Maryland

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Request for Comment: Psychiatric Projections and Projected Need for Historically Underserved Populations

1 message

Jeffrey J. Grossi <JGrossi@sheppardpratt.org> Mon, Jun 23, 2025 at 5:15 PM
To: "mhcc_regs.comment@maryland.gov" <mhcc_regs.comment@maryland.gov>
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Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Comments on Draft Estimates of Need for Acute Psychiatric Services for Historically Underserved Populations

Dear Commissioners,

On behalf of Sheppard Pratt, I appreciate the opportunity to submit comments on the Maryland Health Care Commission's (MHCC) draft estimates of need for acute psychiatric services for historically underserved populations, as outlined in COMAR 10.24.21.05(B)(2)(b).

As the largest nonprofit provider of mental health services in the country, Sheppard Pratt operates two inpatient psychiatric hospitals, including the newly constructed 85-bed facility on our Baltimore/Washington campus in Elkridge, which serve patients referred from nearly every hospital across the State. Maryland's health system continues to experience consistently high levels of emergency department (ED) boarding, especially among children and adolescents with complex psychiatric needs. At Sheppard Pratt, we are seeing a rise in the acuity and length of stay for our inpatient units serving this complex patient population.

One overarching comment is that this report does not consider actual provider input. While data is excellent, provider experience can fill in the gaps in terms of the acuity we are seeing, reasons for ED boarding, and factors that influence discharge from inpatient beds. Based on this direct experience, we respectfully offer the following comments and recommendations on the draft need determinations:

1. **Statewide Assessment**

We urge MHCC to revisit the adolescent bed need estimate on a statewide basis and factoring in patient and health system needs to better reflect real-world acuity and care access barriers. Sheppard Pratt specifically notes that simply adding five additional beds to the Baltimore Upper Shore Health Planning Region will not solve any of the challenges facing ED boarding.

The distinction between general lower intensity beds and specialized high-end psychiatric beds is crucial. It is important that any report consider the need for facilities capable of handling high-acuity cases, rather than just increasing bed numbers without factoring the required level of care.

This specified geographic approach will not address the patient population contributing to ED boarding and does not the take into account the workforce challenges to staff such beds. Simply adding five beds in one area and three in another is not the answer to the complex questions the report should consider. A comparison to our statewide shock trauma system is analogous. The additional psychiatric beds required to address the issues of ED boarding are highly specialized and not transferrable to smaller community hospitals or specified regional boundaries.

2. **Need for Tertiary-Level Psychiatric Capacity**

While the current methodology estimates bed need based on ED length of stay and assumes future patients will mirror historic utilization trends, it does not sufficiently account for tertiary-level patients who routinely wait weeks or months for placement. Traditional utilization projections cannot factor in the patient needs or hospital capabilities. The data will present an incomplete answer without taking into consideration the underlying reasons for the lack of available placements equipped to handle a highly complex patient population.

As detailed in our 2023 REOI submission to address high acuity inpatient psychiatric capacity, Maryland needs at least 75–100 tertiary care beds for both adolescents and adults statewide, especially for patients with dual diagnoses, neurodevelopmental disorders, and severe aggression. We ask MHCC to recognize this distinct unmet need in the final estimates and consider how future certificate of need evaluations might better account for these patients.

The problem is not merely a volume issue but one of care complexity. Many of these youth exhibit severe aggression, dual diagnoses, and behavioral disturbances that general psychiatric and acute care settings cannot safely manage. The group includes individuals with autism, intellectual disabilities, or sexualized and fire-setting behaviors that require specialized care environments with 1:1 or even 3:1 staffing ratios.

3. **Discharge Bottlenecks and the Invisibility of Inpatient Overstays**

The draft analysis focuses on ED boarding as the primary proxy for unmet need but does not factor in inpatient overstays; another systemic bottleneck contributing to psychiatric bed shortages. Patients who are clinically ready for discharge but cannot be placed in appropriate community or residential settings often remain in inpatient units for extended periods, blocking new admissions and skewing utilization rates downward.

This phenomenon particularly impacts youth with severe behavioral needs and co-occurring developmental disabilities. Without addressing discharge barriers, current projections may unintentionally underestimate true need and system efficiency.

Conclusion

We appreciate the Commission's careful analysis and transparency in this process and strongly support efforts to improve psychiatric care access for historically underserved populations. However, we caution against narrowly interpreting utilization data without contextualizing it within the broader ecosystem of systemic care access failures—especially for youth with high-acuity and complex care needs.

Sheppard Pratt urges MHCC to consider a cumulative, statewide strategy to address psychiatric bed shortages, particularly for those with specialized needs. This analysis should also incorporate data on inpatient overstays and delayed discharges into the overall statewide strategy.

We would welcome the opportunity to provide additional data or participate in future discussions as MHCC finalizes its need determinations.

Thank you.

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