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**Testimony to the Executive Office of Health and Human Services
Re: Executive Order 562: To Reduce Unnecessary Regulatory Burden
Presented by: David Matteodo, Executive Director
Massachusetts Association of Behavioral Health Systems
January 8, 2016**

On behalf of the Massachusetts Association of Behavioral Health Systems (MABHS), I appreciate the opportunity to provide these comments to the Executive Office of Health and Human Services regarding Executive Order 562. The MABHS represents 44 inpatient mental health and substance abuse facilities in the Commonwealth, which collectively admit over 50,000 patients annually. Our hospitals provide the overwhelming majority of acute inpatient mental health and substance abuse services in Massachusetts.

I presented at the EOHHS Listening Session in Taunton on October 22, 2015 and these comments should serve as written follow up to my verbal testimony in Taunton. Our comments on regulations and policies which could be improved are focused on four EOHHS Agencies: The Department of Mental Health; the Department of Public Health; Department of Children and Families; and MassHealth. All of these Agencies have an impact on our hospitals and therefore our comments are structured on these areas.

A) Department of Mental Health: The Department of Mental Health's Regulations and Policies should be amended as follows:

24/7 On Site Physician Coverage: Regulation 104 CMR 27.03 (6) (b) should be deleted.
This regulation requires all DMH licensed hospitals to have a physician on site at all times. This requirement is unnecessary, burdensome, and very expensive. To our understanding, Massachusetts is one of only three states that has such a requirement. This DMH regulation also goes beyond any Joint Commission or CMS requirement. It harkens back to previous eras where families and loved ones would just drop patients off at psychiatric hospitals and there would be little or no pre-screening of the admission as is common practice now. There is no evidence that the quality of care is diminished in the states that don't have this requirement. Our hospitals would like to use their resources in a more effective manner. Making this regulation even more problematic is the fact that our hospitals are experiencing significant workforce issues, especially for physicians. Many physicians do not desire to work in psychiatric facilities and recruitment to cover the certain shifts is becoming increasingly problematic. This problem is especially difficult in filling night and weekend physician coverage. Ironically, the regulation tends to not be a major issue for acute general hospitals as there always is a physician somewhere on the premises at all times, although not necessarily a psychiatrist on the unit. Therefore, this regulation establishes a significant burden for only a subset of hospital providers in the DMH licensure oversight; it is important that DMH recognize that as you review this request.

As an alternative to the 24/7 physician on-site requirement, we have suggested to DMH to allow for greater use of Telemedicine to provide physician coverage for evening and night

shifts. Telemedicine is emerging across the country as a cost-effective, efficient approach to providing professional care. Our proposal would essentially allow a Registered Nurse, working in conjunction with a physician to oversee admissions through a telemedicine system. DMH would still be able to ensure quality by approving the telemedicine system and requiring hospitals to have protocols in place for emergency situations. The hours of most difficulty for the hospitals are the evening and night shifts, although this could be worked out by each hospital in collaboration with DMH. Weekend coverage should also be covered by this telemedicine proposal. Changing this regulation is of enormous importance to the hospitals especially given current workforce shortages and the many new beds coming on line in Massachusetts in 2015-16.

Greater use of Advanced Practice Nurses: In the current DMH statutes and regulations, there is an over-reliance on the use of physicians. Again, hospitals are having a great deal of difficulty recruiting physicians to work on our psychiatric units. We believe that there should be greater use of Nurses so that they would have: a) authority to admit patients in coordination with the physician; and b) order restraints. This request may require statutory changes to Chapter 123, but we would request that the Department of Mental Health work with hospitals to make these changes. Nurses are allowed to order restraints in acute hospitals through DPH regulations; similar authority should be allowed by DMH. Also, CMS allows for a Registered Nurse who has specific training to perform assessment of patients in restraints as long as that person consults with the attending on call physician as soon as possible after the assessment. DMH should adopt this CMS provision.

Flexibility on Conditional Voluntary Physician Review: 104 CMR 27.06: For patients admitted on Voluntary Status, including Conditional Voluntary Status there should be a 24 hour period for a physician to examine the patient. Regulation 27.07 (2) defines “immediately” as within two hours: This requirement should apply only to those admitted under Chapter 123 Section 12 (b) who do not voluntarily agree to treatment. All others should be examined within 24 hours as they are voluntarily agreeing to treatment. DMH should strive towards parity with acute care general hospital medical admissions in this area.

Fresh Air Rights (not promulgated to date): Although not yet in promulgated, we request that if regulations are adopted that DMH and EOHHS make explicit that hospitals will not be required by regulation to construct new outdoor areas in order to provide access to Fresh Air. Chapter 476 of Acts of 2014 was quite clear that the right to Fresh Air was contingent on clinical appropriateness and the ability of the hospitals to safely provide access. There was no requirement to construct new areas in Chapter 476 and the Administration should adhere to the Legislative language.

B) Department of Public Health: We respectfully make the following recommendations on the DPH Regulations:

Staffing Requirements: DPH has a requirement for BSAS facilities to maintain certain staffing levels, even if there are unoccupied beds. This requirement is unnecessary and costly and should be eliminated. Given recent demands for services, this requirement has been somewhat muted; however it should be removed as programs need flexibility to make management decisions when there are census fluctuations.

Coordinate Licensure Regulations and Visits with DMH for Private Psychiatric Hospitals: Although generally the dual-licensed program issues have gone fairly well, we would urge that DPH and DMH work collaboratively to make their licensure visits and regulations as coordinated and timely as possible.

Regulation 164.030 AtB: Governing Board must have someone in recovery. This requirement could be a violation of confidentiality. Although the programs have been able to comply with this requirement, DPH should eliminate it. If a program can demonstrate quality, there is no need for the government to have this mandate.

164.303 (3): The prohibition against admitting a patient who has had two or more unsuccessful episodes of supervised withdrawal in the previous twelve months is not realistic given the waiting periods for Medication Assisted Treatment. Also, this regulation may have the inadvertent effect of mandating patients being treated with replacement therapy, even if they are not motivated for such treatment.

164.303 (4): This Regulation should be amended to clarify that the one week waiting period between detoxification attempts should instead be re-written as “ After completing a safe medical detoxification a period of at least one week is required between detoxification episodes of care”.

164.035: Regarding notification to both DMH and DPH of the same information: This can be redundant and costly for the state, particularly if both agencies embark on separate investigations. DPH and DMH should re-visit this matter and clarify which agency would need notification and who would be the lead agency to conduct the investigation.

164.079 (B.2): Freedom from Strip Searches: There should be clarification that patients may be separated from their clothing so staff can ensure there is not contraband entering the unit. This can be done in a manner that maintains the patient’s dignity and self-respect. Programs have commented that this can be a major issue as there can be times when patients are attempting to bring drugs onto the unit.

Virtual Gateway: The requirement that every patient has to be entered into the Virtual Gateway has been cumbersome and very time consuming for certain programs. This requirement can take up to 30 minutes for each patient; DPH should revisit this requirement.

C) Department of Children and Families: Please consider the following request:

Administration of Anti-Psychotic Medications (Rogers):

The most important issue our hospitals face with the DCF regulations pertains to needing to get DCF and Judicial approval to treat youths in DCF custody with anti-psychotic medications. Although well-intended, the need to receive DCF approval through a lengthy, time consuming Judicial process can be harmful to youths in the form of delayed treatment as the hospitals are prohibited from providing necessary medications (absent an emergency), even though the youths may badly need

these medications in order to receive necessary and appropriate treatment. These youths' quality of life, with the appropriate medication regime to help stabilize them, generally improves. We strongly urge DCF to develop a facilitated process for youths in need of more timely treatment. MABHS has filed legislation, S.1028/H.1799 which would mandate EOHHS, DCF, and the Office of the Child Advocate to develop a facilitated process for the administration of antipsychotic medications for hospitalized youths in the custody of DCF. We believe that the Baker Administration should address this matter so that hospitals can provide more timely treatment and better care for these DCF clients. A facilitated process with established timeframes could still allow sufficient oversight by the state to ensure that there were checks and balances against over-prescribing and other possible concerns. The current process takes too long and can be detrimental to patients; staff; and the hospitals. We strongly urge your attention to this issue and we are willing to provide any clinical expertise to assist in efforts to reform the Rogers process.

D) MassHealth: MassHealth policies that prohibit payment for a psychiatric and primary care visit on the same day are not consistent with an integrated care approach. A similar restriction occurs when a medication management visit (which is considered a medical visit), is provided during an office visit, the medication management service will not be paid. As MassHealth moves towards integrated care models, these restrictions should be removed.

Other: MABHS is also requesting that the **Board of Registration in Medicine (BORM)** develop a more expeditious process for approving out-of-state physicians who would like to come to Massachusetts to work in our hospitals. Often hospitals will have to wait months for BORM approval for a psychiatrist who would like to practice in one of our hospitals. Given the physician workforce issues our hospitals are confronted with it is critical that this process be improved: such as a provisional approval to practice in Massachusetts pending final review by the BORM. Any assistance EOHHS can provide in this regard with the BORM would be enormously helpful to our workforce issues.

Thank you for the opportunity to offer these comments. MABHS stands ready to assist EOHHS and the appropriate Agencies in any way necessary to further explain our requests. Please do not hesitate to contact me.

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