POLSINELLI

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Via FedEx

Courtney Avery, Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street
Springfield, Illinois 62761

Re: CGH Medical Center AMI Unit Establishment, Project No. 19-049

Dear Ms. Avery:

Polsinelli represents CGH Medical Center. This letter is written in response to the staff report ("HFSRB Staff Report") issued by the Illinois Health Facilities and Services Review Board ("HFSRB") on November 26, 2019 pertaining to the proposed establishment of an acute mental illness ("AMI") unit for the treatment of patients requiring behavioral health services on an inpatient basis at CGH Medical Center ("CGH"). CGH is provided an opportunity to respond to the HFSRB Staff Report's two negative findings pursuant to Section 6(c-5) of the Illinois Health Facilities Planning Act.[1] CGH appreciates the HFSRB's support and consideration of this well-designed safety net project and the opportunity to comment on the HFSRB Staff Report.

Overview

I. Inadequate Behavioral Health Services Bed Need Methodology

The need methodology for AMI beds does not adequately account for: (i) outmigration (patients involuntarily leaving the planning area for care) or (ii) gaps in care (patients receiving treatment in a safe room rather than a bed unit due to inability to secure a bed for admissions at another location). Further, the minimum AMI beds per 1,000 residents of only .11 beds is too low:

- given the lack of access to AMI services in the planning area,

[1] 20 ILCS 3960/6(c-5).

- in light of the expectation of mental health professional organizations (based on national surveys) that the bed supply per 100,000 residents should be between 40 to 60 beds, and
- in consideration of the growing mental health crisis the State of Illinois faces.

AMI services are primary hospital services, not tertiary care like specialized surgery, high risk neonatal or cancer care where patients may choose to access services at an academic medical center outside of their community. Such deficits in the care delivery system leading to involuntary outmigration should, in fact, be accounted for in order to address the core tenets of the Illinois Health Facilities Planning Act.

There is an identified need in CGH's planning area for additional AMI services due to the unusually low supply of AMI beds in this planning area compared to the State of Illinois overall and compared to metro Chicago. In order to address this need, CGH is proposing to establish an AMI unit with the minimum bed size permitted under the applicable HFSRB rules, entitled Performance Requirements (77 IAC 1110.210(f)(2), specifically ten beds. This project is fully designed to meet a core primary care service deficit in its geographic service area.

According to a study commissioned by the Treatment Advocacy Center, a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness, a safe minimum number of public beds for adequate psychiatric services per 100,000 residents, should be a range of 40 to 60 public psychiatric beds.[2] Across the 34-member Organization for Economic Cooperation and Development, of which the United States is a member, the median number of psychiatric beds per 100,000 people in 2014 was 68 beds.[3]

If one accepts the 40 to 60 bed range for every 100,000 residents as called for based on the Treatment Advocacy Center survey, HSA 1 should have a supply of between 280 to 420 beds rather than the current 76 bed supply which represents only 11 beds per 100,000 people. Eleven

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[2] Estimates were solicited "from 15 experts on psychiatric care in the US, [including] individuals who have run private and state psychiatric hospitals, county mental health programs, and experts on serious psychiatric disorders." Torrey, E. F., Entsminger, K., Geller, J., Stanley, J., Jaffe, D. J. (2008). The shortage of public hospital beds for mentally ill persons. Arlington, VA: Treatment Advocacy Center

[3] Organization for Economic Cooperation and Development. (2013). Health at a glance 2013: Hospital beds by function of health care, 2011 (or nearest year). Paris: OECD Publishing. Retrieved from http://www.keepeek.com/Digital-AssetManagement/oecd/social-issues-migration-health/health-at-a-glance2013/hospital-beds-by-function-of-health-care-2011-or-nearest-year_health_glance-2013-graph72-en#page2

of the planning areas in Illinois do have a supply of 40 or more beds per 100,000 residents. CGH believes that the behavioral health needs of the residents of this State would be more appropriately addressed if the need methodology was updated to reflect the recommended range of beds of 40 to 60 per 100,000 as recommended by this survey.

We also refer the HFSRB members to the report of the National Association of State Mental Health Program Directors describing the decline of psychiatric inpatient capacity in the United States.[4] This report documents the decline in the number of facilities providing inpatient services for behavioral health patients from 471,451 facilities in 1970 to 170,200 such facilities in 2014 representing a 63.9% decrease during that period[5] Due to population growth, the decrease in psychiatric bed capacity as a ratio of patients per 100,000 persons showed even greater capacity decline. With a documented statewide average of 51.2 per 100,000 residents,[6] this report ranks Illinois as 36th in the country for access to inpatient AMI beds.[7] Residents of the State of Illinois deserve a more proper standard of care for this service, particularly given the level of infrastructure that exists in Illinois for both health care services and other public services,

II. Behavioral Health Services Accessibility Limitations

The HFSRB Staff Report for this CON permit application should have provided for a positive finding on Service Accessibility (77 IAC 1110.210(b)(5)) due to the involuntary patient outmigration for this service for an underserved population and gaps in care along with consideration of the fact that Katherine Shaw Bethea Hospital will not consistently accept AMI patients presenting in the CGH emergency department for transfer because of problems with maintaining its own program. Some of these access limitations to the KSB program are likely explained by the difficult payor mix that KSB, as an AMI service provider shares almost universally with other inpatient AMI providers.

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[4]https://www.nasmhpd.org/sites/default/files/TACPaper.2.Psychiatric-Inpatient-Capacity_508C.pdf.

[5] Id. at p. 28.

[6] As we know, this data is skewed to represent a higher supply than exists for this planning area due to the high supply of beds in metropolitan Chicago. See attachment showing disparities between the various planning areas.

[7] Id. at p. 38.

Discussion

A. Need for AMI Beds in Planning Area

(i) Involuntary Outmigration for AMI Services Distorts the Bed Need Calculation

The current stop-gap measure of transferring to distant inpatient programs those patients who present in the CGH Emergency Department in need of an acute mental illness care admission creates enormous gaps in care which should be accounted for in assessing need in the planning area for AMI beds. Because, however, involuntary outmigration is not taken into account in making planning area need determinations, metropolitan Chicago bed use rates are driven up under the current need formula. This has resulted in 65% percent of the State population (those residing in metropolitan Chicago) having immediate access to 78% of the State's beds supply. This imbalance is to the detriment of communities in HSA 1.

(ii) Disproportionate Access to Services between GSA and State of Illinois as a Whole.

We appreciate that the HFSRB staff recognizes the enormous disparity between AMI services access in the State of Illinois as a whole compared to the geographic service area which is noted in the HFSRB Staff Report. Specifically, the ratio of AMI beds to population in the State of Illinois is 1 bed for every 2,290 residents. The bed to population ratio for CGH's defined geographic service area is 1 bed for every 6,950 residents. This means the communities served by CGH have only 1/3 of the access to AMI services that other residents of Illinois have. As the HFSRB Staff Report states on page 14, this disparity "illustrates that no unnecessary duplication of service or maldistribution of service exists in this 21-mile GSA." Relatedly, page 12 of the HFSRB Staff Report states "the combination of a rural/expanded service area, and an inaccessibility to AMI programming in the service area suggests a need for the entire 10-bed complement at CGH Medical Center."

(iii) Access to AMI Service in Whiteside County is a Public Health Imperative.

This lack of access is catastrophic to a vulnerable and underserved uninsured/ Medicaid population suffering from acute mental illness. It is also a significant and unnecessary burden to government payors - in fact, for all payors - for transportation, treatment, and ongoing care that lacks care coordination with the local community behavioral health provider, Sinnissippi Centers and consistency of providers. With the establishment of this AMI unit, CGH Medical Center will improve its role as a health care safety net provider and significantly enhance access to vulnerable patients to what is now, generally recognized an essential, primary care service. As detailed in CGH's CON permit application, providing this service locally addresses one of the

most significant findings of the most recent Whiteside County Community Health Needs Assessment.

Some key facts to understand in analyzing this issue. The population of the Northwestern HSA 1 counties is 136,057,[8]

- In this Planning Area (HSA 1), 62% of inpatient behavioral health patients are admitted to facilities outside of HSA 1.
- 82% of those patients are either uninsured or enrolled under a government health insurance program with either Medicaid or Medicare as their primary benefit.
- Patients presenting in the CGH emergency department and requiring transfer for inpatient behavioral health services were admitted to 50 different hospitals in the State. CGH's inability to consistently gain admission for these patients to hospitals within the planning area or even to a small number of hospitals outside the planning area is a significant indicator of the unacceptable level of access to this service for the communities CGH serves.

B. Service Accessibility is Impaired for the Communities Served by CGH.

The most important fact for the HFSRB members and staff to appreciate in considering this project is the fact that KSB Hospital will not regularly accept transfers for CGH patients that require an AMI admission. Because of this and because of the key priority that Whiteside County has made addressing the need for inpatient behavioral health services in its assessment of the needs of the County, **the proposed project should not have received a negative finding for Section 110.210 (b)(5)(A), Service Restrictions. In fact, CGH is confronted with KSB Hospital's service restrictions on the transfer of behavioral health patients on a daily basis.** Based on the situation that exists in its GSA relating to lack of access to inpatient AMI services, CGH's project addresses services accessibility in three of the permitted five ways. (See Attachment.)

CGH Medical Center does not dispute the AMI occupancy rate at Katherine Shaw Bethea Hospital as outlined in the HFSRB Staff Report. However, as a referring hospital seeking access to behavioral health beds for its patients presenting in the CGH Emergency Department in mental health crisis, the reality is drastically divergent with the impression that rate leaves that there are beds available for the CGH AMI patients. CGH has documented the situation in this planning area in the CON permit application and specifically described how the AMI unit of

[8] Jo Daviess: 21,366, Carroll: 14,312, Whiteside: 55,626, Stephenson: 44,753 (U.S. Census Quick Facts, 2018 Estimates).

Katherine Shaw Bethea Hospital is not an adequate option for patients of CGH who require inpatient admission.

- In the past 24 months, 43% of HSA 1 transports for behavioral health services were outside of the HSA 1. These transports are made after a request to transfer is made and declined. These annual transports alone amount to over $350,000 in unnecessary expenditures funded by tax dollars for nonemergent transports. Uninsured patient transfers are funded by CGH without reimbursement.
- More recent data continues to evidence lack of access for these patients in the Planning Area. From July 2019 to September of 2019:
    - Katherine Shaw Bethea Hospital accepted only 18% of referral requests for admission to its inpatient AMI unit from CGH. The reason KSB stated in rejecting these transfers was a lack of available beds. The other two hospitals in HSA 1 in Rockford did not accept a single referral due to a stated lack of beds. In any case, the Rockford providers are too distant to be an adequate option for CGH's patients.
    - CGH understands that KSB does not typically staff the 14 AMI beds it is licensed for but rather it most regularly staffs a six bed AMI unit. This is reflected by its average daily census of 5.5 patients as reflected in its 2018 data profile. Based on the consistent rejection of the CGH transfer requests, we assume the primary purpose of its unit is to eliminate the holding and treatment of patients in mental health crisis in KSB Hospital's own ED.
    - Particularly given the lack of full or partial reimbursement available for patients needing mental health services (see payor mix noted above), CGH understands that any secondary purpose of alleviating CGH' s problems with getting AMI patients placed closer to their homes is not a priority for KSB given other demands placed on a community hospital like KSB. This is really unfortunate for our patients requiring admission for behavioral health services.[9]

Vulnerable Patients' Right to Receive Timely Care and Treatment

If CGH is approved to operate the inpatient AMI service, it knows that it must do so in spite of its difficult payor mix. In 2018, only 11% of its inpatients were covered under private commercial insurance plans. The remaining 89% of patients consisted of Medicaid, Medicare and uninsured patients. As a safety net provider and the key health care provider in its community, it is willing to take this responsibility on given the inadequate alternatives as they

[9] We note that only one of five criteria needs to be met for a favorable finding on Service Restrictions

exist today. Based on lack of access to inpatient beds, CGH has estimated a $1.2 million annual losses associated with boarding behavioral health patients unnecessarily. With a unit, these losses would be marginalized while providing better care to patients who need these services.

The gap in care behavioral health patients experience is not limited to the inappropriate transfers to distant hospitals. In the past 30 months, 215 patients who presented to CGH Medical Center and were determined to need admission to an inpatient unit were never accepted to any inpatient behavioral health unit. Instead, these individuals were admitted to CGH while awaiting placement. In such instances, medication management was initiated without adjuvant treatment. Subsequent to the initiation of medications, these patients improved after 72 to 96 hours. The patients were then reassessed, and an outpatient treatment plan developed which allowed for discharge to the community behavioral health provider. These patients, despite requiring admission to an AMI unit experienced a gap and care and since they didn't receive the prescribed inpatient behavioral health service, their behavioral health care is not reflected in the AMI bed need data and skews the overall needs assessment for the region.

Right to Receive Quality and Safe Care

CGH Medical Center is fully accredited by The Joint Commission and in good standing. Although CGH does not have a behavioral health unit, its most recent survey noted compliance with ligature risk and safety standards. We have direct visualization of patients and invested significantly in the infrastructure of our designated safe rooms to ensure the safety of behavioral health patients while they await transfer. We cannot ensure the safety of our patients once they transfer and we are aware of a CMS Immediate Jeopardy citation relating to the care and safety of these patients at another area facility which reinforces CGH's view that it needs to admit these patients to its own program.

While this IJ finding was subsequently resolved, the lack of investment in safe care and apparent lack of ability to treat patients originating at our hospital requires CGH Medical Center to take responsibility and provide the services needed for its communities. There is a critically unmet need for psychiatric inpatient services in Whiteside County as well as in the Northwestern counties in Illinois.

Establishment of AMI Unit Has Significant Community Support and No Opposition

Finally, we appreciate HFSRB staff acknowledging the various community stakeholders supporting the CGH proposal to establish an AMI unit. As the HFSRB staff report notes, the CGH proposal is unopposed and, in particular, it is not opposed by Katherine Shaw Bethea Hospital.

Thank you for your consideration of these comments to the HFSRB Staff Report. We look forward to presenting this important project to the HFSRB members at the December 10, 2019 meeting.

Sincerely,

Kara Friedman

Kara M. Friedman

KMF
Enclosures include visuals that may be used in December 10th presentation to the HFSRB

c: Dr. Paul G. Steinke, President And Ceo, CGH Medical Center
Kristie Geil, Vice President, Patient Care Services & CNO, CGH Medical Center

Service Restrictions Criterion
Attachment

Service Restrictions

The applicant shall document that at least one of the following factors exists in the planning area:

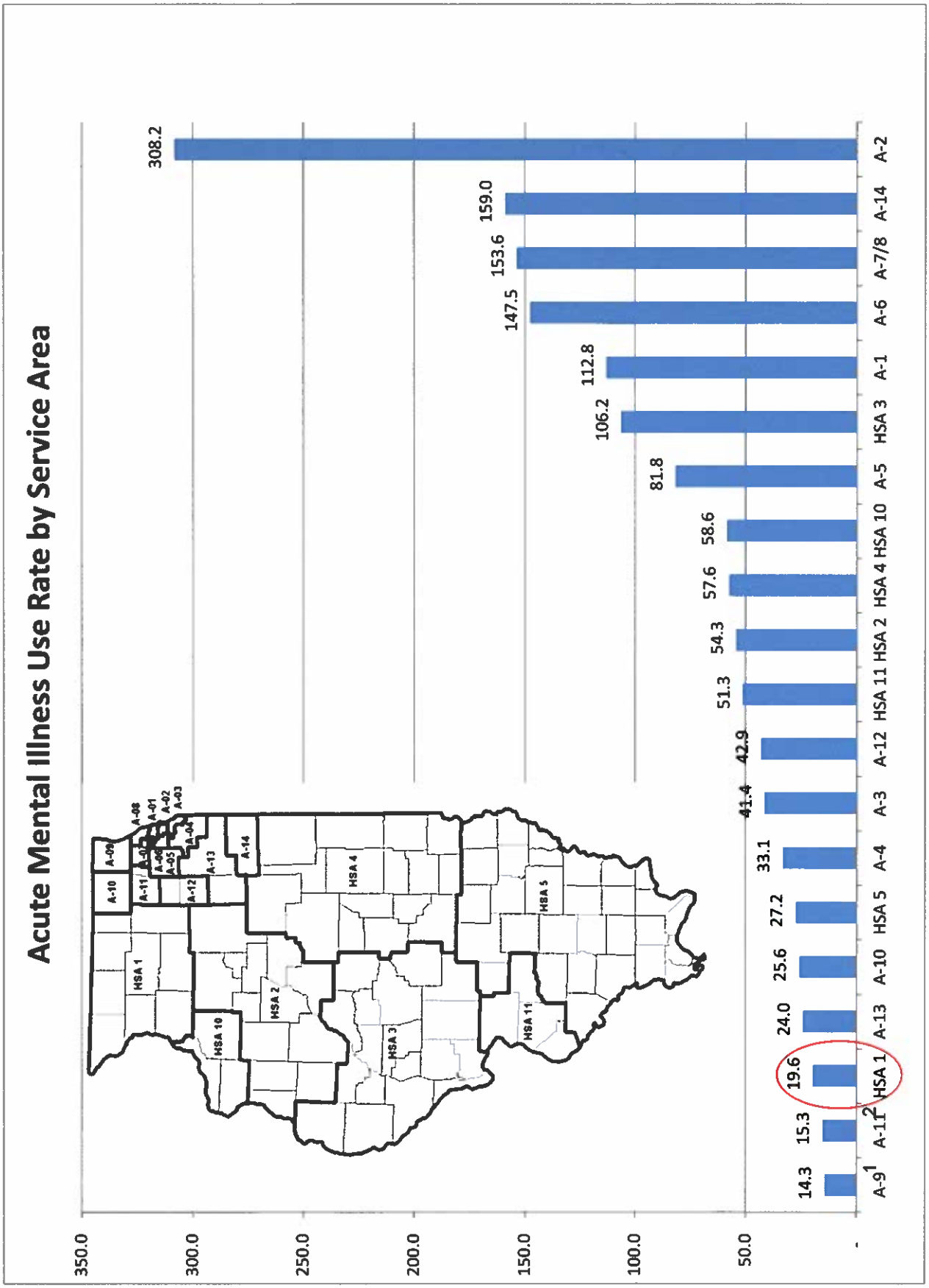
i) The absence of the proposed service within the planning area;

ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;

iii) Restrictive admission policies of existing providers;

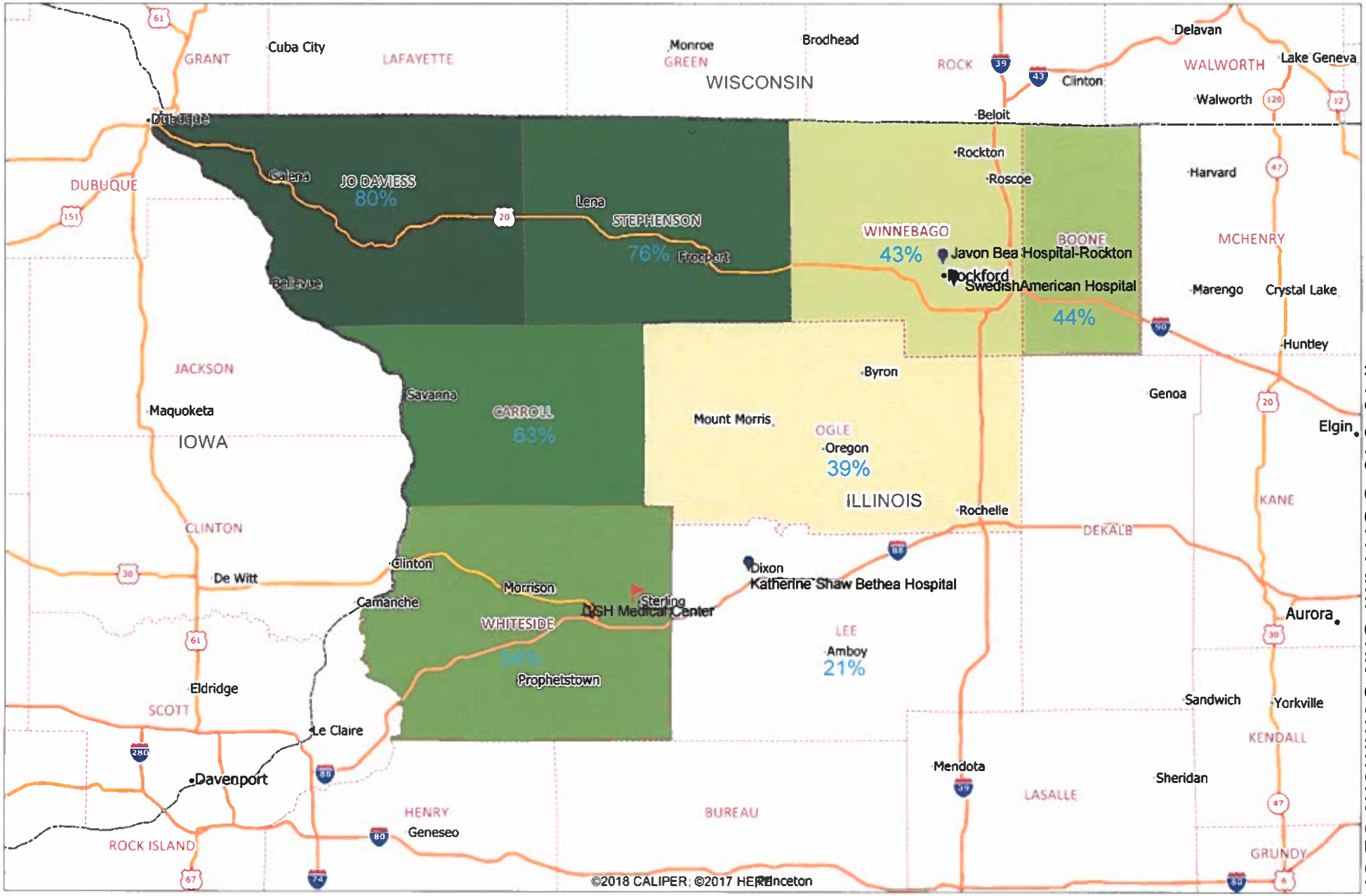
iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;

v) For purposes of this subsection (b)(5) only, all services within the established radii outlined in 77 Ill. Adm. Code 1100.510(d) meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.



1 Lake Behavioral Hospital approved to add 100 AMI beds with a projected completion date of October 1, 2020
2 Does not include State operated Elgin Mental Health Center

Outmigration of Inpatient Psychiatric Care Patients



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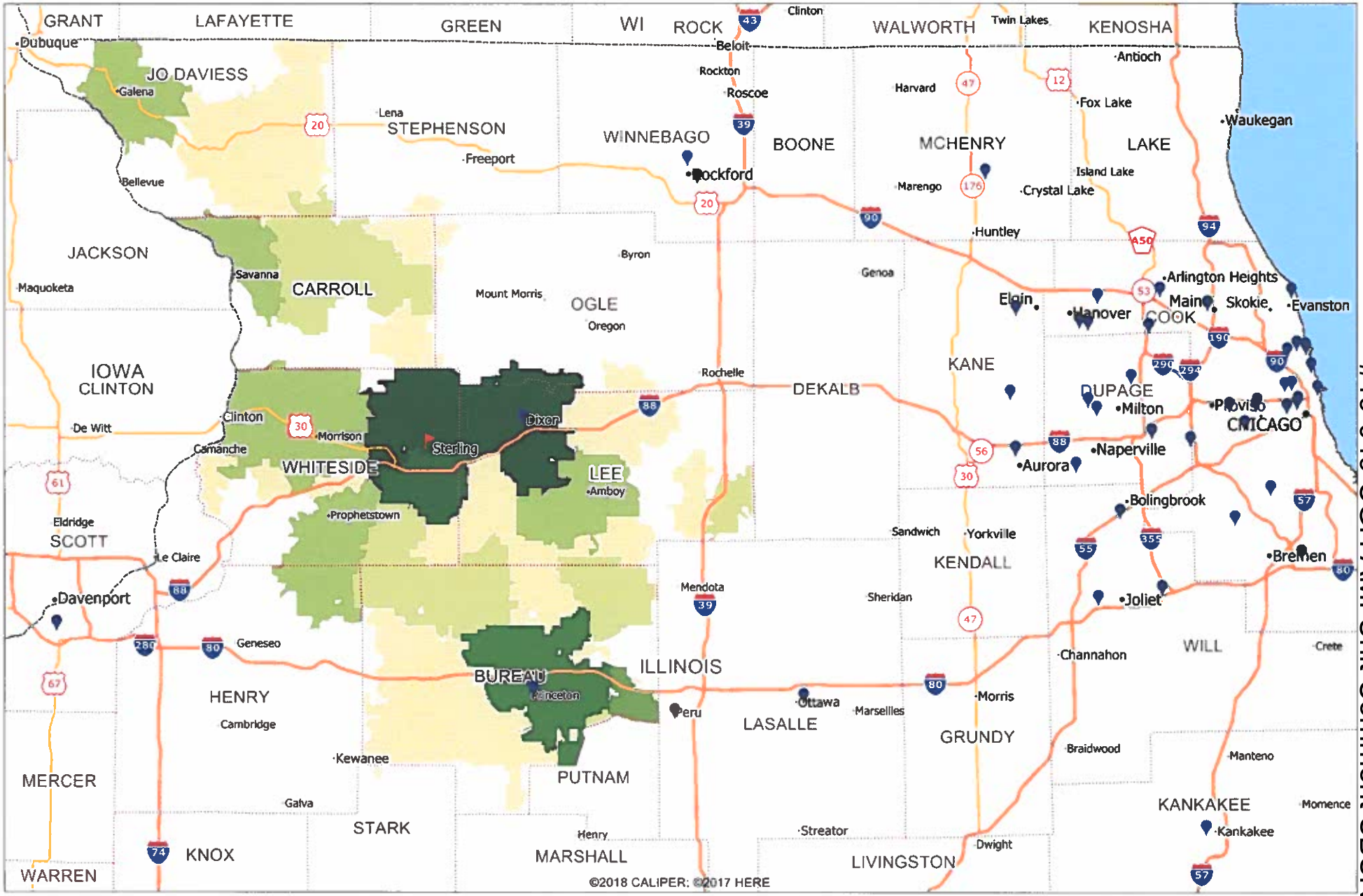
Admissions to Inpatient Acute Mental Illness Programs from CGH Medical Center Service Area



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