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Another Perspective On Psychiatric Boarding

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Last week I took on a topic that recently gained judicial attentions in Washington State: "psychiatric boarding," the practice of holding consumers in psychiatric emergencies in hospital emergency departments while waiting for admission to a psychiatric facility (see Washington Ban On Psychiatric ER Boarding May Have Longer Legs).

Deemed unconstitutional in Washington State, "psychiatric boarding" has sparked a number of questions about the adequacy of the mental health service network – particularly the community-based service network. During my assessments of the situation, I noted that "more beds are part of the solution" – this has garnered some great feedback from my readers. Jim McCreath, President & CEO of Cerebral Palsy of North Jersey (CPNJ) wrote:

You mention that one possible solution to this problem is more inpatient beds. I doubt that anyone would disagree, but I feel strongly that mental health systems need to look at inpatient recidivism when assessing capacity needs. When I was the Vice President for Behavioral Health for a major New Jersey inner city hospital, it was not unusual to have 10-12 adults waiting in the emergency room (ER) for psychiatric admission to our 36 bed unit which was always at 100% occupancy. When we tried to understand if we needed more beds, I wanted us to look at recidivism, because my feeling was it played a role in "clogging," our system. In looking at one year of over 1,000 admissions, we identified 54 individuals who racked up 7 to 9 admissions annually. So, let's say that's roughly 400 plus admissions and at roughly 7 days per admission, we are in the neighborhood of 2,800 days of care annually. If we assume high recidivism is not a given with mental illness, then the 400 plus admissions become a target for reduction before expanding capacity. Since high recidivism is something everyone agrees should be reduced if not eliminated, systems with capacity issues should evaluate how big a role recidivism plays in their system before recommending expansion.

Further assessment helped us determine that among other variables contributing to high recidivism, medication non-adherence stood out. Directly as a result of our concern about inpatient clogging, we established a long acting medication clinic. It has grown over the years and while I cannot say with any scientific certainty what role the long acting clinic plays in that facility's recidivism, their 30-day

psychiatric readmission rate is now reported at about 6%. The inpatient occupancy remains high and there are no back-ups in their ER. As it turned out, there was no need to expand beds.

I do want to clarify that while I believe that adding beds can be part of a possible solution, I don't think it's the most preferable solution from a policy or health plan perspective. I think "better" systems for community-based supports are the best answer—for consumers and payers alike—particularly those community-based systems that have specific accountability for consumer care management. Dr. McCreath's example of a using a community-based solution like a long-acting medication clinic, is just what needs to happen in most communities.

This issue of "psychiatric boarding" comes back to the ever present issue of the very high readmission rates for consumers with mental disorders – with current rates of 19.7% in Medicaid and 20.9% in Medicare (see What Drives Medicaid Behavioral Health Readmission Rates? and How Do Medicaid Readmission Rates Compare To Other Payers?). We have covered the issue before – Is The Focus On Readmission Rates Misguided?, Who Needs To Worry About Readmission Rates?, and Reducing Readmissions In Practice. My hope is that a combination of legal action and value-based reimbursement models will move the needle.