

MARYLAND PSYCHIATRIC SOCIETY



September 5, 2023

Behavioral Health Administration
Maryland Department of Health
Via email to bha.regulations@maryland.gov

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Geetha Jayaram, M.D.

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. The draft regulations seem to be modeling crisis centers on outpatient clinics, yet what they authorize the centers to do is closer to the ED role, but they do not require the centers to have an onsite laboratory or imaging, for example. Most patients with high acuity conditions, including emergency petitions (EP), should be referred to EDs. Our initial [March 27, 2023 comments](#) 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.

High acuity behavioral health care that could involve seclusion or chemical or physical restraints should remain within EDs, as they have the infrastructure and personnel to manage these clinical presentations and potential associated medical complications. 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.

Additionally, an addendum with concerns and inconsistencies between this policy and federal and state regulations is attached for your review. While we are sharing these concerns about specific details of the repropoed 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.

Sincerely,

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

MARYLAND PSYCHIATRIC SOCIETY



June 22, 2023

Via email

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Geetha Jayaram, M.D.

Steven Whitefield, M.D., Medical Director
Maryland Behavioral Health Administration
steven.whitefield@maryland.gov

Dear Doctor Whitefield:

Thank you for meeting with the Maryland Psychiatric Society (MPS) executive committee and staff yesterday. We appreciate the information you shared regarding the crisis services transformation process and your questions regarding the potential role of psychiatric nurse practitioners in this new system.

We further discussed these changes as a group after our joint MPS/BHA meeting and decided to share some additional feedback about the plans, which you mentioned have not been finalized.

In our comments submitted for the proposed crisis services regulations, we had raised concerns related to bringing emergency petition patients to behavioral health crisis stabilization centers. On further reflection and after hearing some of the operational hurdles, we realize that conceptualizing the crisis centers as a place to bring people who are emergency-petitioned may be problematic.

Ideally, the center services 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 emergency petition services from crisis center regulations would alleviate some of the staffing concerns, reduce operating costs, and eliminate use of police and others' discretion when someone must be transported.

Please let us know if there are other contacts with whom we can share this feedback before the regulations are finalized, and feel free to share this letter as needed. We would be glad to be of further assistance.

Sincerely,

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

cc: Eleanor Dayhoff eleanor.dayhoff@maryland.gov

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APA AREA 3 TRUSTEE

Geetha Jayaram, M.D.

August 25, 2023

VIA EMAIL

Marshall Henson, Director of Operations
Maryland Behavioral Health Administration
55 Wade Avenue
Catonsville, MD 21228

Dear Mr. Henson:

Thank you for your detailed August 10 response to the Maryland Psychiatric Society comments submitted on March 27 regarding proposed regulations for behavioral health mobile crisis services and crisis stabilization centers. We appreciate the Behavioral Health Administration's willingness to consider substantive changes to the regulations as proposed.

Your comments do not address our June 22 follow up regarding emergency petitions (EP). Attached please find additional feedback that may not have come to your attention. Removing EP services from crisis center regulations would alleviate some of the staffing concerns, reduce operating costs, and eliminate use of police and others' discretion when someone must be transported. Although diverting EP patients from hospital emergency departments (ED) would reduce ED volumes, we urge that high acuity behavioral care that could involve chemical or physical restraints remain within hospital EDs, which have the infrastructure and personnel to manage these clinical presentations. EPs should not be part of the ambulatory crisis stabilization plan.

We acknowledge that we do not fully understand the plans as they are currently conceptualized and would welcome being informed about considerations that may not be apparent as written. We remain available to assist you with the clinical considerations involved with high acuity patients, which we are concerned are not adequately reflected in the current plan. A meeting may be the best way to facilitate this exchange. Please contact Heidi Bunes at heidi@mdpsych.org with any questions or to schedule a date.

Thank you very much for considering our views.

Sincerely,

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

Cc: Steven Whitefield, M.D.

Maryland Psychiatric Society Feedback on
Draft Reproposed Regulations COMAR 10.63 and COMAR 10.09.16

COMAR 10.09.16

- The 5th page, halfway down, refers to the initial nursing assessment and physical exam by a registered nurse in collaboration with the physician or psych NP. Psych NPs cannot perform physical exams to any degree unless they are dual licensed with family medicine. The psych NP scope is limited so the collaboration should be with the physician.
- On page 6, a list of services that are not covered by the crisis walk in program includes prescribing medication, administering medication, several other entries, and administering injections. This seems to prevent the walk-in center from seeing patients who need urgent refills on their psychiatric meds, so patients will need to go to other urgent cares or EDs for that if their outpatient provider is unavailable. Administration of long-acting injectable medications (LAIs) also seems to be excluded. In the case of LAIs especially, we suggest some flexibility, in limited cases.
- Later on that page there is a reference to providers not being reimbursed by the program for transportation costs. It is not clear if this refers to their personal transportation costs or the transportation costs related to patient care. If the latter, it should not apply when a patient needs transport to their next level of care, such as admission to the inpatient psychiatry unit or transfer to the hospital. This needs further clarification.

COMAR 10.63.01

- "Crisis" under 22 letter A is defined as the experience of stress, emotional or behavioral symptoms, and difficulties with substance use. Yet, not all substance use amounts to a crisis and there are already specialized services to provide treatment for people with substance use disorders. Adding another outlet for this population should be done with care.
- On page 5, Psych NPs are in the list of professionals who could serve as medical director. Psych NPs should not be medical directors for an overall practice, especially if they are ultimately responsible for the somatic care of patients who present to the crisis center, as that is outside of their scope. Psych NPs do not have the education, training and expertise to serve as medical directors.
- On page 14, it is unclear what it means by the crisis center needing to be able to "process involuntary admissions according to health general article." This needs clarification.
- On page 15, as part of the description of services, the crisis walk-in center is considered as able to initiate, maintain, and prescribe psychotropic and somatic medications as appropriate. There are two issues with this: 1- the scope of a psych NP is very limited, and they should not be responsible for prescribing somatic medications. The decision to reconcile home medications, including which ones to initiate, modify, and discontinue, is completely outside of the scope of someone whose training is limited to the basics of psychiatry. Many patients are being treated with non-psychiatric medications, which psych NPs have not been trained to manage. 2- there is a reference to the walk-in center as being able to initiate and prescribe long acting injectables but other parts of the policy say that those will not be administered. It is confusing that crisis centers would be prescribing LAIs and not administering them.
- On page 17, the reference to a physician or psych NP doing an initial evaluation no later than 4 hours after admission is a lofty goal. Even for emergency petitions, regulations require evaluations within 6 hours of presentation. Depending on the volume of patients, 4 hours could be unreasonable. There is also no language related to the reality that psych NPs cannot be the licensed professional evaluating emergency petition patients.
- On page 18, the reference to the crisis walk-in centers having written referral agreements with hospital psychiatric units is too vague. It is unclear if that means that providers would be

credentialed to facilitate direct admissions to the hospital. There are also no details about whether patients who need psychiatric admission would be directly transferred to inpatient units and therefore the crisis center would be treated like an emergency facility, versus people who need admission being transported to EDs for further processing of their psychiatric referral.

- On page 21, under 4A, there is a reference to staff obtaining an order for seclusion or restraint no later than one hour. This is incorrect, as federal regulations require the order to be placed within 15 minutes of the initiation of seclusion or restraint. There is also allowance within the federal guidelines for a qualified RN to perform a face-to-face evaluations, instead of a physician. There is no mention of this allowance in the COMAR policy, which would render COMAR more restrictive than federal guidelines. This is to be avoided.
- Finally, on page 21 under #7, the draft policy states that restraint and seclusion shall never occur simultaneously for an individual. This is different than in the hospital setting, where being simultaneously restrained and secluded is permitted under very specific circumstances. There is also no mention in the description of the seclusion room about an anteroom requirement, which is part of environment of care standards for federal government regulations. Furthermore, there's no reference to required visiting hours. The state requires at least one hour a day of visiting for inpatient psychiatric units. It is unclear if the crisis centers are going to allow visitations.