Public Hearing Presentation
Comments on Proposed Change to Psychiatric Policy PSY -2
State Medical Facilities Plan

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Presented by Edward A. Rush
President and Chief Executive Officer
Iredell Memorial Hospital, Inc.

Ladies and gentlemen, good afternoon. My name is Ed Rush and I am the President and Chief Executive Officer of Iredell Memorial Hospital. I am here today to present our reasons for supporting the petition for a revised Policy PSY-2 in the Proposed 2009 State Medical Facilities Plan.

We agree that LME Service Area 8 – Iredell, Surry and Yadkin counties – needs more psychiatric beds. At least twice a week, we struggle to place psychiatric inpatients who come or are brought to our emergency room and for whom we or others must request involuntary admission. Caring for these people results in placements as far away as Duke University. Some, we can send to closer facilities, Frye or Broughton. These patients absorb endless hours of staff time and take up critical space in our emergency department while we are looking for placement. They require so much time because they must be involuntarily admitted to a psychiatric unit. Iredell Memorial does not have a psychiatric unit. No hospital in our mental health area has a psychiatric unit with involuntary commitment beds. If gasoline prices result in any limitation on the travel radius for our local law enforcement agencies, who now transport most of these

patients hours away, we will have no way to care for a very difficult group of patients. Moreover, community-based care for these patients after discharge is difficult to coordinate; and, too often, they return to the emergency room.

Last year, we transferred 100 such patients; 90 percent were adults between the ages of 15 and 54. When psychiatric unit beds accept only voluntary admissions, or only geriatric patients, they do not address our need. Without a directive policy, however, this is the type of CON application that we have seen in the past when psychiatric beds appeared in the State Medical Facilities Plan.

Iredell Memorial treats approximately 45,000 patients a year in its emergency room. When one person ties up multiple staff, after we have done all we can to medically stabilize him or her, everyone else in the emergency room suffers the consequences. Care takes longer, we develop a bed shortage, and staff feel the stress. The Division of Mental Health has opted wisely for community-based care; now we need coordination of that policy with the policies in the State Medical Facilities Plan.

The Proposed 2009 Plan completely removes Policy PSY-2. While it may be time to update the policy, completely removing it could produce a very detrimental effect on our community. The 2009 Plan includes 107 new psychiatric adult beds, and when it is updated for the beds that were in the 2007 Plan for our area, but were unapproved, the 2009 Plan will have 119 beds. This is a one-time opportunity for the State to assist local communities with their new burden to care for persons who have severe mental health problems and who are submitted for involuntary admission. In our Service Area, we need beds that are

designated and designed for involuntary admissions. Without that designation, the beds cannot accept our most difficult patients. The patients stay in our emergency room, sometimes for days; they require substantial additional staff to protect them and other people in the hospital; and we are left to search throughout the state for an available involuntary bed. The 12 beds in the Plan are too few to justify an investment for Iredell Memorial Hospital. However, it would be most unfortunate if there were no basis in the Plan for considering our area's need for involuntary beds when an applicant does step forward.

In removing PSY-2 and making no replacement, the Plan takes away a one-time opportunity to solve a big problem and may create a bigger problem. All of the beds could be allocated in one year, the calculated "need" will have disappeared, and the real problem will not be solved.

The old Policy PSY-2 had directive value. It required acute care hospitals applying for beds to convert excess acute care inventory. Implicitly, it discouraged applicants from converting skilled beds to psychiatric beds. Two hospitals in our county, Iredell and Davis, share the burden of caring for a substantial number of mental health patients in our skilled bed units. If one of us were to discontinue the skilled care service, the burden would shift lopsidedly to the other. The Proposed 2009 Plan reports a deficit of 49 nursing home beds in Iredell County, too few to generate a bed allocation, but enough to cause a major problem if one pulls out.

I believe that David Swann and Crossroads have made a very thoughtful proposal for a substitute Policy PSY-2. It would require the LME in each area to

weigh in regarding the area need for involuntary beds; I hope it would assure areas like Iredell, Yadkin and Surry, that applicants for new psychiatric beds are required to designate those beds for involuntary admissions. As I understand the proposal:

> *PSY-2 "To support the State Mental Health initiative regarding community placement of persons who require psychiatric hospitalization, facilities proposing to develop or add psychiatric beds shall demonstrate that the proposed beds will meet the needs of the Local Management Entity service area, in which the proposed beds will be located, for involuntary admission beds. Skilled nursing beds are a critical component of community mental health care; therefore, new psychiatric beds should not result in a loss of hospital-based skilled nursing beds."*

I would prefer that the policy require that in areas with no involuntary beds, any new psychiatric beds must accept involuntary admissions. The proposed policy provides flexibility for areas that do not need involuntary beds, it assures local input to the planning process, and for Iredell County, it gives us some assurance that any new psychiatric beds added next year will meet our desperate need for involuntary admission capacity. Involuntary designation does not prohibit use of beds for voluntary admissions; it just assures that the beds can be used for patients admitted involuntarily.

Thank you for your time and thoughtful attention to these comments.

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