Agenda Item 1

Psychiatric Services Clinical Advisory Group (CAG) Executive Summary

The CAG met on November 6, 2019 and November 20, 2019 to provide additional input that may inform changes to the State Health Plan Chapter for Psychiatric Services (COMAR 10.24.07). This summary describes some of the key points raised by individuals and does not necessarily reflect a consensus by CAG members. A roster of CAG members, meeting agendas, discussion guides, and full meeting summaries are available online.[1]

Placement Challenges

- There is a need for more acute care beds for all ages
- Emergency department (ED) boarding is common and results in further deterioration
- Length of time that may be acceptable to board a patient in the ED is highly variable by patient
- Mental health assessments cannot take place until a patient is sober; this can delay the identification of need for a placement
- A family may be forced to keep a child in the ED in order to maintain the child's priority position for a specialized psychiatric bed
- Sometimes there is too much emphasis on waiting for a specialized unit when it may be preferable to have non-specialized treatment sooner
- Families may prefer a patient be placed closer to home

Discharge Delay

- Delays in discharge can result in decompensation
- Patients who are not helped by treatment or not adherent with medication may be in an acute psychiatric bed for months or bounce back; ideally, they would be in a long-term care facility
- There is virtually no access to State beds, as priority is for those waiting for forensic assessments
- Lack of residential treatment availability delays discharge of some patients
- There are more barriers to discharge when multiple agencies have to coordinate their efforts (e.g. an adult with developmental disabilities who is not returning home or a child with developmental disabilities is discharged)

Caring for High Acuity Patients/Specialized Patient Populations

- Staffing challenges may occur due to facilities treating patients with specialized needs when they do not have specific programs/resources; this can result in a less efficient use of resources
- Specialized programs can improve care by congregating patients with high levels of need
- A suggested change is that all programs could be required to have some baseline ability to respond to high intensity needs, similar to the expectations for medical/surgical units, rather than increasing the staffing ratio
- More private psychiatric rooms would be helpful in building capacity to care for high acuity patients because they often require a private room; this may contribute to the low occupancy rates that MHCC observes

[1] https://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_pysch_services.aspx

- Need another neurobehavioral unit for children; currently there are two in Maryland, but most states have none
- Specialized programs in certain geographical locations might not be feasible (e.g. due to finances, staff expertise/availability)
- More geriatric psychiatric beds would be helpful because this population requires greater resources
- Children/adolescents have seasonal use patterns (i.e. occupancy is lower during summer)

Involuntary Patients

- There is a need for more acute care beds for involuntary patients
- Infrastructure to care for involuntary patients is challenging/expensive; burden is not equally shared
- Facilities that do not take involuntary patients often operate at full capacity

Financial Considerations

- Reimbursement rates are not stratified based on the intensity of resources required
- Financial risk may be a barrier to opening specialty units, especially if current unit is breaking even

Reduction of the Need for Acute Psychiatric Care

- The whole continuum of mental health services affects the needs for acute inpatient care
- There are behavioral health deserts outside of Baltimore and DC regions
- Preventive care is important and may be especially difficult to access for patients who do not qualify for Medicaid; need more services regardless of insurance coverage
- It would be helpful for group home staff to have more tools for hands-on de-escalation
- 14 non-public schools often cater to people with autism; those services help prevent hospitalizations
- For individuals with a developmental disability over age 21, there are no school-based services; it would be helpful to have more programs beyond respite (e.g. in-home applied behavioral analysis)
- Need more long-term care beds for children and adults
- A CON requirement that requires providers to develop partnerships with community providers would not be onerous; this issue might already be addressed by other requirements
- START assessment identified a dearth of middle range of services
- Regulations prohibit staff at group homes from providing certain medications prn, sometimes necessitating a visit to the ED
- Regulations do not adequately support telepsychiatry and home visits by physicians

Defining Need

- It is challenging to define need because other services on the continuum affect need and access to some of those other services may not improve, even if a need have been identified
- If expansion of acute psychiatric beds are limited because patients would be better treated by community or outpatient resources then the immediate problem may not be addressed
- Need could be defined based off of time spent boarding in the ED
- Drive time or patients served outside of their health planning region may be another way to determine need; different drive time standards may be appropriate for specialized beds