Constantino, Mike

12-073

From: Clare.Ranalli@hklaw.com
Sent: Wednesday, October 10, 2012 5:05 PM
To: Constantino, Mike
Subject: FW: Page 9 - MSMC/CON Application
Attachments: Page 9 - MSMC.PDF

Dear Mike:

Please find a replacement page 9 for the MSMC application to establish a psychiatric unit. The Hospital intended to surrender 14 medical surgical beds in order to add the 14 AMI beds. It wants to make this part of the project.

Also, separately I am going to send you a report regarding the utilization/ALOS that addresses some of the negatives on the criterion in the SBR. I am hopeful that the SBR can be amended to at a minimum address the reduction in MS as part of the project, and also reflect the average length of stay generally for the types of DSMs affecting the proposed patient population, which is very close to the ALOS estimate contained in the application, and based on the number of referrals anticipated will result in target utilization of the 14 beds.

As always, thank you.

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From: Yothment, Mary Jane (CHI - X66512)
Sent: Wednesday, October 10, 2012 5:02 PM
To: Ranalli, Clare Connor (CHI - X66567)
Subject: Page 9 - MSMC

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Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available**. **Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: MetroSouth Medical Center	**CITY:** Blue Island, Illinois
REPORTING PERIOD DATES: **From:** January 1, 2011	**To:** December 31, 2011

Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	272	6,584	28,831	-14	258
Obstetrics	30	2,974	5,116		30
Pediatrics					
Intensive Care	28	1,123	4,784		28
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	0	N/A	N/A	+14	**14**
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other (identify)					
TOTALS:	**330**	**10,681**	**38,731**		**330**

Constantino, Mike

From: Clare.Ranalli@hklaw.com
Sent: Wednesday, October 10, 2012 5:06 PM
To: Constantino, Mike
Subject: MSMC CON for establishment of AMI category of service
Attachments: img-X10160621-0001.pdf

Per my previous email.

October 8, 2012

Criteria 1110.234 Project Utilization: "The applicant provided 280 referrals for the second year after project completion. The applicants stated that the ALOS would be 12 days however this is twice the planning area average of 6 days. We believe the ALOS proposed by the applicants is excessive and if the planning area ALOS was used the projected utilization would be 33%."

The State's Brief discounts the ALOS (average length of stay) offered by our application of 12 days. This information as stated in the application came from a conservative estimate from Signets extensive history of treating this age population. Reaching out for a governmental authority to validate this information we offer up the "Impacts Associated with the Inpatient Psychiatric Facility PPS: Final Report" prepared for the Centers for Medicare & Medicaid Services (CMS), March 2010. The principle author of this report is Edward M. Drozd, Ph.D. and is referred to as the Drozd Report.

On page 6 of the Drozd Report is a table showing Distinct Part Units (DPU) with an ALOS of 11.3 days. DPU's are an administrative distinction Medicare allows to qualify for the Inpatient Psychiatric Facility Prospective Payment System, which allows exemption for the Medical Diagnostic Related Group system of payment. The federal government has acknowledged the care for this population is more time consuming and very difficult to predict length of care needed tied to the diagnosis. The DPU population is predominately 65 and older simply because of the qualification requirements to receive Medicare. There is an adult population that is disabled who receives Medicare, so it isn't a totally homogeneous population. The unit we are proposing will be a DPU whose patients are 65 and older. Because of who qualifies for Medicare benefit, being age, we propose 95% of the patients cared for will be Medicare Beneficiaries. This is in part why our ALOS is higher than the 11.3, it doesn't have the adult population bringing down the average, their ALOS being an ALOS of 6.1. To support this claim we also offer up the following Pepper Report shows the Fourth quarter of 2011 average of 11.3 (this is tracking DPU's) supporting the continued average for these patients. On that table, the Scatter beds are those psych patients cared for in hospitals that are not freestanding (Med/Surg) or housing patient in DPU beds showing the 6 day ALOS consistent with the figure used in the State's Brief for our CON.

Table 2-2
ALOS for Psychiatric Admissions, by Setting

Year	Freestanding state hospital ALOS (days)	Freestanding non-state hospital ALOS (days)	DPU ALOS (days)	Scatter Bed ALOS (days)
2003	80.5	14.4	11.2	6.1
2004	80.4	14.4	11.1	6.0
2005	74.0	14.6	11.1	6.1
2006	72.2	14.9	11.3	6.1
2007	74.2	14.4	11.3	6.1

SOURCE: RTI International analysis of discharges from IPFs and general acute hospitals using the 2003–2007 100% MedPAR files.

Table 2-2 from page 6 of "Impacts Associated with the Inpatient Psychiatric Facility PPS: Final Report"

Inpatient Psychiatric Facility (Units Only) Q4FY11 Report
Nationwide Top DRGs
Discharges for most recent 4 quarters, ending Q4 FY2011
In Descending Order by One-Day Stay Totals Per DRG

TMF Health Quality Institute

DRG	DRG Description	Total Discharges for DRG	Proportion of Discharges for Each DRG to Total Discharges	Average length of Stay for DRG
885	Psychoses	209,997	72.6%	11.3
057	Degenerative nervous system disorders w/o MCC	27,202	9.4%	13.4
884	Organic disturbances & mental retardation	19,626	6.8%	12.8
881	Depressive neuroses	9,738	3.4%	7.1
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	7,011	2.4%	6.6
882	Neuroses except depressive	3,017	1.0%	6.8
056	Degenerative nervous system disorders w MCC	2,151	0.7%	14.9
886	Behavioral & developmental disorders	1,892	0.7%	11.3
880	Acute adjustment reaction & psychosocial dysfunction	1,852	0.6%	8.0
883	Disorders of personality & impulse control	1,227	0.4%	10.8
071	Nonspecific cerebrovascular disorders w CC	700	0.2%	12.1
895	Alcohol/drug abuse or dependence w rehabilitation therapy	629	0.2%	10.1
876	OR procedure w principal diagnoses of mental illness	484	0.2%	21.7
918	Poisoning & toxic effects of drugs w/o MCC	409	0.1%	6.9
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	373	0.1%	8.9
781	Other antepartum diagnoses w medical complications	362	0.1%	10.1
081	Nontraumatic stupor & coma w/o MCC	304	0.1%	8.4
894	Alcohol/drug abuse or dependence, left ama	287	0.1%	3.3
690	Kidney & urinary tract infections w/o MCC	230	0.1%	9.0
070	Nonspecific cerebrovascular disorders w MCC	127	0.0%	13.2
Top 20 DRGs Nationwide		287,618	99.4%	11.3
All DRGs Nationwide		289,350	100.0%	11.3

* Data Source: Medicare PPS Inpatient Claims

Table taken from "Pepper Report" on 4th quarter 2011 ALOS by DRG

14 beds at 730 days (two years) equals 10,220 patient days for 100% utilization. 286 referrals times 11.3 days (ALOS) equals 3,232 patient days. 3,232 patient days time 2 (2 years) equals 6,764 patient days. 6,764 divided by 10, 220 patient days equals 66.2 percent utilization, on internally generated historical referrals. With the aging of our population and the increased need for this specialty care, reaching 75% utilization within the allowed time frame will not be an issue.

Criteria 1110.730 Planning Area Need: "There is a calculated excess of 60 AMI beds in the planning area."

Unfortunately the current Illinois law doesn't make a distinction between specialty services in the care of Acute Mentally Ill (AMI) patients. It is clinically dangerous to mix these populations. One would not place an Adolescent patient on an adult unit without dire consequences, and mixing geriatric patients with adult patients can be just as hazardous. The patient profile and specific needs of these age groups are very different. The mental health industry has understood this and has developed dedicated units to meet these needs. In service area A-03 two hospitals were granted CON's to open dedicated units in excess of "Planning area need" to answer just this need. I am sure because the wisdom of the board saw the special needs of dedicated units for age groups other than adult. An evolving change in the care of the adult mentally ill patient is we have better medications to treat and maintain the adult serious and persistent mentally ill, ALOS are shortening, and the need for adult AMI inpatient beds is changing. The need for Adult AMI beds is going down and need for specialty beds such as Adolescent beds and Geriatric beds is going up. Since the AMI occupancy rates aren't segregated by age group the changes in adult inpatient needs would be hard to disseminate as compared to the growing need of dedicated units such at adolescent and geriatric care units.

Criteria 1110.730- Unnecessary duplication of Service: "There are 11 Facilities within 30 minutes not at the target occupancy of 75%"

Your typical geriatric psychiatric patient is usually in their late 70's, has some form of dementia, already has multiple co-morbid conditions (diabetes, congestive heart failure, hypertension, etc). Probably has renal insufficiency and may have liver insufficiency. Their admission is related to dysfunctional behavior, such as delusional thinking, hallucinations, combative behavior, etc. Most of the time their admission is the first time in their life they have received inpatient psychiatric care. In the pharmacological treatment of this population the adage is "start low, and go slow." Referring to starting with a low dose of medication and titrate slowly. The medications we use can be very toxic and the elderly body isn't as resilient to bounce back. The typical Adult AMI facility does not want to care for the medically compromised patient which you frequently see in the elderly population. Adult patients are very different than this profile, and it can be dangerous to mix them with a different age group of patients on the same unit. Having a dedicated geriatric psychiatric unit in a medical surgical hospital is a great benefit since it isn't uncommon for the elderly population to need emergent medical care, which would be readily available. The care of the family for the elderly patient is paramount, since their understanding of the disease process and expectations of what is possible for the care of this population

is usually clouded by unrealistic expectation. Being able to go to their local hospital would help to support the care of both the patient and their family. Of the four hospitals in our service area two of them have dedicated geriatric units for inpatient care, of the eleven hospitals within a 30 minute drive from our location there is only one more unit open and another in the development stage. The total dedicated geriatric units currently open to receive patients within 30 minutes of us reflects a much needed expansion of this dedicated service product. There will not be a duplication of this specialty service.

In addition, we continuously face extreme difficulty finding appropriate placement for patients due to basic and/or special medical needs. Adult AMI units are very selective of the patients they are willing to receive any type of co-morbidity is perceived as disqualifying them for care in their facilities. It is proposed the need for specialty beds to treat a unique mental health population would satisfy going over the "Planning Area Need" by population in a Southland hospital allowing families to continue receiving treatment for their loved one in a local hospital.