

MARYLAND PSYCHIATRIC SOCIETY



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March 11, 2024

Jourdan Green

Director, Office of Regulation and Policy Coordination
Maryland Department of Health
201 West Preston Street, Room 512
Baltimore, MD 21201

To Whom It May Concern:

As a state medical organization with nearly 800 physician members who specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders, the Maryland Psychiatric Society (MPS) appreciates this opportunity to provide feedback on the revised behavioral health crisis regulations COMAR 10.63 and COMAR 10.09.16 Mobile Crisis Teams (MCT) and Crisis Stabilization Centers (CSC). We support the addition of crisis services to the continuum of behavioral health care in our state, including the funding that is essential to their success.

New CSC services can help meet the need for urgent outpatient care, so problems do not escalate to the level of acute care (with associated wait times for beds) and incarceration. However, CSCs are not interchangeable with hospital emergency departments (ED) and their services should be limited to low to mid acuity levels. Most patients with high acuity conditions, including emergency petitions (EP), should be referred to EDs. Our initial comments in 2023 raised this concern indirectly, but we subsequently shared this view with Dr. Whitefield on June 22, who confirmed this problematic approach, and with Mr. Henson on August 25. Conversations surrounding our concerns continued with Dr. Whitefield and BHA through the fall and into early 2024. We find it very concerning that the newest proposal removes the provision for a medical director and only specifies that there an on-call physician available.

Ideally, the CSCs should be aligned with what people expect from a Patient First or Minute Clinic when seeking care for general medical concerns. High acuity behavioral care that could involve chemical or physical restraints, should not be part of an ambulatory crisis center plan and should remain within hospital emergency departments. Emergency departments have the built in infrastructure and are prepared with personnel to manage these types of patient clinical presentations and the potential medical complications that can ensue from the use of chemical and physical restraints such as intramuscular medication, physical restraints, and seclusions. Removing EP services from CSC regulations would alleviate some of the staffing concerns, reduce operating costs, and eliminate use of discretion when someone must be transported. EPs should not be part of the ambulatory CSC plan.

We are also concerned that there is no requirement for sub-acute beds for patients awaiting admission or detoxing. Considering that patients requiring detox or those being EP'd will be served in the proposed CSC facilities, the need to "hold" them is critical while they are inpatient admission or complete detox.

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An addendum with our concerns is attached for your review. While we are sharing these concerns about specific details of the repropounded regulations, we want to underscore that we still disagree with including EP services. We are available to assist you with the clinical considerations involved with high acuity patients, which we are concerned are not adequately reflected.

We urge MDH to strongly consider our above recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read "Carol Vidal". The signature is written in a cursive, flowing style.

Carol Vidal, M.D., Ph.D.
President



Subtitle 21: Maryland Registry & Referral System

- Under section 0.4 "Use": This will require EDs and inpatient psychiatric units to register patients needing outpatient care/community-based care within 48 hours of their presentation. For EDs, this will be an increased burden. Inpatient units often don't know what a patient may need after 48 hours; as their treatment has just begun. This would also be burdensome for the referring facilities. It's unlikely that they'd be calling to get help with patient placement – rather they would be calling to give patient info, which poses HIPAA violation concerns.
- The daily reporting of bed availability is a requirement that we have yet to see data to support. Requiring facilities to submit this information three times a day is unrealistic and time consuming. BHA needs to produce actual data before we support this proposed change. We feel strongly that BHA needs to research innovative methods to report bed availability in real time.

Subtitle 63: Community-Based Behavioral Health Programs and Services

10.63.03.21 Behavioral Health Crisis Stabilization Center (BHCSC) Program

- (A), the definition section - States these programs are designed to "*provide an alternative to emergency departments for behavioral health crisis care, emergency petition assessment, and avoidable inpatient or carceral admissions.*" It is our opinion that the reference to prison/carceral admissions is not relevant. The language choice is inaccurate and conflates clinical decision making (e.g. "admission") with criminal justice processes.
- (C), Program Services.
 - (2) These programs, "*process involuntary admissions according to Health General Article 10-613.*" Our understanding is that this part of the code defines involuntary admission as "*including every admission of a minor to a state facility.*" This reference is not correct. We find it confusing to use language about involuntary admissions when referring to CSC programs. It can be interpreted as CSCs are accepting involuntarily certified patients who otherwise need to be on hospital inpatient units.
 - (6) This section discusses providing medical screening at triage for the presence of any condition of sufficient severity to require transfer to an appropriate facility for immediate medical or surgical care. If this is a feature of the crisis stabilization center programs, then CSCs should not be staffed with only a nurse and psych NP. We acknowledge that CSCs will not collect laboratory specimens as outlined under the limitations section, however for many patients' medical clearance needs to include blood work. Patients will not be able to be referred directly from these programs into inpatient units if they are not considered medically stable; and for many that includes a full set of labs. (This includes urine toxicology screens, etc.)
- (F) BHCSC Program Quality Assurance and Reporting.
 - (7) This wording outlines that, "*an initial evaluation by an approved physician or psych NP will be completed no later than 4 hours after admission.*" If CSCs will be accepting EP'd patients the current requirement is that patients are evaluated within six hours, not four. It is troubling that these proposed regulations are setting a higher standard than what currently exists in hospital emergency departments.
 - (a) This sections states that part of the patient's assessment will be "*a medical*

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- *evaluation,*” although this is not clearly defined. There is no indication that CSCs will be staffed consistently with physicians, provide blood work or complete physical exams; it is unclear how these regulations define a complete medical evaluation.
- (b) Missing from this section is any indication that care provided would be trauma informed, recovery oriented, person-centered, and culturally informed.
- (J) Environmental/Life Safety Requirements. Section (f), details the 4 space requirement of the seclusion room without any reference made to an anteroom or bathroom being required. Under the behavioral health standards both require an anteroom and a bathroom near the seclusion room.