Acute Psychiatric Treatment Committee
April 5, 2022

Chairman Nelson and Committee Members, I am Tim Blasl, President, of the North Dakota Hospital Association. Thank you for the opportunity to respond to the draft report on the Acute Psychiatric and Residential care project prepared by Team Schulte Consulting, LLC.

Ever since the study started, we looked forward to being part of discussions about how to improve the mental health delivery system in North Dakota. All hospitals across the state play a critical role in providing mental health services to their communities. But it is an unfortunate fact that hospitals and their emergency departments are often the primary source of acute care services for people with mental illness. With inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. We can and should do better.

It is difficult to comment because the draft report was not shared publicly until late yesterday. I was made aware of the draft by a reporter. We have not had a chance to digest the recommendations or get input of many members. But, let me start by saying our members strongly support reforms to promote mental health care access, including maximizing psychiatric services through telehealth, improving data collection and analysis, and defining levels of care for mental health so that everyone knows what constitutes the highest level of acuity and only those patients go to the State Hospital. It is critical that we better define which patients should appropriately be cared for in the State Hospital so that they are taken care of at the right place with the right level of service and transferred there within a reasonable time. Currently, the process of transferring a patient in need of State Hospital care can take several days or weeks, unfortunately tying up acute care beds. One of the state's PPS hospitals, as an example, had patients with complex needs who had to wait more than 40 days before being accepted at the State Hospital. It is hard to understand why the report does not address these kinds of wait

times for high acuity patients and why the report concludes that North Dakota has the right number of psychiatric beds. Our hospitals universally report major difficulty in finding acute psychiatric inpatient beds for patients who need them.

We do have concerns with some of the comments in the report. We are concerned with accusations that hospitals are “dumping” patients. Let me be clear in stating that we know of no North Dakota hospitals that turn away any patient who presents to their emergency room. We expect that alleged violations would be reported to, and dealt with, by the North Dakota Department of Health as the licenser of hospitals. We are also concerned that the consultant does not appear to understand the requirements imposed on hospitals by the federal Emergency Medical Treatment & Labor Act (EMTALA). Medicare-participating hospitals that offer emergency services must take all patients who come to the hospital by providing a medical screening examination. If the screening shows the patient has an emergency medical condition, the hospital must provide the patient with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur. Again, we know of no hospitals that fail to follow these requirements. The report recommendations also show a fundamental misunderstanding of EMTALA. Hospital emergency rooms must take all patients - no matter which state they come from. We can’t take North Dakota patients in our emergency rooms but turn away Minnesotans as suggested.

To implement other recommendations in the report, there would need to be regulatory changes. The Medicare 96-hour rule for Critical Access Hospitals which limits the length of patient stays and North Dakota Administrative Code requirements for hospital psychiatric services which require, among other standards, that the physician in charge be a psychiatrist licensed in North Dakota and the nursing personnel be a separate staff who are assigned to the hospital psychiatry services[1] are just two examples. Can we create crisis stabilization beds in Critical Access Hospitals as suggested in the report? Yes, but the challenge is how to staff those beds and pay for them. We do not have enough workforce as it is even in the larger cities - particularly psychiatric nurses. And reimbursement would have to change because specialized psychiatric beds are expensive to construct in accordance with Medicare Conditions of

[1] ND Admin. Code section 33-07-01.1-36.

Participation. One existing room alone can easily cost $100,000 to retrofit to properly care for a psychiatric patient.

In summary, we hope that we will have a chance to review the final report in advance of this Committee's consideration of it so that we can bring meaningful input about how we can work together to improve North Dakota's mental health care system.

Thank you for your time today. I would be happy to try to answer any questions you may have.

Respectfully submitted,

Tim Blasl, President,
North Dakota Hospital Association