May 20, 2025

Mandi Posner, Deputy Director
Center for Health Care Quality
California Department of Public Health

Provided via email to: CHCQRegulations@cdph.ca.gov

Dear Deputy Director Posner:

On behalf of more than 400 hospitals and health systems, including 32 free-standing acute psychiatric hospitals and 72 general acute care hospitals with psychiatric units, the California Hospital Association (CHA) offers the following recommendations on acute psychiatric hospital staffing regulations.

These recommendations follow the California Department of Public Health (CDPH) announcement on April 29 that it would be developing new regulations, and all recommendations support one critical fact: staffing mandates for psychiatric hospitals must reflect the nationally recognized, multi-disciplinary team approach to providing high-quality care and safety for patients experiencing a mental health crisis.

CHA is grateful for the opportunity to provide recommendations specifically in response to the discussion questions that CDPH provided as an attachment to All Facilities Letter 25-16. Attached is also a sample acute psychiatric hospital daily schedule, which CDPH requested for informational purposes.

As CDPH commences work to develop minimum staffing regulations for acute psychiatric hospitals, the department should consider that patients who are experiencing mental health crises have very different clinical and environmental needs than those who need care in general acute care hospitals.

California's staffing requirements for medical-surgical hospitals are largely focused on nursing personnel because patients hospitalized for physical health conditions receive critical treatment performed most appropriately and typically by nurses (e.g., wound care, dressing changes, IV insertion, diagnostic tests, assistance with mobility, etc.). Acute psychiatric hospitals, however, focus primarily on restoring the emotional well-being of patients whose mental health symptoms put them at imminent risk of harming themselves or others. This treatment is typically — and appropriately — performed by an interdisciplinary team of health professionals.

Acute psychiatric hospitals provide 24/7 safety monitoring, individual and group therapy, coaching on coping skills, therapy with clinical and social work staff, and help with medications, among other treatments. This model necessitates a tailored, multidisciplinary care team approach that includes registered nurses (RNs) as well as a variety of other personnel who are vital to keeping patients safe while they receive care, including licensed vocational nurses (LVNs), licensed psychiatric technicians (LPTs), mental health workers (MHWs), counselors, social workers, and others.

Unfortunately, California lacks sufficient access to this life-saving model of psychiatric inpatient care. Well-established benchmarks suggest that at least 50 staffed psychiatric beds are needed per 100,000 people.[1] While countries in Europe average 75 beds per 100,000 people,[2] California only has a mere 25 — fewer than even Mississippi or Montana.

Psychiatric beds and units have been shuttered in recent decades, due in part to cost pressures and inadequate reimbursement, along with rising labor shortages and costs. In CDPH's design of psychiatric hospital staffing ratios, clinical factors must, of course, be paramount. To support that principle, CHA recommends a multi-disciplinary care team approach with a proven, national track record that aligns with clinical best practices. But as the state creates a standard for personnel in psychiatric hospitals, it cannot ignore the current challenges in meeting demand, driven by a longstanding shortfall in clinical professionals needed to support access to inpatient psychiatric care.

In collaboration with CHA and other stakeholders, CDPH has an opportunity to establish minimum statewide staffing ratios that ensure patient safety and effective care, while maintaining the viability and sustainability of acute psychiatric hospitals in California.

CHA appreciates the opportunity to provide information that helps ensure the regulations under development are informed by the decades of combined expertise and knowledge of psychiatric hospital leaders throughout the state.

We look forward to working with you.

Sincerely,

Kirsten Barlow

Kirsten Barlow, MSW
Vice President, Policy

[1] RAND Health
[2] European Commission

1. **What is the method used by acute psychiatric hospitals to determine real-time staffing needs?** Existing state regulations require every acute psychiatric hospital to have a method for determining psychiatric nursing staffing requirements that is based on an assessment of patient needs.[3] In order to comply, assessments of patients' needs are conducted in multiple ways and help determine how frequently each patient requires face-to-face observations (such as every 15 minutes or more frequently) or whether additional staff should be utilized.

   First, upon admission, each patient receives a thorough nursing assessment, which can include up to 20 different components — everything from risk of self-harm or aggression to medical concerns, as well as patient strengths and needs and treatment goals. Each patient also receives a physical exam from a physician, a psychiatric evaluation from a psychiatrist, psychosocial and discharge planning assessments from social work staff, and several other assessments that inform their treatment and discharge plan. Hospitals use common, evidenced-based tools including the *Columbia Suicide Severity Risk Scale*, *Assessing and Managing Suicide Risk (AMSR)* tool, and the *Broset Violence Checklist*.

   Additionally, each patient receives a face-to-face assessment from an RN to determine their acuity level several hours before the end of each eight- and/or 12-hour shift. Hospitals use an acuity staffing tool to assign numerical weights to a list of specific patient features or risks. Once each patient is assessed, a nursing supervisor reviews the report and determines any staffing adjustments that should be made to ensure the appropriate number and skill mix of staff who should be present for each shift.

   Examples of "high acuity" patient features that could necessitate additional staff include:
   - High risk of suicide
   - Need for more assistance with self-care or feeding
   - Starting of a new medication
   - Multiple acute crises that needed to be de-escalated over the previous shift

   Further, hospitals conduct patient observation ("rounding") on every patient around-the- clock, which is carried out by primarily by MHWs either every five minutes or every 15 minutes. Patient observation through rounding is the primary tool an acute psychiatric hospital uses to ensure patients are safe. These team members must immediately report any behavior changes they observe to nursing staff.

   By design, patients do not spend much time alone or in their rooms. During waking hours, a highly structured daily routine with therapeutic activities is one of the most important tools to treat patients. As a result, multiple types of staff have opportunities throughout the day to observe patients and identify any changes or risks that could necessitate additional observation or additional staff being brought onto a unit.

   Ultimately, nursing supervisors determine whether additional staff above baseline levels should be deployed to ensure safety and quality of care.

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[3] California Code of Regulations (CCR) Title 22, Sec.

2. What is the minimum nurse to patient ratio needed for a unit that cares for adults? Is the minimum staffing the same for every shift? How should other mental health workers be included in the nursing ratio? Please explain.

Clinical best practice standards suggest that creating a safe and effective healing environment is about more than the raw number of nurses or other staff who are present — it's also about having the right skill mix on a multi-disciplinary team of individuals who each bring unique training to their roles.[4]

Further, the multidisciplinary team approach is consistent with current state and federal requirements. State regulations for acute psychiatric hospitals that treat involuntary patients require a multi-disciplinary approach, mandating that nursing personnel are always present and that physicians, psychiatrists, RNs and mental health workers are always either present or available. [5] Federal Medicare Conditions of Participation require acute psychiatric hospitals and psychiatric inpatient hospitals to have adequate numbers of nursing personnel and non-licensed mental health workers to provide nursing care for each patient's active treatment program.[6]

To ensure patient safety and high-quality care is provided, CHA strongly recommends staff ratios include a mix of RN, LVN, LPT, and MHW personnel, with at least 50% being composed of RNs or LVNs.

- *CHA recommends a 1:6 ratio for adult patients, composed of a combination of the following personnel, at least 50% of whom must be either registered nurses or licensed vocational nurses:*
  - *Registered nurses*
  - *Licensed vocational nurses*
  - *Licensed psychiatric technicians*
  - *Mental health workers*

In addition to the important role nurses and LPTs play in the provision of care, MHWs (also called "mental health technicians" or "mental health counselors" at some hospitals) are critical members of staff teams and work under the direction of a licensed nurse. MHWs interact with patients on a continual basis throughout the day. In many hospitals, they are the staff who orient new patients to the hospital and its daily program, wake patients in the morning and escort them to and from all meals and activities, as well as observe, document, and report to a licensed nurse any changes they see in a patient's behavior or appearance.

In addition to the staffing levels that hospitals provide based on national best practices, existing state and federal requirements mandate that additional, on-call staff be brought into the hospital or unit

[4] American Board of Professional Psychology, *Journal of Psychosocial Nursing and Mental Health Services, Management for Psychiatrists, 3rd Edition*
[5] CCR, Title 9, Sec. 663
[6] 42 Code of Federal Regulations, Sec. 482.62

whenever needed to safely care for patients with particularly acute symptoms (e.g., 1:1 observation of patients with acute suicidal ideation or behaviors or patients with aggressive or assaultive behaviors).

It is important to recognize that, beyond the minimum staff ratios CDPH is developing, hospital care is provided throughout the day by a variety of additional professionals who interact with patients. These include, but are not limited to:

- Psychiatrists
- Physicians and physician assistants
- Advanced practice nurses and nurse practitioners
- Psychologists
- Social workers
- Licensed mental health therapists and counselors
- Addiction therapists
- Certified recreational and occupational therapists
- Dietitians
- Pharmacists
- Spiritual care providers

3. Is there a need for different staffing levels depending on the age of patients, such as children or adolescents? How should other mental health workers be included in the nursing ratio? Please explain.

Minimum staffing levels should be — and are currently, in practice even without these regulations in effect — more intensive for units that treat children and adolescents, given their increased need for adult guidance and supervision, different developmental needs, and elevated risk for self-harm.

- ❖ *CHA recommends a 1:5 ratio for child and adolescent patients, composed of a combination of the following personnel, at least 50% of whom must be either registered nurses or licensed vocational nurses:*
  - *Registered nurses*
  - *Licensed vocational nurses*
  - *Licensed psychiatric technicians*
  - *Mental health workers*

4. Which factors are considered when determining additional staffing requirements above the minimum ratios? Do you include the following?

a. Patient acuity, for example, risk of harm to self or others.
b. The results of an environmental risk assessment completed to ensure the patient receives care in a safe setting pursuant to the Code of Federal Regulations section 482.13(c)(2).
c. The need for active clinical care including assessment, treatment, and discharge planning.

Yes, hospitals consider all these factors when considering adding staff above the minimum ratios. Please see responses to Questions #1 and #6 for more detail.

5. **General Acute Care Hospitals have a process wherein a committee reviews and validates the system used to determine staffing requirements at least annually, should Acute Psychiatric Hospitals have a similar process? Please explain.**
   CHA supports the concept that acute psychiatric hospitals should utilize a committee to review and validate the system a hospital uses to determine its staffing requirements. Currently, acute psychiatric hospitals each have a staffing plan that is re-evaluated at least annually, with staff input, for any changes to the clinical needs of patients presenting to the hospital, and the need for any changes to programming.

6. **Do you have any further recommendations for the Department to consider when drafting acute psychiatric hospital nurse to patient ratio regulations?**
   CHA urges CDPH to view the patient ratio regulations it is developing within the broader context in which acute psychiatric hospitals operate and to consider the other important strategies they employ to ensure patients are safe.

   The raw numbers of nurses and other staff are not the only — or even primary — driver of whether a patient receives safe and effective treatment. Hospital leaders assemble multi-disciplinary teams that contain the right mix of experienced and empathic individuals who contribute their unique training and professional expertise to patient care.

   Additionally, patients are kept safe through other non-personnel driven means. For example, each hospital takes great effort to provide a safe and healing “environment of care.” This includes ensuring the physical environment does not include features or objects that at-risk patients could use to harm themselves or others, security systems, monitoring, and more.

   Many hospitals are implementing technological solutions to improve patient safety and staff accountability. Examples include electronic rounding systems such as Observsmart, which use geolocation to ensure staff who are rounding on patients are doing so at required time intervals. Many hospitals use electronic tablets to provide real-time input on the timing of staff observation rounds. If a patient’s pre-programmed observation time of every five or 15 minutes is delayed, an alert sounds and supervisors are immediately notified.

Attachment 1. Sample Daily Acute Psychiatric Hospital Patient Schedule

The sample daily schedule below is provided for illustrative purposes only to describe the typical routine and therapeutic activities occurring in acute psychiatric hospitals and units throughout hospitals in California. In addition to the group-based activities described below, a psychiatrist sees individual patients daily, and masters' degree-level social workers and other licensed mental health professionals meet with patients and family members on an ongoing basis to discuss treatment progress and develop discharge plans.

Time	Activity and Staff Roles
6:30 a.m.	**Wake-up, hygiene, clean room:** Typically supported by licensed vocational nurses (LVNs), licensed psychiatric technicians (LPTs), and mental health workers (MHWs). Additionally, registered nurses (RNs) and these other personnel support nursing staff in conducting room-by-room patient assessments and checking vital signs.
7 a.m.	**Breakfast:** Typically supported by LPTs, LVNs, and MHWs.
7:30 a.m.	**Treatment Goals Group:** Typically supported by LPTs, LVNs, and MHWs.
8 a.m.	**Unit clean-up/phone calls:** Typically supported by LPTs, LVNs and MHWs. **Medication Pass Time:** Typically supported by RNs, LVNs, and LPTs.
9 a.m.	**Psychoeducation Group:** Typically supported by licensed staff, depending on the topic, including licensed clinical social workers, licensed marriage and family therapists, and licensed professional clinical counselors.
10 a.m.	**Recreational Therapy:** Typically supported by licensed occupational or recreational therapists.
11 a.m.	**Cognitive Behavioral Therapy Group:** Typically supported by licensed staff, depending on the topic, including licensed clinical social workers, licensed marriage and family therapists, and licensed professional clinical counselors.
Noon	**Lunch:** Typically supported by LPTs, LVNs, and MHWs.
12:30 p.m.	**Therapeutic Games:** Typically supported by LPTs and MHWs.
1:30 p.m.	**Nursing Group:** Typically supported by RNs.
2:30 p.m.	**Art/Music therapy:** Typically supported by licensed occupational or art therapists.
3:30 p.m.	**Unit clean-up/phone calls/snacks:** Typically supported by LPTs, LVNs, and MHWs.
4 p.m.	**Gym or outdoor activities:** Typically supported by MHWs.
5 p.m.	**Rest & relaxation/quiet time/journaling**
6 p.m.	**Dinner:** Typically supported by LPTs, LVNs, and MHWs.
6:30 p.m.	**Gym or outdoor activities:** Typically supported by MHWs.
7 p.m.	**Family visitation time/phone calls/nacks**
8 p.m.	**Medication Pass Time:** Typically supported by RNs, LVNs, and LPTs. **Hygiene, clean room:** Typically supported by LPTs, LVNs and MHWs.
9 p.m.	**Rest/lights out:** Patient rounding observations continue during sleeping hours, typically supported by MHWs.