Perham Health
SANFORD

January 3, 2013

Mr. Stefan Gildermeister

Director, Health Economics Program

Minnesota Department of Health

85 E. Seventh Place, Ste 220

St Paul, MN 55101

Re: Recent conference call questions and request for DRG detail

Dear Mr. Gildermeister,

The following is additional detail resulting from our discussion during our recent conference call, both MDH pre-questions and those that arose during our call. We also received the *DHS Mental Health Acute Care Needs Report* from Nathan and have reviewed the report.

Exhibit A contains DRG information which may be helpful. Exhibit B is CMS Form 437 upon which CMS (via state surveyors) use to determine eligibility for participation in federal funding. Exhibit C is the requested Scope of Service document.

Thank you. We hope we have answered all MDH questions so we can move forward to the next step in the moratorium approval process.

Katie Lundmark

Ms. Katie Lundmark

Vice President for Long Term Care

Perham Health

735 3rd St SW

Perham, MN 56573

Cc: Nathan Hierlmaier, MDH

Chuck Hofius, Perham Health

Fred Deloye, BHC

Susan Tabor, BHC

Question#1 Posed in Nathan's email dated 12/20/12

What specific services are anticipated to be provided at this new facility that are not available in other care settings such as the Perham Health Hospital, Perham Living Nursing Facility or on an outpatient/homecare basis? Please provide a few clinical examples of a non-identified patient(s).

Answer: This was addressed extensively during the call and to reiterate: The proposed program is an acute care psychiatric unit for the elderly population (over age 64) that is not offered by Perham Health hospital or the nursing home. The geriatric acute psychiatric program will provide treatments to help patients achieve relief from the sufferings associated with acute psychiatric and behavioral symptoms. The criteria for admission to an acute psychiatric program are as follows:

Suicidal

Homicidal

Active psychotic

Acute Depression

Delirium (may or may not be medication induced)

Danger to self or others

Failure of psychiatric out-patient, partial or day treatment

Social Withdrawal

Sudden and unexplained changes in behavior

Dementia with Behaviors

Alzheimer's with Behaviors

(see attached DRG list in Exhibit A)

The new facility will provide a safe setting for older adults who will benefit from individual and group treatment for stabilization of acute psychiatric and behavioral symptoms and crisis. The care is directed by psychiatrists experienced in geriatric care with a care team including nurses, social workers, occupational therapists, and valuable input from the patient, their family, their local physician or others involved in their on-going care when discharged back to their home setting. An individualized treatment plan is developed to focus on the patient's unique needs. The care at the geriatric psychiatric hospital will include:

- A thorough assessment and diagnosis – evaluation of disturbed behaviors/thoughts/mental status
- Behavioral stabilization, management and supervision
- Medication adjustment and/or stabilization
- 24-hour nursing care
- Access to multi-disciplinary care team
- Specialized education for patient, family and caregivers
- Discharge planning and referral services for successful return to former living arrangement and full integration to home/community or seek setting that provides supports necessary for behaviorally healthy living.

What is presently experienced in rural MN for geriatric behavioral health needs:

Geriatric behavioral health care is typically managed in rural, out-patient settings by psychiatric nurse practitioners collaborating with family practice physicians in out-patient settings; i.e. medical clinics and nursing home collaborations. This is the ideal manner of management for the chronic symptoms of depression, anxiety, schizophrenia, bi-polar, personality disorders, etc. When behavioral symptoms elevate to the point of a mental health crisis such as physical and verbal aggression, likelihood of harming self or others, and manic or severe depressive states; then families and/or caregivers of the senior, elderly population typically rely upon their local emergency department for immediate help and assistance to help them navigate the limited and complex landscape of in-patient mental health services for seniors in rural settings. So often, these patients have not had on-going assistance from mental health practitioners; either due to undiagnosed mental health needs, inability to access appropriate care or unwillingness to do so. In reality, a large majority of geriatric mental health care is more of a "crisis management" issue with referral resources being limited and unwieldy.

Especially in the elderly, medical conditions and psychiatric conditions affect each other exponentially. Cognitive decline, malnutrition, social isolation, and medication non-compliance can affect each area of health. When family members and/or caregivers observe the elder patient to be behaving differently and/or with extreme uncontrolled behaviors, family and/or caregivers seek help. A medical clinic and/or emergency department becomes the gateway to seeking answers as to "why" a change in behavior and "now what can be done about it." The typical scenario involves bringing the elder to the emergency room, where physicians run a battery of medical tests to rule out medical emergencies and/or causes of these behaviors. If it is found there is no medical basis for the present behavioral/mental health crisis, then the physician, medical social worker, nursing staff and family members attempt to find an in-patient mental health setting that can address these needs.

We have heard from colleagues in the region and our own observations become testimonial that due to lack of mental health in-patient options for the geriatric population; keeping this patient in the acute care setting often becomes the only option available and can even amplify the symptom logy of the mental health crisis. Physical and verbal aggression, wandering, manic or severe depressive states can increase causing greater challenges for nursing staff and physicians who are primarily equipped to work with acute care medical conditions rather than mental health crisis.

The frailness of the elderly population, coupled with their distorted perception of reality during a mental health crisis presents considerable challenges. Fall risks, elopement and medication management issues are higher than what can be typically managed in small, rural acute care hospitals.

Question #2 from Nathan's email

Can you please identify how your proposed increase in inpatient mental health capacity addresses *specific availability of community based mental health services in your area?*

Answer: Adding a now non-existent acute care psychiatric inpatient program for the elderly in this area will complete the menu of available care options to the community. At current, folks meeting this criterion needed to travel beyond the Perham MSA to seek care and frequently, programs outside the area are full and unable to care for local residents. Traveling beyond 50 miles in the winter months is problematic and potentially dangerous. With a local program, families will be able to participate in family meetings with the treatment team and be involved with discharge planning.

Question #1 from Conference Call:

Is the unit and/or will the unit treat chemical dependency?

Answer: The unit is not a chemical dependency treatment program and patients needed detox will not be accepted. However, if the psychiatric issue and diagnosis are primary and there is underlying

chemical dependency or substance abuse issues, those will be addressed along with the primary presenting problem(s).

Question #2 from Conference Call:

Will the program accept admissions on a 24/7 basis?

Yes and explanation offered within the Scope of Service document, Attachment C.

Additional information requested:

Informal Survey of Colleagues

In 2011, the Perham Health social service department did an informal survey with colleagues in the region to ascertain a perceived need for geriatric, psychiatric, in-patient services. Colleagues involved in this survey included hospital and nursing home social workers, county adult protection workers, public health nurses, psychologists and family & emergency room physicians. The geographic area of colleagues involved includes Becker, Wilkin, Clay, Otter Tail, Hubbard, Douglas, Wadena, Mahnomen, Polk and Grant counties. From this informal survey we heard a consistent message of support and desire for a geriatric psychiatric in-patient unit to serve this area. Especially areas west of Perham are without any option specialized for geriatric psychiatric in-pt care. Statements from two colleagues attest to this support: Margaret Williams, Disability Unit Supervisor with Otter Tail County Human Services states; "I believe there is a need for geriatric psychiatric in-patient treatment services in Otter Tail County. The great distance to other facilities is a major factor for families, case managers and law enforcement. I believe a local provider would have a better understanding of services available upon discharge of these consumers back to their community." Connie Jensen, social worker at St. Francis Nursing Home in Breckenridge echoes a similar concern about present resources: "Distance has ALWAYS been an issue to families when we've presented this kind of recommendation. Their concerns include difficulty in supporting their loved one from a distance and the expense and magnitude of travel. When we consider in-patient psychiatric care for our nursing home residents, the only options in the Fargo-Moorhead area are those with a mixed population, not specific to the uniqueness of the geriatric population. The need will be increasing in the future."

Exhibit A

Most prevalent DRG's/Geriatric psychiatry PPS programs per CMS*.

056 Degenerative nervous system disorders w MCC

057 ..... Degenerative nervous system disorders w/o MCC

080 ..... Nontraumatic stupor & coma w MCC

081 ..... Nontraumatic stupor & coma w/o MCC

876 ..... O.R. procedure w principal diagnoses of mental illness

880 ..... Acute adjustment reaction & psychosocial dysfunction

881 ..... Depressive neuroses

882 ..... Neuroses except depressive

883 ..... Disorders of personality & impulse control

884 ..... Organic disturbances & mental retardation

885 ..... Psychoses

886 ..... Behavioral & developmental disorders

887 ..... Other mental disorder diagnoses

894 ..... Alcohol/drug abuse or dependence, left AMA

895 ..... Alcohol/drug abuse or dependence w rehabilitation therapy

896 ..... Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC

897 ..... Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC

*Source: Federal Register, 8/2012. PPS Program

Exhibit B

CMS Form 437

Please see form on the next three pages.

Form Approved
OMB No. 0938-0358

PSYCHIATRIC UNIT CRITERIA WORK SHEET

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE UNIT	FACILITY NAME AND ADDRESS *(CITY, STATE, ZIP CODE)*
NUMBER OF BEDS IN THE UNIT	SURVEY DATE	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY		
VERIFIED BY		

ALL CRITERIA MUST BE MET FOR EXCLUSION FROM MEDICARE'S HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS)

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
	§412.25 Excluded Hospital Units: Common Requirements				
A1105	(a) Basis for exclusion. In order to be excluded from the prospective payment system, a psychiatric unit must meet the requirements under §412.25(a) and (b) which include:				
A1106	(1) Be part of an institution that (i) Has in effect an agreement to participate as a hospital; (ii) Is not excluded in its entirety from the prospective payment systems; and (iii) Has enough beds that are not excluded from the prospective payment systems to permit the provision of adequate cost information, as required by §413.24(c)	Has the state agency (SA) verified with the CMS Regional Office (RO) that the hospital has a current agreement to participate in the Medicare program and to ensure that the hospital is not already excluded in its entirety from PPS, such as a psychiatric hospital?			
A1107	(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.	Are the same admission criteria being applied to all patients?			
A1108	(3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.	Are the psychiatric unit medical records separate from other hospital records? Are the records readily available for review?			
A1109	(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.	Does the hospital have a policy ensuring prompt transfer of information to the unit?			
A1110	(5) Meet applicable State licensure laws.	Has the unit verified current active licensure of its professional staff? Does the unit meet any special licensing requirements of the state?			

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1111	(6) Have utilization review standards applicable for the type of care offered in the unit.	Does the hospital have a utilization review plan that includes psychiatric services?			
A1112	(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds.	Is the area containing the psychiatric unit beds separate from the beds in the other units of the hospital?			
	§412.27 Excluded Psychiatric Units: Additional Requirements:				
A1120	(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately on in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification.				
A1121	(b) Furnish, through the use of qualified personnel, psychological services, social work, psychiatric nursing, occupational therapy, and recreational therapy.				
A1122	(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:				
A1130	(1) **Development of Assessment/Diagnostic Data.** Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.				
A1131	(i) The identification data must include the inpatient's legal status.	Legal status is defined by state statutes and dictates the circumstances under which the patient was admitted and/or is being treated (i.e. voluntary, involuntary, committed by court)			
A1132	(ii) A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.	Is the diagnosis written in DSM nomenclature? If the diagnosis is absent, is there written justification for the omission? (for example, the patient was psychotic on admission and not accompanied by family) Is treatment provided for physical illnesses requiring immediate attention? Is there an evaluation and treatment plan for identified physical illnesses that may impact the patient's psychiatric outcome?			

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1133	(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.	The records should include who, what, where, when, and why the patient was admitted to the facility.			
A1134	(iv) The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.	Does the assessment include the following components? 1) Factual and historical information, 2) Social evaluation (baseline social functioning including strengths and weaknesses), and 3) Conclusions and Recommendations (in anticipation of social work's role in treatment and discharge planning).			
A1135	(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.	At a minimum, the screening neurological exam includes a detailed description of gross testing for cranial nerves II through XII.			
A1140	(2) **Psychiatric Evaluation.** Each inpatient must receive a psychiatric evaluation that must:	The psychiatric evaluation must include the following components: 1) Chief complaints, reaction to hospitalization, 2) Past history of any psychiatric problems and treatment, including previous precipitating factors, diagnosis, and course of treatment, and 3) Past family, educational, vocational, occupational, and social history.			
A1141	(i) Be completed within 60 hours of admission;				
A1142	(ii) Include a medical history;	Does the evaluation include any medical conditions that may impact the patient's recovery/remission?			
A1143	(iii) Contain a record of mental status;	Does the mental status record describe the appearance, behavior, emotional response, verbalization, thought content, and cognition of the patient?			
A1144	(iv) Note the onset of illness and the circumstances leading to admission;	Are the identified problems related to the patient's need for admission?			

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1145	(v) Describe attitudes and behavior;	Does the problem statement describe the behavior(s) which require modification in order for the patient to function in a less restrictive environment?			
A1146	(vi) Estimate intellectual functioning, memory functioning, and orientation; and				
A1147	(vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.	For the purposes of this regulation, words such as "youth", "pretty", "social security income" and "has a car" do not represent assets.			
A1150	(3) **Treatment Plan.** (i) Each inpatient must have an additional comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and	Is the treatment plan a result of collaboration between the patient and the treatment team? Is the treatment plan individualized? Is there a primary diagnosis upon which the treatment interventions are based? Are the treatment plan goals written in a manner that allows for changes in the patient's behavior to be measured? Are the treatment plan goals relevant to the patient's condition? Does the treatment team encourage the patient's active participation and responsibility for engaging in the treatment regimen? For patients who have been secluded or restrained, have less restrictive interventions been considered prior to the use of seclusion or restraints? What is the rationale for use of seclusion and/or restraints? If the use of seclusion and/or restraints is a frequent occurrence, does the treatment plan document alternative interventions to address and treat negative patient behavior?			
A1151	(ii) The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.	Does the patient require 24 hour specialized psychiatric care? Is the patient receiving all aspects of treatment to which the unit has committed itself, based on the assessment, evaluation, and plan of care? Do the policies and procedures adequately direct staff on alternatives or less restrictive interventions prior to the use of seclusion and restraints? Has the staff documented that less restrictive therapeutic interventions have been reviewed and/or attempted?			

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1160	(4) **Recording Progress.** Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities.	Does the content of the treatment notes and progress notes relate to: 1) the treatment plan 2) what the staff is doing to carry out the treatment plan, and 3) the patient's response?			
A1161	The frequency of progress notes is determined by the condition of the inpatient and must be recorded at least weekly for the first two months and at least once a month thereafter;				
A1162	and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.				
A1165	(5) **Discharge Planning and Discharge Summary.** The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or after care as well as a brief summary of the patient's condition on discharge.	Does the discharge planning process include the participation of the multidisciplinary staff and the patient? Are the details of the discharge plan communicated to the post-hospital treatment entity?			
A1170	(d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures, and engage in discharge planning, as follows:				
A1171	(1) **Personnel.** The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to –				
A1172	(i) Evaluate inpatients;	Is there adequate staff to ensure that admission work-ups are completed in a timely manner?			
A1173	(ii) Formulate written, individualized, comprehensive treatment plans;	Are all members of the treatment team able to contribute their data and perspectives toward formulation of the treatment plan?			

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1174	(iii) Provide active treatment measures; and	Is the distribution of staff consistent with particular patient needs? Is staffing sufficient to carry out treatment plans?			
A1175	(iv) Engage in discharge planning.	Does the record indicate that staff has participated in discharge planning? Are staff aware of discharge plans for the patients they are working with?			
A1180	(2) **Director of Inpatient Psychiatric Services; Medical Staff.** Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.				
A1181	(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.				
A1182	(ii) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	Are there appropriate professional staff available to provide necessary medical and treatment services? Does the unit have policies and procedures to direct medical and direct care staff in situations when patients become agitated and aggressive, posing a potential threat to self or others?			

Number of Physicians

SPECIALTY	FULL-TIME (A)	PART-TIME (B)	CONSULTING (C)
Psychiatry			
Neurology			
Other*			
Other*			
*Specify			

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1183	(3) **Nursing Services.** The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.				
A1184	(i) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric and mental health nursing, or its equivalent, from a school of nursing accredited by the National League of Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.				
A1185	(ii) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.				

Number of Nursing Personnel Assigned to Unit *(Full-Time Equivalents)*
(A) R.N._____ (B) L.P.N.S. _____(C) AIDES _____

Day of Survey-Number of Nursing Personnel *(Full-Time Equivalents)*

SHIFT	R.N.	L.P.N.	AIDES	OTHER
Day				
Evening				
Night				

Average bed-size of adult patient ward _____ beds

R.N. Duty Roster *(Full-time Equivalent)* — For at least one complete week

SHIFT	SUN.	MON.	TUES.	WED.	THURS.	FRI.	SAT.
Day							
Evening							
Night							
Relief							

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1186	(4) **Psychological Services.** The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures.	Are the patients in need of psychological therapy or testing receiving those services in a timely manner, and with sufficient intensity?			
A1187	(5) **Social Services.** There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished.	Does the social services director periodically audit the quality of social work services?			
A1188	The services must be furnished in accordance with accepted standards of practice and established policies and procedures.				
A1189	Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.				
A1190	(6) **Therapeutic Activities.** The unit must provide a therapeutic activities program.				
A1191	(i) The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychological functioning.	Has the unit ensured consistent availability and provision of individualized therapeutic activities and rehabilitative services based on patient's needs?			
A1192	(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.	Are there clearly defined monitoring and evaluation mechanisms to conduct consistent and timely review of the quality and appropriateness of therapeutic and rehabilitative services?			

Exhibit C

Perham Health: Geriatric Psychiatry

Scope of Service

Hospital: Perham Health, Geriatric Mental Health Inpatient Program

Service(s) provided: *The Geriatric Mental Health Hospital provides acute inpatient care for the elderly suffering from mental illness. Most frequent diagnosis are; depression, psychosis, delirium, and dementia with behaviors.*

Hours of operation: *This acute hospital unit is open and provides acute nursing care 24/7. Admissions are accepted 24/7 as well but most admissions occur during business hours. A pre-screening visit is available as needed and referrals may be made by anyone concerned.*

Patient populations served: *The program serves all elderly over age 64 as well as those over 55 who may be suffering from early onset Alzheimer's symptoms and behaviors.*

Skill mix: *The acute care program is staffed with RN's, Social Workers, Activity Therapists, Occupational Therapists, and Certified Nursing Assistants. The treatment team is led by a board certified Psychiatrist.*

Core Staffing and methods for determining and modifying staffing to meet patient or process needs:
Staffing is based on Medicare requirements and an acuity scale is used to determine skill mix beyond Registered Nurses, Social Workers, Certified Nursing Assistants, and Occupational Therapists.

Description of assessment and reassessment practices, including timeframes:
Upon admission, patients are assessed by nurses, social workers, occupational and/or recreational therapists and physicians. Daily assessments are completed by nursing and the medical director/psychiatrist sees patients a minimum of three times per week/more often if indicated.