Boarding of Pediatric Psychiatric Patients Is a No-Fly Zone for Value

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Evolving concepts about the interwoven nature of physical and mental health have slowly, but incompletely, chipped away at the "reductionistic anachronism of mind/body dualism"[1] that has historically separated them. The article, "Impact of Boarding Pediatric Psychiatric Patients on a Medical Ward," in this edition of *Hospital Pediatrics*, however, highlights a series of challenges in which a patient's body occupies a medical bed, but the mind is not getting the therapy it needs. The authors describe how psychiatric patients boarding on a medical floor receive little of the care they need while incurring high costs. Psychiatric boarding, which delays treatment when patients are most vulnerable, directly compromises all domains of quality (including safety, effectiveness, efficiency, timeliness, patient-centeredness, and equity) and is far from the high-value care we seek to deliver.

The root of the problem, which must be addressed to ameliorate the situation, is that mental health care is grossly underfunded, which has led to insufficient physical and professional capacity. Since the 1960s, an appropriate emphasis on deinstitutionalization has led to a reduction in the number of psychiatric beds. Yet despite a desire to shift to outpatient and community resources, insufficient funds were dedicated to the establishment of an adequate outpatient infrastructure.[2] Today, despite severe bed shortages in many regions, psychiatric hospitals have little incentive to expand capacity due to low and declining reimbursement rates. Although reimbursements vary around the nation, children often have to wait long periods of time for placement as supply has not kept pace with demand. Even then, while insurance plans may cover several days of inpatient treatment, the number of approved days is often insufficient to cover the course of treatment and follow-up care.

Although increasing reimbursement and capacity are essential, this will take time. In the meantime, reasonable short-term steps should be taken to improve the value of care for psychiatric patients on inpatient medical units. This, however, will not be easy. There are legitimate reasons why general floors cannot attend to the unique needs of psychiatric patients. The structure and design of psychiatric facilities revolve around the ability to establish and maintain safety to prevent harm or suicide and to provide a therapeutic milieu that is conducive to counseling, therapy, and observation. Although it is common practice for hospitalists to initiate treatment of patients on a medical unit and then hand off care to other providers, the care plans for psychiatric patients rely on the establishment of a trusting therapeutic alliance that remains consistent throughout treatment. Thus, a medical unit cannot fully replicate the care provided in a specialized psychiatric facility. Although appropriate medications may be initiated on a medical unit,

the core treatment relies on careful execution of a specialized biopsychosocial plan to address the internalized symptoms of depression, anxiety, and psychosis so often seen in patients requiring inpatient psychiatric care.[3] This aspect of treatment, which may involve a combination of medications, individual psychotherapy, behavioral modification, group therapy, and play strategies, must be administered by trained mental health professionals in a controlled setting.[4]

Because we cannot create new facilities or beds overnight, innovations on how care is delivered should be considered. Instead of keeping patients in a holding pattern, nonpsychiatric hospitals could train and/or hire nurses to provide specialized care for psychiatric patients awaiting transfer. Similarly, because adding staff is somewhat easier than adding buildings and beds, nonpsychiatric hospitals could also increase the number of psychiatrists, therapists, and counselors to increase the likelihood that patients are started on an effective care plan while they await more specialized treatment. If nonpsychiatric hospitals could start the treatment process, time spent boarding would not be wasted, and perhaps these patients would require fewer days in specialized units once transferred, which would also increase functional capacity. Another potential compromise is for hospitals to concentrate staff and beds for psychiatric services in a designated area. Although not ramping up to the full status of a dedicated psychiatric unit, concentrating these beds could allow staff members to more effectively initiate treatment, thereby increasing the value of care. A third potential compromise would be to bring boarding patients during the day to intensive outpatient treatment centers, such as day hospital programs, if they are available.

Until reimbursement issues are addressed, funding for any of this work will remain low. According to a recent survey, almost half of Pediatric Psychiatry Consultation/Liaison services in the United States report inadequate staffing to meet clinical needs, and more than half report insufficient funding to support the service in its current form.[5] Traditionally, responsibility for mental health issues has been delegated to local counties. However, with counties often unable to meet local need, increasing reimbursement rates for mental health providers in the long term is essential to incentivize hospitals to increase their staffing and bed capacity and to allow for the expansion of alternate intensive outpatient treatment centers, so that this vulnerable population of children and adolescents can receive the care they need.

The American health care system is being challenged to raise its value, which means attending to the quality of care provided and its cost. The boarding of children and adolescents in need of inpatient psychiatric treatment is a prime example of low-value care, and addressing this problem demands innovations in how we deliver services and how we pay for them. Children and their families deserve no less.

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