addition of cross corridor doors. Where there are concerns over elopement and wandering, special access and egress control may be needed. All control points into and out of the unit may need to be fitted with specialized locks.

B. Safety. Existing building features may need to be replaced to remove hazards. Psychiatric patients may use parts of the building to harm themselves or others. This may include replacement or removal of door closers; grab bars, plumbing fixtures, and casework. This may include retrofitting exist ceiling and sprinkler heads to prevent opportunities for suicide.

C. Operational space. The facility must identify certain dedicated spaces for use by psychiatric patients and staff. These include:

- Quiet/seclusion/de-escalation room
- Quiet activity room/group therapy
- Noisy activity room/dining room

The sub-group has not identified specific areas where incentives could be identified directly related to a facilities built environment. In the survey of CAHs, many of them also indicated their current hospital building contained significant challenges to converting operation space. In the rare instance that the hospital had space, the capital costs to renovate the building would be millions of dollars. Another hospital recently indicated converting a room to a seclusion room would pose significant challenges to their becoming an Evaluation and Treatment facility. However, it is our understanding that meeting the above minimum standards would not typically pose significant barriers to existing hospitals.

Department of Health Construction Review Services (CRS) does provide on-site technical assistance to facilities wishing to explore this approach. The fee is $500 for technical assistance. One incentive we could propose is to waive the technical assistance fee for hospitals wishing to explore transitioning med/surgical beds to inpatient psychiatric beds.

5. Court Process & Transitions

CMHAs are currently providing mental health treatment services in rural communities across the state. Court processes, timelines for consumer due process, and transition resources back into the community after hospitalization can easily become challenging. These processes are frequently magnified in rural, frontier communities.

Small rural hospitals that would like to expand medical services in its community adding mental health treatment services can develop working relationships with its local RSN, CMHA, emergency medical response teams, county government, and local health care providers. Court processes and procedures are well defined in RCW 71.05 and court recognition of new psychiatric treatment services should be welcomed in underserved areas of the state.

To support efficient due process procedures, the workgroup recommends hospitals work with courts and local CMHAs to:

- Consider conducting involuntary treatment hearings at the hospital which will decrease transportation time and costs as well as support efficient use of hospital staff time.
- Work with rural communities to schedule hearings on Tuesday and Friday to ensure due process.
- Allow RSNs to retain the responsibility for due process and court costs.
- Work on relationships with DMHPs. Some small rural communities experience limited DMHP resources, which can increase demand for services, creating delays and access challenges.

To support consumer transitions from hospitalization to communities, the workgroup recommends hospitals work with a variety of resources including CMHAs, emergency medical response teams, county government, RSNS, and other providers to address:

- Rapid response to help consumers – response teams, telemedicine, transportation.
- Housing alternatives for consumers after hospital discharge; provide a link to housing.
- Work with state and local housing authorities to consider the lack of low income housing in some rural communities.

RESPONSES TO SURVEY OF RURAL HOSPITALS

The Washington State Hospital Association surveyed rural hospitals, including all Critical Access Hospitals, and four rural non-Critical Access

Hospitals in the state. Thirty-eight percent of hospitals responded to the survey – 15 hospitals. Overwhelmingly, the results showed that rural hospitals believe they would struggle to provide specialty inpatient psychiatric services in their communities. The top concerns of the hospitals included:

- Fee-for-service payment rates are not sufficient to cover the cost of care.
- The numbers of patients needing inpatient psychiatric services in their community is very small and would not support a unit.
- Recruiting and attracting the professional staff, psychiatrists, and nurses would be a significant challenge.
- Significant remodeling and adding of new construction would be required to open new services. Due to lack of physical space, many of the hospitals indicate their current buildings are inoperable for psychiatric patients.

Some other interesting results from the hospitals included:

- Given that Critical Access Hospital psychiatric services would be paid similarly to other hospitals providing psychiatric services, all of the respondents said they could not operate a psychiatric unit under the current payment method for Medicaid fee-for-service programs.
- One rural, non-Critical Access Hospital and three Critical Access Hospitals said they were interested in providing psychiatric services if two financial incentives were provided: 1) the payment rate paid the cost of care (the current payment rate does not appear sufficient); 2) Significant capital investments of more than $1 million were available for renovations. ***NOTE:*** Two of the four hospitals recognized they are located in very rural and remote areas where transportation to the unit could provide significant challenges. These two hospitals also indicated they would need to be able to use telemedicine to provide services.
- Only one rural, non-Critical Access Hospital said it was seriously exploring opening a psychiatric unit and could operate under the current payment system. This hospital identified the need for capital dollars to move the project forward.

APPENDICES

- Map of current critical access hospitals
- Map of current list of mental health Evaluation and Treatment Facilities
- Decision Tree for Psychiatric Services in Critical Access Hospitals
- The New Blue H: A Report on the Findings of the 2014 Rural Health Workgroup, a Partner Project Between the Washington State Department of Health and the Washington State Hospital Association
- Washington State Institute for Public Policy, *Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts; Parts One and Two.*
- Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Critical Access Hospital.*

REPORT LINKS

- Washington State Institute for Public Policy, *Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts; Parts One and Two.* Link: http://www.wsipp.wa.gov/ReportFile/1092/Wsipp_Inpatient-Psychiatric-Capacity-in-Washington-State-Assessing-Future-Needs-and-Impacts-Part-One_Full-Report.pdf & http://www.wsipp.wa.gov/ReportFile/1093/Wsipp_Inpatient-Psychiatric-Capacity-in-Washington-State-Assessing-Future-Needs-and-Impacts-Part-Two_Full-Report.pdf

- Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Critical Access Hospital.* Link: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf.

- Washington State Health Care Authority: Critical Access Hospital Rates. Link: http://www.hca.wa.gov/medicaid/hospitalpymt/pages/inpatient_cah.aspx