National Rural Health Association Policy Brief

Policy solutions addressing psychiatric boarding of rural youth

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Introduction

Childhood mental health diagnoses and suicide rates have been rising throughout the country for decades, leading to many national children's health associations declaring a national state of emergency in children's mental health.[1] Compared with youth living in urban areas, 2020 data shows that rural youth have higher emergency department (ED) visit rates for self-harm, including suicide.[2] Rural youth experiencing a mental health crisis and visiting an ED for evaluation and treatment may require a higher level of care. If inpatient psychiatric hospitalization is deemed necessary for the youth's safety and stabilization, the youth may then be held either voluntarily or involuntarily until an available and appropriate mental health facility accepts them for transfer.

Known as "psychiatric boarding," this practice – wherein patients are held in the ED after the decision to admit or transfer has been made but no beds are available – has worsened in rural areas. This is attributed to chronic underinvestment in mental health services and escalating patient needs, coupled with workforce shortages. More than 60 percent of rural Americans live in areas designated as mental health provider shortage areas (HPSAs).[3] Psychiatric boarding can exacerbate patients' underlying conditions and lead to a high-cost burden on the medical system, reduced system efficiency, and a range of other individual and system-wide challenges.[4] Recent literature suggests pediatric psychiatric boarding has become more common and longer on average than before the COVID-19 pandemic.[5] Rural areas are underrepresented in research regarding pediatric psychiatric boarding, despite youth in rural areas experiencing poorer mental health outcomes and worse health care access than their urban counterparts.[6-7]

Analysis

Since the onset of the COVID-19 pandemic, the proportion of ED visits for mental health concerns such as suicide, self-harm, and depression has significantly increased, along with the likeliness and length of admission.[8] According to a web-based survey of pediatric hospitalists across the country, 75 percent of respondents reported an increase in boarding duration during the pandemic, and 84 percent reported increased boarding frequencies.[9] Rural communities experienced a 39.6 percent increase in the number of youth mental health visits that resulted in hospital admission.[10]

Boarding times in rural hospitals tend to be longer than boarding times in urban hospitals, disproportionately impacting rural youth. Additionally, the average pediatric boarding times observed in rural hospitals exceed the four-hour standard set by The Joint Commission to support patient safety and quality of care.[11] Another factor that contributes to increased boarding times in rural EDs is their lack of preparedness to treat mental health issues in the pediatric population. Only one-third of rural EDs have policies related to pediatric mental health or transfer agreements to an appropriate treatment center.[12]

Coinciding with the longstanding and worsening challenge of rural pediatric psychiatry boarding times in emergency rooms, Congress has attempted to slow rural hospital closures with the

establishment of the rural emergency hospital (REH) designation in Section 125 of the Consolidated Appropriations Act 2021. REHs are rural hospitals that provide outpatient services, including emergency and observation services, but not inpatient care. A designation requirement is to maintain an annual average length of stay of less than 24 hours per patient.[13] In July 2022, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that disputed the notion that psychiatric boarding will occur frequently enough to seriously affect an REH's average length of stay.[14] The recent increased frequency, likeliness, and length of pediatric psychiatry boarding in emergency rooms may present a challenge in implementing this recent solution attempting to improve rural hospitals' fiscal sustainability.

Previously published NRHA policy briefs have recognized the lack of access and availability of the mental health workforce but have not addressed the impacts of pediatric psychiatric boarding in rural areas. This policy brief aims to explore the topic and provide suggestions for how NRHA can advocate to improve pediatric psychiatric boarding.

Policy recommendations

NRHA proposes the following policy recommendations to reduce boarding times and improve mental health outcomes in rural communities.

Improve data collection: Invest in the development and improvement of mental health data collection systems in rural areas, specifically as it relates to youth psychiatric ED boarding for patients in rural communities.

- *Standardize reporting protocols:* Implement standardized reporting protocols for pediatric psychiatric boarding incidents in rural settings. This includes creating a uniform reporting template that health care facilities must use to document each case's details, such as boarding duration, youth age, chief complaint, boarding reason, outcomes, and referral pathways.
- *Foster transparency:* To increase awareness of trends, needs, and best practices in rural communities, increase the transparency of commitment practices by states for pediatric psychiatric boarding, as well as the availability and variability of outpatient, intensive outpatient, partial hospitalization, crisis residential, assertive community treatment, assisted outpatient treatment, wellness recovery action plan, in-home supportive services, and acute crisis services available.
- *Encourage collaboration:* Encourage collaboration and information sharing among various stakeholders, including health care providers, law enforcement, schools, and community organizations to create a more comprehensive understanding of the factors contributing to pediatric psychiatric boarding in rural areas.

Upstream solutions: Reduce the number of children requiring psychiatric emergency evaluation and the acuity of their psychiatric emergencies to decrease the burden on rural EDs throughout the U.S.

- *Expand collaborative and integrated outpatient care:* Incentivize the expansion of innovative, preventive, and integrated outpatient care by expanding HHS's role, evaluating the payment

structure of collaborative care reimbursement codes, and requiring demonstrated collaboration to receive federal funding.

- *Expand telepsychiatry services:* Invest in telepsychiatry infrastructure and develop partnerships with local rural hospitals and providers to improve access to psychiatric and mental health care for rural youth. Increased tele-mental health will enable patients to access mental health care prior to the onset of a psychiatric emergency or during boarding and reduce the time that patients in need go without services. This could include offering telemedicine consultations, virtual therapy sessions, and remote assessments.

Infrastructure improvement: Optimize existing systems, personnel, and resources for rural children experiencing psychiatric emergencies.

- *Optimize bed registries in rural facilities*: Incentivize the integration of specialized decision support tools and decision-analytics models into mental health bed registries to better understand and address the evolving dynamics of demand and supply in mental health services.[15] Establish a real-time electronic mental health bed registry at the state, regional, or national level to enhance efficiency in ED discharge planning. This registry should provide up-to-date information on the availability of quality mental health care options in and for rural communities, including real-time updates on bed openings, wait times, accepted insurance, payment options, service details, eligibility criteria, and referral pathways.[16] Ensure universal access to this database for all personnel involved in the care of youth facing psychiatric crises.
- *Improve mental health education and training:* Incentivize universal training annually for medical staff in safety planning procedures to empower rural patients and families to better cope with mental health distress and prevent psychiatric crises.[17] Provide annual training for non-psychiatric health care staff in de-escalation, emotion regulation strategies, and behavior management techniques to reduce the likeliness, intensity, duration, and frequency of patients' dangerous behaviors.
- *Promote the adoption of mental health bridge clinics:* Similar to the University of Kentucky's opioid use disorder (OUD) bridge clinic, where providers refer patients to receive transitional care for OUD and other behavioral health disorders, rural EDs may consider adopting a similar model to treat adolescents with substance use disorder (SUD) and/or mental health disorders to increase access to services and reduce morbidity and mortality.

Downstream solutions: Increase the number of services, personnel, and resources addressing rural pediatric psychiatric emergencies.

- *Strengthen crisis response teams in rural communities:* Crisis response teams can provide the assessment, intervention, and support needed to make outpatient referrals with appropriate safety plans in place.
- *Workforce development:* Increase the workforce necessary to deliver mental health care across different rural settings, patient acuity levels, and geographic locations.

Recommended actions

Expand collaborative and integrated outpatient care:

- Require that federal funding be contingent upon demonstrating meaningful collaboration with rural organizations receiving these funds for mental health. Tie federal funding to high-need areas with a focus on rural and/or underserved communities.
- Support HHS's Strategic Plan FY2022-2026 Objective 1.4 by tasking HHS with the organization, administration, and oversight of mental health care across all states and territories with an emphasis on rural communities.[18]
- Increase reimbursement from CMS for health care providers and administrators who actively participate in crucial clinical care, logistical coordination, collateral collection, and supportive collaborations with rural providers. These collaborations would extend both within and beyond their own organization. The goal is to incentivize and reward individuals and organizations for contributing to various aspects of mental health care, including care delivery, quality improvement, planning, feedback solicitation, and implementation. This financial incentive could recognize and support those who engage in efforts that enhance and expand mental health care services, particularly in rural areas.

Expand telepsychiatry services:

- Increase broadband capacity and resources to support telepsychiatry services.
- Support statewide telepsychiatry models to provide evidence-based care to youth in rural communities.
- Incentivize rural hospitals and providers to participate in telepsychiatry services through inclusion in CMS' value-based reimbursement models.

Develop bed registries:

- In H.R.7666, Restoring Hope for Mental Health and Well-Being Act of 2022, expand patient registry programs to include bed registry programs.
- In FY24 SAMHSA should modify its Transformation Transfer Initiative funding opportunity to include a focus on EDs in rural communities and their ability to participate in a national and multi-level of care psychiatric bed registry program.[19]
- Require all inpatient psychiatric facilities receiving CMS reimbursement for either Medicaid or Medicare to participate in an electronic national bed registry.
- Require HHS to complete a national evaluation of psychiatric boarding challenges, issues, and effective models (e.g. Alameda model[20], Milwaukee Boarding Project[21]), as well as effective state standards that emphasize rural communities. Task HHS with updating this evaluation every 10 years.

Improve mental health education and training:

- Encourage the Department of Labor to promote apprenticeships of peer support specialists to increase aspects of the mental health workforce in rural areas.
- Incentivize rural EDs to utilize HRSA's toolkit, *Critical Crossroads: Pediatric Mental Health Care in the Emergency Department*, which has been developed to better prepare EDs to manage and coordinate care for adolescents in mental health crisis.[22]

Promote the adoption of mental health bridge clinics:

- Incentivize FORHP, SAMHSA, and CMS to allocate funding for demonstration projects in rural communities to evaluate the affordability, accessibility, and efficacy of this model for the mental health needs of youth in rural communities. Other federal partners may consider utilizing discretionary funding to pilot a similar model that includes a focus on the adolescent psychiatric population in rural communities.
- Incentivize EDs to task at least one employee with coordinating placement for youth presenting with psychiatric complaints in the appropriate aftercare, be it an inpatient psychiatric hospital unit, partial hospitalization program, intensive outpatient program, or other outpatient programs.

Strengthen crisis response teams:

- Expand federal grants to support multidisciplinary rural crisis services across the continuum of care (e.g. mobile crisis teams, police co-responder programs, mental health helplines, crisis hubs, etc.) to provide timely and effective care for youth experiencing a mental health crisis in rural areas.
- Use existing models within the Department of Justice and Bureau for Justice Assistance to integrate telehealth modalities into mental health and substance use responses within law enforcement (or similar entities) working in rural communities to expand community capacity.
- Expand collaborative care models in pediatric clinics in rural and underserved areas. One such model is offered by the North Carolina Statewide Telepsychiatry Program for Pediatrics.[23]

Workforce development:

- Subsidize mental health training for rural peer support specialists, community health workers/navigators, pharmacists, physicians, nurse practitioners, nurses, nursing assistants, and physician assistants through federal and state funding streams.
- Provide subsidies to payers for career pathways for non-traditional health care providers.
- Create multidisciplinary, nationally accredited mental health professional training programs for rural areas through federal agencies such as CDC, SAMHSA, HRSA, etc. and in partnership with relevant higher education institutions.

- Utilize technical and vocational colleges as a bridge to rural hospitals for apprenticeship programs (e.g. creating psychiatric nursing pipelines, social work professions) that focus on rural communities.
- Task CMS with funding the expansion of the number of, slots in, and administrative support for general psychiatry residency and child and adolescent psychiatry fellowship programs with a focus on rural communities. Although CMS began distributing 200 slots per year over 5 years in 2023 to rural and underserved areas demonstrating the greatest need with funding totaling $1.8 billion over the next 10 years, it does not appear to specify how many of these slots must be allocated to psychiatric residency or fellowship programs or how these slots may have administrative support for the unique considerations of each rural community.
- Congress should establish a federal tax credit for providers practicing in rural areas, such as those modeled on several state rural workforce retention programs that leverage their state tax system: Oregon, New Mexico, Alabama, Georgia, Louisiana, and Montana.[25]
- Allocate increased funding towards scholarships, loan forgiveness programs, and streamlining the administrative burden of applying for and disbursing these funds to foster a more diverse and inclusive workforce, with a specific focus on addressing the needs of rural areas.
- State Offices of Rural Health (SORH) should be encouraged to participate in the coordination of convening primary c offices and J-1 visa sites to increase collaboration amongst these entities, improve youth psychiatric workforce capacity, and engage in public-facing information-sharing activities with behavioral health stakeholders about the J-1 visa program and processes. A solution to the management of this process is for SORHs to connect stakeholders with the 3R Net Program, J-1 visa program, state loan repayment program, National Health Service Corps, and other appropriate partners that aim to build mental health workforce capacity.

Conclusion

Pediatric psychiatric boarding is a pressing policy issue that has significant implications for rural communities. Worse mental health disparities and diminished health care access in rural areas, along with nationwide increases in youth who go to the emergency room for psychiatric emergencies, have exacerbated pediatric psychiatric boarding, which can have detrimental effects on patients, families, providers, and systems. It is crucial for policymakers to address pediatric psychiatric boarding by investing in more mental health resources for children in rural areas before psychiatric crises happen and to address the increase in children who require a higher level of psychiatric care. By taking these steps, we can ensure that all children, regardless of where they live, have access to the mental health care they need to thrive.

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