Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland

Report at the Request of the House Health and Government Operations Committee

January 2022

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maryland health services cost review commission

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Executive Summary

In a September 2021 briefing before the House Health and Government Operations Committee on HB 1121 (Chapter 29 of 2020) - Maryland Mental Health and Substance Use Disorder Registry and Referral System, the Vice Chair of the Committee asked the Health Services Cost Review Commission to convene a workgroup to consider the following questions, which were raised in the September briefing:

1. What short-term (0-5 years) solutions can be implemented to address the following:
   - Lack of availability of psychiatric beds;
   - Crisis support;
   - Reimbursement and payment for psychiatric services; and
   - Weak reinvestment of federal government and revenue for reform dollars[1]
2. What solutions can be implemented to address long emergency department (ED) wait times for pediatric patients, including children with developmental disabilities?

The problem of long ED wait times and hospitalizations with excess length of stay for individuals experiencing psychiatric crises are longstanding, multifaceted, and complex. The impact of this problem is worse on patients with complex needs and patients who are under the age of 18. No single intervention will solve these problems.

MDH is making progress on implementing the bed registry and referral system required by HB 1121 and the related pilot program, as well as other initiatives that should improve ED boarding and unnecessary hospitalizations, and long length of stay for behavioral health patients. In addition, many State agencies, including MDH, OOCC, MHCC, and HSCRC, are actively engaged in implementing and planning projects and programs that 1) help keep people stable in the community, so they do not need acute psychiatric services; 2) increase the availability of community-based services for people in crisis, which divert people from the ED to other, more appropriate, settings of care, and 3) address issues with throughput in the ED.

While much work is being done to address the problem of ED wait times and hospital overstays for behavioral health patients, many challenges remain. These challenges include data availability, the sustainability of existing funding streams, legal issues (particularly related to children under the supervision of the Department of Human Services), and a shortage of workforce. The State Agencies contributing to this report look forward to continuing to work with the legislature to address these challenges.

[1] HSCRC is considering a proposed Revenue for Reform policy that would encourage hospitals to invest retained revenues in care transformation efforts and in the community to improve population health. This policy is not yet final.

Introduction

In a September 2021 briefing before the House Health and Government Operations Committee on HB 1121 (Chapter 29 (2020)) - Maryland Mental Health and Substance Use Disorder Registry and Referral System, the Vice Chair of the Committee asked the Health Services Cost Review Commission to convene a workgroup to consider the following questions, which were raised in the September briefing:

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   - Lack of availability of psychiatric beds;
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   - Weak reinvestment of federal government and revenue for reform dollars[2]
2. What solutions can be implemented to address long emergency department (ED) wait times for pediatric patients, including children with developmental disabilities?

The problem of long ED wait times and hospitalizations with excess length of stay for individuals experiencing a psychiatric crisis is multifaceted and complex. The bed registry and referral system required by HB 1121 and the related pilot program are key tools that should help with this problem. As detailed below, MDH is actively working to implement both the registry and referral system and the pilot program. In addition, MDH is moving forward on other projects that should have an impact on reducing ED wait times and hospital overstays for behavioral health patients, including activities specifically targeted to adolescents.

While the bed registry and referral system and related pilot are important tools to address this problem, no single intervention will solve ED wait times and hospital overstays. Solving this complex problem requires many solutions, including 1) initiatives that help keep people stable in the community, so they do not need acute psychiatric services; 2) increasing the availability of community-based services for people in crisis, which divert people from the ED to other, more appropriate, settings of care, and 3) addressing issues with throughput in the ED. Access and capacity for each of these service categories is impacted by payment source (including coverage of services by insurance and adequacy of payment), workforce availability, and the patient’s age and other diagnosis (ex. developmental disabilities, comorbidities, and co-occurring conditions).

This report will first review progress made by the Maryland Department of Health (MDH) on the registry and referral system required under HB 1121, the related pilot project, and other key initiatives designed to reduce ED boarding and hospital overstays for behavioral health patients. The report then provides existing

[2] HSCRC is considering a proposed Revenue for Reform policy that would encourage hospitals to invest retained revenues in care transformation efforts and in the community to improve population health. This policy is not yet final.

data that helps to inform the issue. Finally, the report reviews recently launched (since 2019) initiatives and initiatives that are in planning for implementation that may positively impact this problem in the next few years. These initiatives will be organized into three categories:

- **Helping People Stay Stable**: Improving access to programs and interventions designed to help people with behavioral health conditions stay stable, so that crisis-level services are not needed.
- **Helping People in Crisis**: Strengthening the community-based behavioral health crisis response system to provide people in crisis with opportunities to receive care in an appropriate setting.
- **Helping People in Emergency Departments and Hospitals**: Ensuring there is adequate capacity, reimbursement, and technology to quickly connect patients in ED and Hospital beds with appropriate care, whether that care is an inpatient psychiatric bed or an outpatient and/or community-based service.

The report also described challenges that continue to negatively impact behavioral health patients by increasing ED wait times and inpatient bed overstays.

The content of this report was gathered through collaboration with the Maryland Health Care Commission (MHCC), MDH (including the Behavioral Health Administration (BHA), and the Opioid Operational Command Center (OOCC), with additional contributions from a workgroup with representatives from State agencies, the Maryland Hospital Association (MHA), CRISP, behavioral health advocates, and legislators.

Maryland Mental Health and Substance Use Disorder Registry and Referral System Implementation

HB 1121 (Chapter 29 (2020)) - Maryland Mental Health and Substance Use Disorder Registry and Referral System required MDH to implement a statewide system through which health care providers can identify and access available inpatient and outpatient mental health and substance use services for patients. Technology to link patients to inpatient and outpatient services can, if well implemented, reduce workload on ED staff (by eliminating the current phone calls required to find appropriate services) and reduce ED wait times, both by finding appropriate placements for people in the ED and by improving hospital thruput by improving placements of patients ready for discharge from inpatient beds to another appropriate setting.

HB 1121 states that the implementation of these registry and referral system is subject to the availability of funds. MDH applied to the Maryland Department of Information Technology (DoIT), through the Major Information Development Project (MITDP) for funding. MDH's submission is under review.

As reported in the September briefing and regular update letters to the Health and Government Operations Committee from MDH, the Department is taking steps to implement the registry. A core set of MDH staff from BHA, Operations (including procurement and HR), Information Technology, and Government Affairs, meet weekly to ensure that progress continues to be made on this project. The Secretary joins these calls

regularly, emphasizing that this project is a priority for the MDH. Key accomplishments on this project include:

1. **Establishing the Maryland Mental Health and Substance Use Disorder Registry and Referral System Advisory Committee**. The Committee met January 7th, 2022.
2. **Hiring a project manager for the project**. The new hire is skilled in government IT projects, a skill set that is crucial to the success of this project. The project manager began employment on January 3rd, 2022.
3. **Conducting a feasibility study**. This feasibility study, which was provided to the Health and Government Affairs Committee in September 2021, detailed the technical and staffing requirements for this project, provided a project timeline, identified three 3 potential partner vendors: OpenBeds, Juvare, and Behavioral Health Link and described other State's experience with these vendors.[3] Additional information about these potential partner vendors can be found in the appendix.
4. **Seeking funding**. MDH is working closely with DoIT to include this project in the proposed FY 2023 IT budget. MDH applied to DoIT, through the Major Information Technology Development Project (MITDP) for funding. MDH's submission to the MITDP is under review.

MDH is providing regular updates to the Health and Government Operations Committee on this project through separate correspondences.

As stated in the feasibility study, once funding is available, MDH expects that procurement and vendor selection will take approximately 6 months if the process runs smoothly. Once funding is secured for this project, a standard procurement process will occur, which will ensure that all willing vendors are fairly evaluated to find the best solution for the State while ensuring that the selected technology solution conforms with the requirements of HB 1121.

Once a vendor is onboard, an approximately 6-month design, development, and implementation (DDI) phase will begin. During the DDI phase, the product would be customized to meet Maryland's needs.[4] Depending on the vendor, it is possible that incremental product releases will allow for interim releases

[3] Additional potential vendors (including referral vendors like Xferall) have reached out to MDH to provide information about their products. Xferall was mentioned in the feasibility study but was not reviewed in detail in that document.

[4] HSCRC is aware that at least one potential vendor in this space claims that the design, development, and implementation phase could be as short as 2 months for hospital referrals. This is not much different than the implementation time for OpenBeds, a potential vendor evaluated in the feasibility study, which expected to have an implementation phase of three to six months, depending on the contracting process and pre-work to support adoption by providers. All vendors will have a chance to provide information on their ability to meet the project requirements and meet or exceed expected project timelines through the procurement process.

during this time, so that limited functions can come onboard early, followed by more robust functionality over time. Ultimately, MDH expects the registry and referral product to be fully implemented by March 2024. This is a purposefully conservative time estimate, to manage expectations, and may be shortened depending on the vendor's capabilities.

Perhaps more important than the technology solution is the adoption and effective use of the registry and referral tool by providers. Providers must update and use the system frequently and accurately for it to be effective. MDH and the selected vendor will provide training to providers on use of the product.

Building from a successful effort at Howard County General Hospital, BHA plans to work with two hospitals in different jurisdictions to embed a behavioral health navigator into the discharge planning teams in the hospital's emergency department.[5] The behavioral health navigator will coordinate closely with existing local care teams charged with problem solving complex adolescent behavioral health cases along with existing local behavioral health authorities to identify and expedite community referrals. This project will serve as the pilot program required by HB 1121. If the pilot program is successful, the State may expand the behavioral health navigator model. The goal is for the hospital-based behavioral health navigators to be a key staff resource to ensure that the registry and referral system, once available, is updated and used by each hospital.

Children and adolescents are one of the populations most effected by hospital and ED overstays. The Maryland Children's Cabinet has a three-year plan for 2021-2023 which includes goals related the following topics:

- identifying children in crisis and meeting their needs;
- developing residential treatment center (RTC) capacity for dual diagnosed individuals (this strategy is discussed in more detail below); and
- near-real time tracking by the Department of Human Services (DHS) of youth with behavioral health needs who are in hospitals.

This plan contains many steps that are directly relevant to addressing ED boarding times and hospital overstays in pediatric patients[6]. As a component of this plan, MDH established the Adolescent Hospital Overstay Grant Program (AHPGP). In late 2021, MDH announced an RFP for $5 million in grant funds to expand RTC capacity for youth. RTCs are an important non-hospital facility type for patients who are being discharged from EDs or hospital inpatient beds. The focus of these grants is to provide care to the children

[5] HSCRC notes that MHA has reported that some hospitals in the State already have a behavioral health navigator role. This pilot will provide that resource to two hospitals in need of support to facilitate referrals.
[6] State of Maryland Children's Cabinet, Interagency Plan: Developing Resources To Address the Complex Needs of Maryland Youth in Care, available at http://goccp.maryland.gov/wp-content/uploads/Childrens-Cabinet-Interagency-Hospital-Overstays-Plan.pdf

and adolescents that are the hardest to move out of hospitals (resulting in hospital overstays). By expanding bed capacity in RTCs for adolescents, this program frees up inpatient hospital beds for patients who need them that would otherwise be occupied by patients who are ready to be discharged for another setting. The increased availability of both inpatient and RTC beds, in turn, will help reduced ED wait time for adolescents who need those services. The first 4-6 patients are expected to be admitted to these programs by the end of December 2021 and additional capacity will be added in 2022. Similarly, DHS has released an RFP for more congregate care beds, to expand capacity in this setting. This expanded capacity will have a similar expected impact on inpatient and ED wait times for adolescents.

Another key accomplishment that occurred in December is the Center for Medicaid and Medicare Services approval of the renewal of Maryland's Medicaid §1115 HealthChoice waiver, which goes into effect on January 1, 2022. As a part of this waiver renewal, CMS approved a new waiver of Medicaid's prohibition of Medicaid reimbursement for specialty behavioral health services provided in Institutions for Mental Disease (IMDs) (e.g. specialty psychiatric hospitals and other residential facilities with more than 16 beds).[7] This waiver will allow for Medicaid reimbursement of placements in IMDs, including state facilities, for Medicaid-eligible patients, providing a key source of additional federal funding for these services.[8]

Background Information on Wait Times, Capacity, and Reimbursement

This section provides background information on available data on ED wait times and hospital stays for behavioral health patients, bed capacity and access to behavioral health services, and information about reimbursement for those services.

Time in the Emergency Department and Inpatient Setting

Understanding the problem of ED wait times and hospital overstays for psychiatric patients is difficult without consistent availability of data. Historically, the Centers for Medicare & Medicaid Services (CMS) has collected data from hospitals nationwide on three quality measures that are important to understanding ED wait times.

- Measure ED-1, measures the time, in minutes, from arrival to the ED to admission for patients who are admitted to the ED. This measure was retired by CMS after 2018 and data after 2018 is not

[7] Maryland Medicaid has had a waiver of the IMD exclusion for substance use disorder services as part of its §1115 HealthChoice demonstration since 2017.

[8] The annual per person costs in a state facility exceed $200,000 per year, which is borne by the General Fund for persons age 21-64, due to the federal Institutions for Mental Diseases (IMD) exclusion, which precludes Medicaid reimbursement. The IMD exclusion also impacts non-State facilities with more than 16 beds, including Sheppard Pratt.

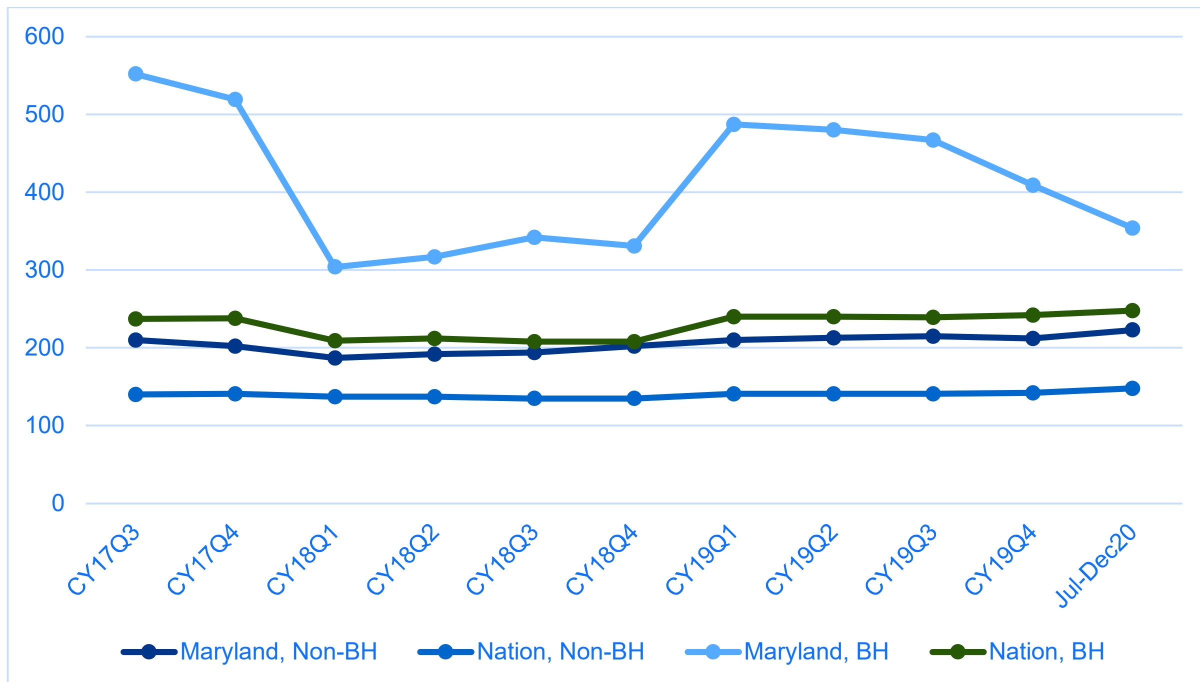
available. HSCRC staff could not access behavioral-health specific data on this measure from CMS's website.

- Measure ED-2, measures the time, in minutes, from the time a decision is made to admit a patient until that patient was admitted to the hospital. This measure was retired by CMS after 2019 and data after 2019 is not available. CMS plans to collect this measure again in an electronic format beginning with Q1 2022 but will stop collecting the measure by 2024. HSCRC intends to continue to collect this electronic measure after 2024, as HSCRC believes it is important to measuring quality of care in hospitals in Maryland. HSCRC staff could not access behavioral-health specific data on this measure from CMS's website.
- Measure OP-18, measures the time, in minutes, from the time that a patient arrives at the ED until the patient is discharged, for patients who are not admitted to the hospital. This data is available separately for behavioral health and non-behavioral health patients. This measure is still being collected by CMS.

These measures do not separate pediatric and adult patients, so it is not possible to see wait times for only pediatric patients.

When comparing data on patients that were discharged from the ED, behavioral health patients spent more time in the ED than non-behavioral health patients, both in Maryland and in the nation.

Figure 1: Median Time, Arrival to ED to Discharge, Non-Admitted Patients, CY 2017 Q3 - CY 2019 Q4



HSCRC believes that the ED wait time quality measures from CMS are important to measuring quality in Maryland hospitals and has advocated that CMS continue these measures.

The problem of ED wait times in Maryland is long-standing. In 2017, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and HSCRC partnered to evaluate the impact of hospital overcrowding on EMS response times and Maryland's patient population and to develop a plan to address ED overcrowding.[9] The report noted that emergency department overcrowding has worsened due, in part, to an increase in behavioral health patients. Behavioral health patients have complex service needs which take time for ED staff to address. In addition, psychiatric patients may require isolated space and ongoing supervision for extended periods, which impacts ED room and staff availability and ED throughput. Finally, it is challenging for ED staff to find appropriate placements for behavioral health patients.[10] For patients who do need crisis-level services, community-based crisis services are often the best treatment option (rather than a hospital emergency room).

An MHCC analysis of 2018 emergency department data found that "boarding of 24 hours or more occurs across regions and age ranges but is a particular issue for patients from central Maryland and for adolescents statewide".[11] A 2019 MHA study found that 42% of behavioral health patients experience a delay in discharge from emergency departments (defined as every hour the patient remains in the ED after 4-hours after the discharge decision is made) and patients under 18 wait twice as long as adults. [12] Additionally, three of the top five most common reasons for discharge delays were associated with placement setting barriers, including facilities denying admission, taking too long to process referrals, or lacking bed space. Those reasons accounted for over half of the delay days in the study. [13] It is important to note that while some of these overstays are due to waits for an inpatient bed, ED boarding also occurs in the case of patients who are waiting for a placement in a community-based setting that is safe and appropriately matched to their level of need. Patients should be treated in the least restrictive appropriate setting, and hospitals are a restrictive setting.

[9] MIEMSS and HSCRC, Joint Chairmen's Report on Emergency Department Overcrowding, 2017, available at http://dlslibrary.state.md.us/publications/JCR/2017/2017_29a.pdf
[10] MIEMSS and HSCRC, Joint Chairmen's Report on Emergency Department Overcrowding, 2017, available at http://dlslibrary.state.md.us/publications/JCR/2017/2017_29a.pdf
[11] State Health Plan for Facilities and Services: Acute Psychiatric Services, COMAR 10.24.21, Effective August 9, 2021, page 4. Available at http://www.dsd.state.md.us/artwork/10242101.pdf
[12] Maryland Hospital Association, Behavioral Health Patient Delays in Emergency Departments, 2019. Available at https://www.mhaonline.org/docs/default-source/resources/behavioral-health/behavioral-health-patient-delays-in-emergency-departments-study-2019.pdf
[13] Maryland Hospital Association, Behavioral Health Patient Delays in Emergency Departments, 2019. Available at https://www.mhaonline.org/docs/default-source/resources/behavioral-health/behavioral-health-patient-delays-in-emergency-departments-study-2019.pdf

A separate 2019 MHA study looked at hospital discharges of behavioral health patients. This report found that three percent of behavioral health patients experienced a discharge delay from acute care hospitals, and "60 percent of discharge delays were due to lack of bed space at the preferred placement setting, denied admission to a preferred placement setting, or delays in processing a referral."[14] Individuals with dual diagnosis (such as developmental disabilities), adolescents, and the elderly were more likely to experience discharge delays and experience longer delays than other behavioral health patients.

To focus on pediatric patients more specifically, MHA recently conducted an eight-week data collection study on pediatric hospital overstays from September 29 through November 17, 2021. The goal of the project was to assist the State in understanding the number and characteristics of children and adolescents up to age 21 in hospital emergency departments and inpatient units experiencing discharge delays. This study covered all pediatric overstays, not just psychiatric overstays. The age, gender, unit, and reason for discharge delay were collected weekly from participating individual hospitals using a point in time data collection method. ED patients were included in the study if they had been in the ED for longer than 48 hours, and inpatients were included if they remained admitted beyond medical necessity (i.e., medically clear for discharge, but waiting for another placement to accept them, etc.). While MHA is still working through the analysis, initial review indicates that the most often cited reason for a youth meeting overstay criteria is waiting for an inpatient psychiatric bed.

A 10-day analysis of ED patients by MIEMSS during November 2021 found that behavioral health patients comprised a median 24% of ED boarders on any afternoon. "ED boarding" occurs when emergency diagnostic and therapeutic interventions are complete and the patient is ready for a disposition from the ED, but there is no place to go. Most often, this is because of lack of availability of an admission bed or, in the case of the need to transfer to another facility for optimal care, the lack of available appropriate options and inability to effect acceptance by a receiving clinician. During the 10-day evaluation period, on each afternoon approximately 74 (median) behavioral health patients remained in Maryland EDs, despite their emergency evaluation being complete, because of no available disposition options. However, not every hospital replied to the query each day, meaning the actual number of stranded patients is most certainly greater. Moreover, behavioral health patients tend to have longer ED boarding times than other patient groups. For example, at any one time (e.g., snapshot), ED boarders with a medical problem have been boarding 7.4 hours (median), compared to behavioral health patients who have been boarding 33.7 hours (median). Further, because of the magnitude of outlier situations (e.g., behavioral health patients who are ED boarders for exceptionally long times) the average behavioral health ED boarder has been in that status

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[14] Maryland Hospital Association, Behavioral Health Discharge Delays in Maryland Hospitals, 2019, available at https://www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf

for more than 70 hours. While behavioral health patients comprise 24% of boarders at any moment, they represent 68% of the total boarding time among all patient types.

Capacity and Access

Given that the most cited reason in the MHA study for ED overstays for pediatric patients is availability of an inpatient bed, and one of the most common reasons for an inpatient overstay for a behavioral health patient is lack of an appropriate community-based setting, it is important to understand data related to capacity and access.

Hospital Services

Psychiatric inpatient hospital services are provided in State hospitals, private psychiatric specialty hospitals, and in psychiatric units in general acute hospitals. "General acute hospitals and private psychiatric hospitals primarily provide acute psychiatric inpatient services, while State psychiatric hospitals primarily provide longer-term inpatient psychiatric care and care for forensic patients."[15]

The Maryland Health Care Commission (MHCC) routinely monitors hospital capacity in the State for private psychiatric hospitals and psychiatric units in general acute hospitals. According to MHCC data, "in general acute hospitals and private psychiatric hospitals, there appears to be sufficient physical capacity for handling the demand for acute inpatient care."[16] However this capacity may not result in adequate availability of hospital services for behavioral health patients who are children or adolescents and/or have complex needs (such as developmental disabilities, dementia, or other neurological issues). Table 1 shows the occupancy rate of adult inpatient psychiatric beds in acute general hospitals is approximately 74% of the licensed beds statewide in the fourth quarter of 2020. Use of psychiatric hospital beds by adults has been declining over time (23% decrease in adult discharges per 100,000 Maryland residents between 2009 and 2019).[17]

[15] Maryland Health Care Commission, White Paper: Maryland Acute Psychiatric Hospital Services, April 2019. Available at https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/White%20Paper%20-%20Maryland%20Acute%20Psychiatric%20Hospital%20Services__20190503.pdf

[16] Maryland Health Care Commission, White Paper: Maryland Acute Psychiatric Hospital Services, April 2019. Available at https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/White%20Paper%20-%20Maryland%20Acute%20Psychiatric%20Hospital%20Services__20190503.pdf

[17] State Health Plan for Facilities and Services: Acute Psychiatric Services, COMAR 10.24.21, Effective August 9, 2021, page 4. Available at http://www.dsd.state.md.us/artwork/10242101.pdf

Table 1: General Acute Hospital Adult Inpatient Psychiatric Bed Use, 10/01/2020-12-31/2020[18]

Hospital Name	Discharges	Patient Days	Allocated Licensed Psych Beds	Average Quarterly Bed Occupancy Rate
MERITUS	178	1,017	18	61.4%
UNIVERSITY OF MARYLAND	162	1,709	44	42.2%
UM PRINCE GEORGE'S	367	2,280	32	77.4%
FREDERICK HEALTH	198	914	21	47.3%
UM HARFORD MEMORIAL	205	1,647	31	57.7%
JOHNS HOPKINS	405	6,140	108	61.8%
UM SHORE AT DORCHESTER	94	931	16	63.2%
SINAI OF BALTIMORE	165	1,853	24	83.9%
GRACE	145	1,003	27	40.4%
MEDSTAR FRANKLIN SQUARE	508	2,900	40	78.8%
ADVENTIST HEALTHCARE WHITE OAK	3	29	10	3.2%
MEDSTAR MONTGOMERY	162	1,016	14	78.9%
TIDAL HEALTH PENINSULA REGIONAL	142	934	13	78.1%
SUBURBAN	220	1,416	24	64.1%
UPMC WESTERN MARYLAND REGIONAL	134	568	17	36.3%
MEDSTAR SAINT MARY'S	131	520	12	47.1%
JOHNS HOPKINS BAYVIEW	93	1,398	20	76.0%
CHRISTIANA UNION	113	646	8	87.8%
CARROLL HOSPITAL	122	883	20	48.0%
MEDSTAR HARBOR	291	2,433	36	73.5%
UM MEDICAL CENTER MIDTOWN	176	2,107	37	61.9%
CALVERT HEALTH	98	472	8	64.1%
NORTHWEST	356	2,641	37	77.6%
UM BALTIMORE WASHINGTON	190	1,393	24	63.1%
HOWARD COUNTY GENERAL	220	1,736	20	94.3%
ADVENTIST HEALTHCARE SHADY GROVE	771	8,971	117	83.3%
MEDSTAR SOUTHERN MARYLAND	253	1,829	28	71.0%
UM SAINT JOSEPH	180	1,360	18	82.1%
HOLY CROSS GERMANTOWN	114	417	6	75.5%
TOTAL	**6,438**	**56,120**	**830**	**73.5%**

[18] Source: HSCRC data, analyzed by MHCC.

Table 2: Inventory of Psychiatric Hospital Beds for Children and Adolescents - Current and Approved Maryland December 2019[19]

Hospital	Location	Bed Inventory, Children	Bed Inventory, Adolescents
Adventist HealthCare Shady Grove Medical Center	Rockville	12	24
Brook Lane	Hagerstown	17	20
Calvert Health Medical Center[20]	Prince Frederick	0	8
Carroll Hospital	Westminster	0	4
The Johns Hopkins Hospital[21]	Baltimore City	15	15
MedStar Franklin Square Medical Center	Roseland	0	11
MedStar Montgomery Medical Center	Olney	0	5
Peninsula Regional Medical Center[22]	Salisbury	0	0
Sheppard Pratt Hospital	Towson	20	71
Sheppard Pratt at Ellicott City[23]	Ellicott City	0	22
Suburban Hospital[24]	Bethesda	0	24
University of Maryland Medical Center	Baltimore City	10	0
TOTAL[25]		**74**	**204**

Adults, children (age 0-12), and adolescents (age 13-17) are served in different units, which ensures patient safety and appropriate care. As shown in Table 2, five private psychiatric and general acute hospitals provide inpatient psychiatric services to children and 10 provide such services to adolescents. In addition,

[19] Source: HSCRC data, analyzed by MHCC.
[20] Calvert Health Medical Center is licensed to operate eight total psychiatric beds and is authorized to serve adults and adolescents. It reports that it only serves patients aged 15 and older and does not have a specific allocation of beds for adults or adolescents but does operate with appropriate segregation of patients by age. It is planning to undertake an expansion and reconfiguration of psychiatric bed capacity that will create distinct units for adolescent and adult patients but MHCC has not yet received a specific proposal for review at this time.
[21] The Johns Hopkins Hospital reports operation of a 15-bed child and adolescent unit with no specific allocation of bed inventory among the two age groups.
[22] Peninsula Regional Medical Center in Salisbury has been authorized to develop a 15-bed unit for children and adolescents.
[23] A replacement hospital located in Elkridge is under construction and is anticipated to open in early 2021. It will be designed to operate a 22-bed adolescent unit.
[24] Suburban Hospital is licensed to operate 24 total psychiatric beds and is authorized to serve adults and adolescents. It reports that it only serves patients aged 15 and older and does not have a specific allocation of beds for adults or adolescents. The number of adolescent patients it can serve at any given time will vary based on the "milieu" or therapeutic environment created by the patient mix and number of patients present on the unit at any given time.
[25] A hospital can adjust bed inventories to allocate varying levels of bed capacity for specific patient populations that it is authorized to serve based on demand for bed capacity, so long as bed capacity is not increased. Therefore, this bed inventory represents current bed allocations that may change over time.

one state hospital provides acute psychiatric services to adolescents. No state hospital provides acute psychiatric services to children.[26] Between 2009 and 2019, the number of acute psychiatric discharges per 100,000 Maryland residents declined by 7% for adolescents and increased by 2% for children.[27] Hospital capacity for children and adolescents is concentrated in central Maryland, making access more difficult for patients in Western Maryland, Southern Maryland, and the Eastern Shore.

COVID had some impact on hospital capacity by worsening pre-existing staff shortages; while hospitals may have beds, they may face limitations in staffing those beds. In addition, due to COVID restrictions, rooms that previously housed two patients are now only able to accommodate one patient, further limiting bed space.

The MDH manages the State hospitals, which primarily provide services to forensic patients. The State hospitals currently have a waitlist due to increased referrals from the criminal justice system. As a result, capacity is not available in State hospitals for other high need referrals.

Community-Based Services

A wide variety and complexity of services exist outside of the hospital setting. Due to limited staff HSCRC was not able to gather data on service capacity and access for community-based psychiatric services in the time allotted to complete this report.

Reimbursement

Hospital Services

Funding for psychiatric services is complicated and depends on the service provided, the setting in which the service is provided, and the patient's source of insurance (if any).

In FY2021, for inpatient psychiatric services provided in hospitals, 42% of charges were funded by Medicaid, 28% were funded by Medicare, 23% were funded by private insurance, and the remaining 7% of charges were a mix of charity care, self-pay, and other payment sources. In the same fiscal year, for outpatient hospital-based services, 46% were paid by Medicaid, 24% by commercial insurance, 18% by Medicare, and the remaining 12% were a mix of charity care, self-pay, and other payment sources.

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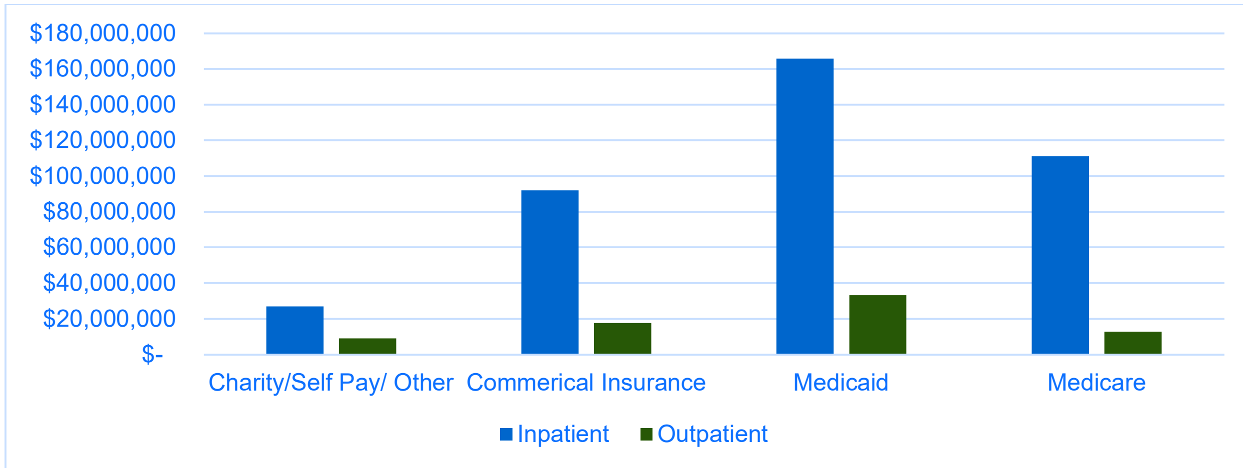
[26] Maryland Health Care Commission, White Paper: Maryland Acute Psychiatric Hospital Services, April 2019. Available at https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/White%20Paper%20-%20Maryland%20Acute%20Psychiatric%20Hospital%20Services__20190503.pdf

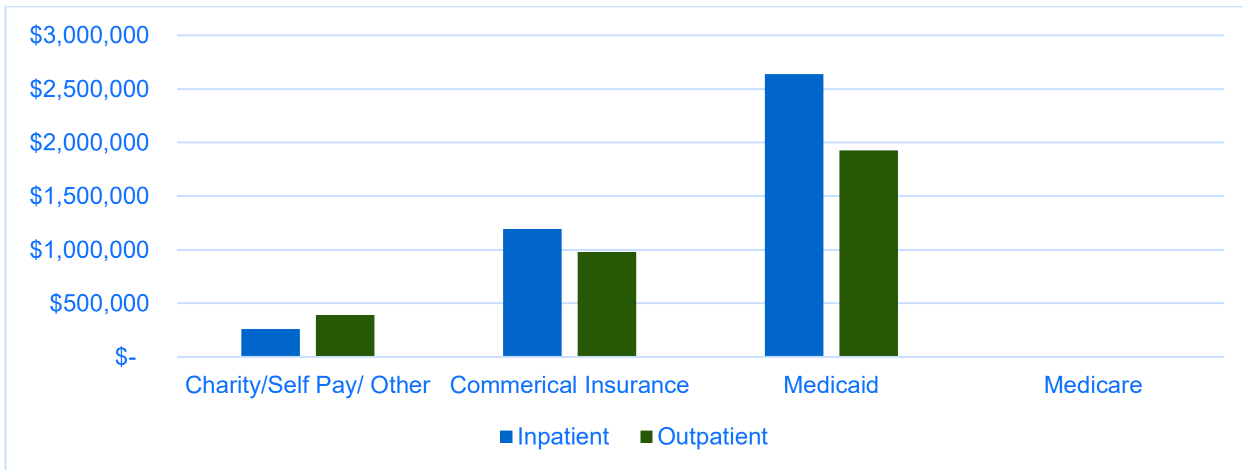
[27] State Health Plan for Facilities and Services: Acute Psychiatric Services, COMAR 10.24.21, Effective August 9, 2021, page 4. Available at http://www.dsd.state.md.us/artwork/10242101.pdf

Figure 2: Hospital Charges for Psychiatric Services by Payer Source, All Ages, FY 2021[28]



The distribution of payers differs by age group (see Figure 3, Figure 4, and Figure 5). Medicare generally is not a source of payment for psychiatric services at hospitals for children and adolescents, while it is the second largest source of payment for adults. As a proportion of total hospital charges, children also use proportionally more outpatient hospital services than other age groups.

Figure 3: Hospital Charges for Psychiatric Services by Payer Source, Children, FY 2021



[28] Source: HSCRC

Figure 4: Hospital Charges for Psychiatric Services by Payer Source, Adolescent, FY 2021

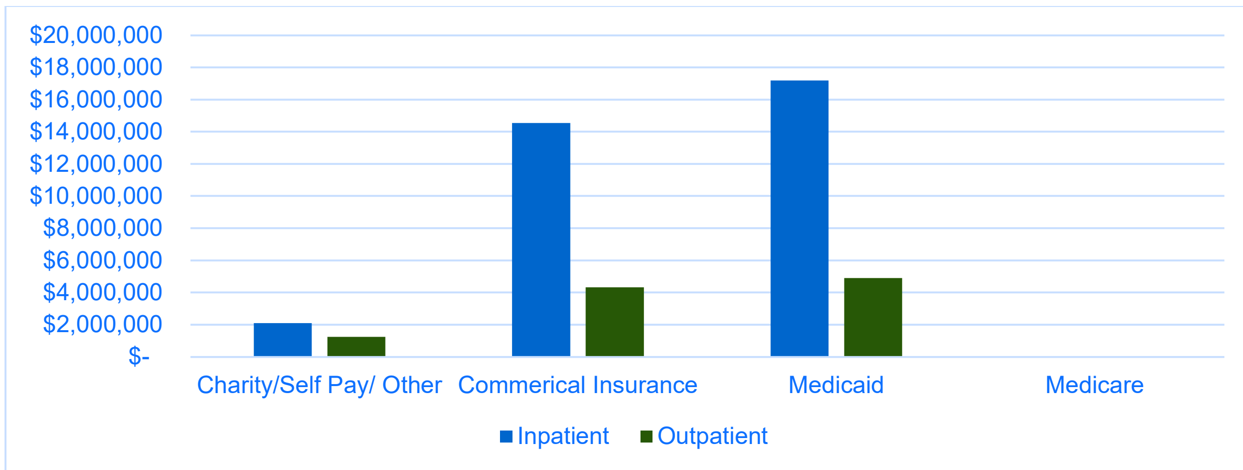
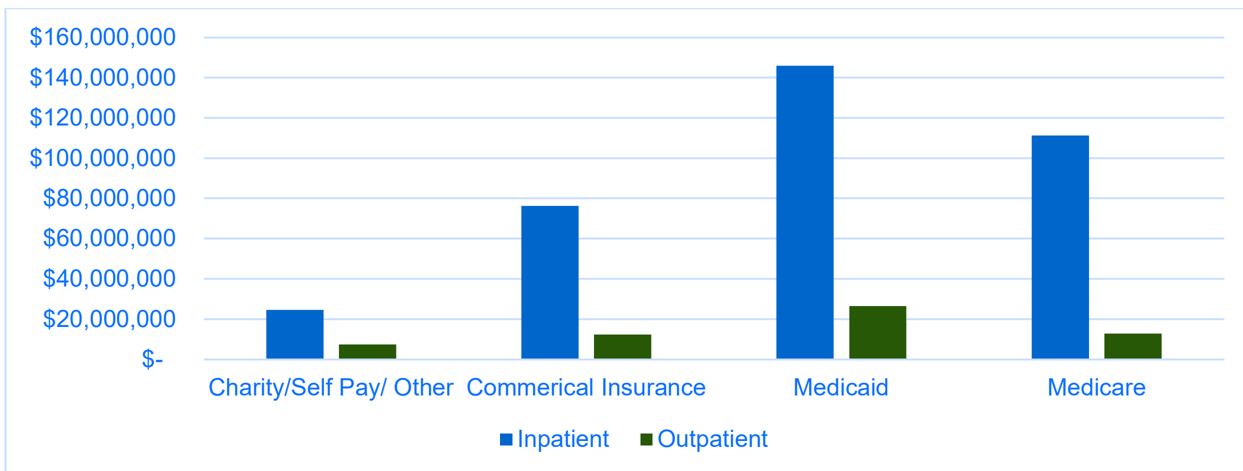


Figure 5: Hospital Charges for Psychiatric Services by Payer Source, Adult, FY 2021



Community-Based Services

Outside of the hospital setting, funding for psychiatric services becomes more complex. Maryland's strong public behavioral health system uses a braided funding approach to provide care to people with Medicaid and the uninsured. Medicaid provides a comprehensive benefit package for behavioral health and substance use disorder (SUD) services. According to multiple workgroup members, Medicaid's coverage of these services is often more generous than the coverage provided by commercial insurance plans or Medicare. For example, commercial insurance products often do not cover in-home stabilization services or residential care, or only cover those services for a short period of time. Due to the variety and complexity of community-based services and insurance benefit packages, HSCRC was not able to gather data on the sources of funding for community-based psychiatric services in the time available to complete this report.

Other Sources of Background Information

The information in this report is limited by the lack of availability of certain data points and the limited time in which this report was completed. HSCRC staff encourages readers to also review other reports on this topic produced in the last few years, including the following:

- Maryland Hospital Association, A Roadmap to an Essential, Comprehensive System of Behavioral Health Care for Maryland: A Study and Recommendations by Hospital Leaders, June 2018.[29]
- Maryland Institute for Emergency Medical Services Systems, Joint Chairmen's Report on Emergency Department Overcrowding, December 2017.[30]
- Health Services Cost Review Commission, Status of Hospital Partnerships with Community Behavioral Health Providers, 2016.[31]
- Maryland Health Care Commission Center for Health Care Facilities Planning and Development, White Paper: Maryland Acute Psychiatric Hospital Services, April 2019.[32]
- Maryland Hospital Association, Behavioral Health Patient Delays in Emergency Departments Results from the Maryland Hospital Association Behavioral Health Data Collection, February 2019.[33]

Help People Stay Stable: Strengthening the Outpatient & Community Behavioral Health System

The need for crisis and acute psychiatric services will always exist. However, ensuring adequate access to quality community-based behavioral health facilities and community-based resources (e.g., clinics and individual mental health providers) is crucial to minimizing the incidence of acute psychiatric events by providing on-going care to individuals with behavioral health and SUD conditions. Community-based behavioral health facilities and community-based resources are also important for individuals who need to be discharged from a hospital or an emergency department to another setting of care. Without placement in an appropriate community-based setting, hospital or ED discharge may be delayed. For patients with higher acuity and specialized programmatic needs, such as juvenile patients who require residential treatment

[29] Available at: https://mhaonline.org/docs/default-source/publications/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf
[30] Available at: http://dlslibrary.state.md.us/publications/JCR/2017/2017_29a.pdf
[31] Available at: http://dlslibrary.state.md.us/publications/JCR/2016/2016_80.pdf
[32] Available at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_shp_comar_10_24_07_White_Paper_Md_Acute_Psych_Hosp_Services.pdf
[33] Available at: https://www.mhaonline.org/docs/default-source/resources/behavioral-health/behavioral-health-patient-delays-in-emergency-departments-study-2019.pdf

beds and geriatric patients in need of skilled nursing facilities, this problem is more pronounced[34]. Finally, community-based care is the best setting for addressing social determinants of health, including patient needs for connection to housing services, food, and other social supports. These supports, in turn, can help patients stay in the community, as absence of these key services make it harder to maintain mental health and are a risk factor for needing higher levels of care.

Several new or soon to be implemented behavioral health initiatives in the State are focused on improving access to outpatient (non-hospital-based) behavioral health and SUD care to help keep patients stable and out of hospital emergency departments. These initiatives include the following:

- **Behavioral Health Integration in the Maryland Primary Care Program (MDPCP):** The Maryland Primary Care program was implemented in 2019. All 525 primary care practices participating in MDPCP are required to integrate behavioral health into their practices. As of Q3 2021, 100% of MDPCP practices reported developing a strategy for integrating behavioral health into their practice workflows via the Care Management or Collaborative Care Model, Primary Care Behaviorist Model, or other approaches for addressing behavioral health needs. MDPCP also provides funding to make social workers, CHWs, and care managers available to the practices. These staff work with patients to ensure they get the care and services they need to stay healthy. In addition, as of Q4 2021, over 300 MDPCP practices have implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify and appropriately refer patients with substance use disorders before the substance use creates a crisis. MDPCP practices also receive an incentive payment to improve performance on screening patients for depression. The MDPCP program provides payments directly for Medicare enrollees, while also focusing on total practice transformation that benefits patients across all payers.
- **Maternal Opioid Misuse (MOM) Model:** The MOM Model, a cooperative agreement between the federal Center for Medicare and Medicaid Innovation (CMMI), funds Medicaid MCOs to provide enhanced case management services for pregnant and postpartum individuals with Opioid Use Disorder (OUD). MOM Model program funding also supports IT investments and building provider capacity to treat this population. The model requires screening and referral for anxiety and depression. This program started as a pilot program in St. Mary's County in FY 22 and will scale statewide in later fiscal years. This demonstration is set to run through 2024, however, Medicaid plans to continue the program after the demonstration period ends.
- **The Maryland Quality Innovation Program (M-QIP)**: Led by Maryland Medicaid, M-QIP is a state-directed risk-based payment aimed at substance use disorder providers providing somatic/medical

[34] Maryland Hospital Association (June 2018). A Roadmap to an Essential, Comprehensive System of Behavioral Health Care for Maryland: A Study and Recommendations by Hospital Leaders. Available: https://mhaonline.org/docs/default-source/publications/roadmap-to-an-essential-comprehensive-system-of-behavioral-health-care-for-maryland.pdf

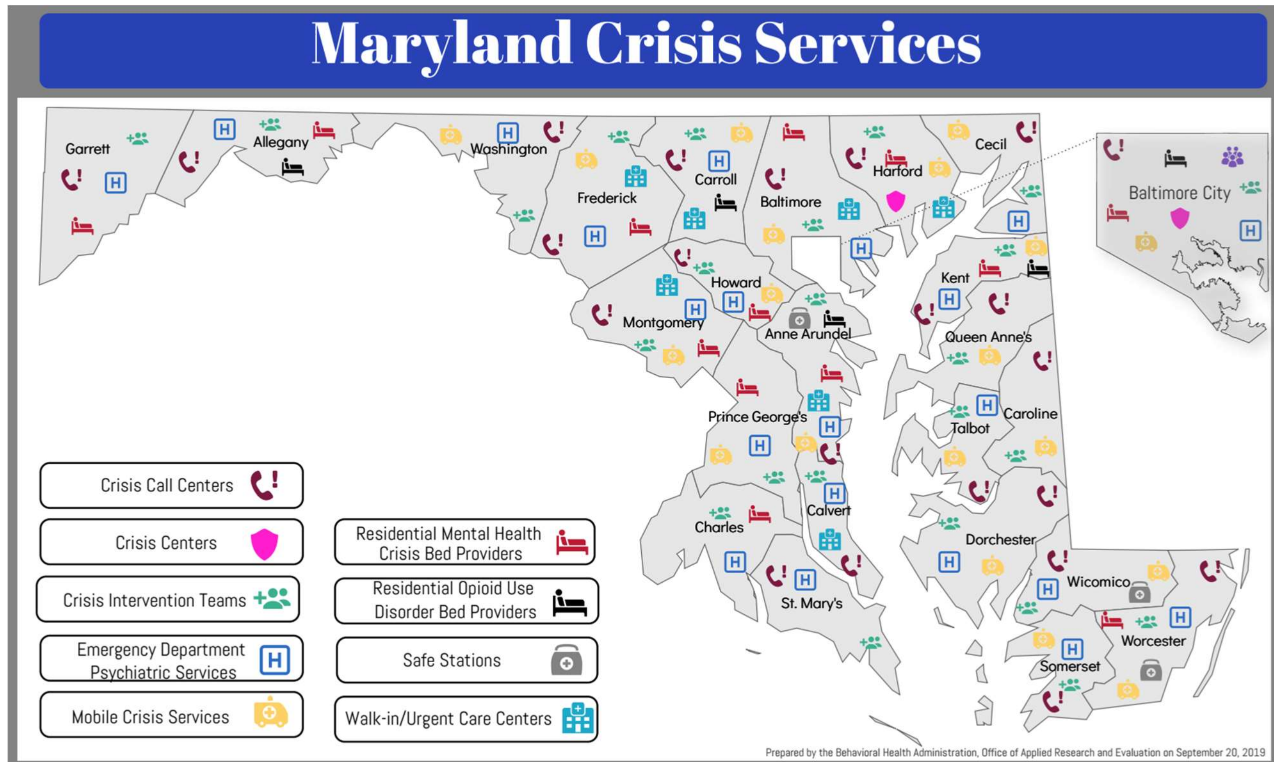
wrap-around services at the treatment center. The purpose of this program is to increase access to medical care for individuals receiving substance use disorder treatment. Participating providers receive risk-based payments based on achievements on quality metrics. This program began in 2020 and runs through 2024.

- **Treatment Gap Analysis of Substance Use Disorder Services:** In FY 21, the Opioid Operations Command Center (OOCC) and the Behavioral Health Administration in MDH (BHA), commissioned the Hilltop Institute to conduct a research study to analyze capacity and adequacy of SUDs treatment services in Maryland and conduct a gap analysis. This study includes systematic literature review and environmental scan of other state opioid control programs and will be completed in 2022. The OOCC will use the findings of the study to guide the expansion of community-based substance use programming. Expansion of these services should reduce ED utilization for behavioral health needs.
- **Annual OOCC Competitive Grants to support the Inter-Agency Opioid Coordination Plan:** The OOCC provides annual grants to state agencies, local governments (including local school systems), and community-based partners for funding for projects that align with the goals established in the state's Inter-Agency Opioid Coordination Plan and match Administration policy priorities of prevention & education, enforcement & public safety, and/or treatment & recovery. Grants support projects to increase community services for substance misuse disorders, which has the potential to reduce ED utilization. These grants are competitive.
- **Collaborative Care Model (CoCM) Pilot Program**: Maryland Medicaid has a CoCM Pilot Program in three settings that began delivering services in FY 2021 and will run through FY 2023 to support behavioral health in primary care settings. CoCM is a patient-centered, evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. Commercial carriers and Medicare cover these services.

Help People in Crisis: Strengthening the Community-Based Crisis Response System

A robust crisis response system can help prevent ED visits by providing community-based services to people in crisis. A strong crisis system can also help keep people out of the criminal justice system. Crisis services, including crisis call centers, crisis centers, crisis intervention teams, mobile crisis services, safe stations, and other related services, exist across the State.

Figure 6: Maryland's Comprehensive Crisis Services (2020)[35]



- **Crisis stabilization centers:** These centers are open 24/7 and provide screening, assessment, crisis intervention and management, brief treatment, and linkages to social services and behavioral health services. Crisis stabilization centers are located in Anne Arundel, Baltimore City, Baltimore, Frederick, Harford, Montgomery, Washington, Lower Shore Counties.
- **Crisis Observation and stabilization**: In Prince George's County, 23-hour crisis observation and stabilization services are available, which provide supervised care to deescalate the severity of the crisis and/or the need for urgent care.
- **Mobile Crisis**: Deploys a professional and a peer to deescalate a crisis and provide continuity of care and support beyond crisis exists in the following counties: Allegany, Anne Arundel, Baltimore City, Baltimore County, Calvert, Carroll, Cecil, Charles, Frederick, Garrett, Harford, Howard, Mid-Shore Region, Prince George's, Washington, Wicomico, and Worcester.
- **Urgent Care/Walk-in**: Provides intensive crisis services to individuals who otherwise would be brought to Emergency Departments. Urgent Care/Walk-in Centers Provide up to 23 hours of immediate care and linkage to community-based solutions, including same day appointments and walk-ins. BHA is using funding through the Federal Mental Health Block Grant to fund expansion of

[35] Source: BHA

these services. These services are available with varying hours of accessibility, in Baltimore, Carroll, Charles, Garrett, Harford, and Howard Counties and in the Mid-Shore Region (all nine counties on the Eastern Shore).

- **Mental Health Residential Crisis Beds**: Residential crisis beds are used to prevent or provide an alternative to a psychiatric inpatient admission. Patients generally stay in these beds for a couple of days. Residential Crisis Beds are available in: Allegany, Anne Arundel, Baltimore City, Baltimore County, Caroline, Charles, Carroll, Frederick, Garrett, Harford, Howard, Montgomery, Prince George's, and Worcester Counties.
- **State Opioid Response (SOR) Crisis Beds**: These beds are co-located within an American Society of Addiction Medicine (ASAM) licensed Residential Substance Use Treatment Program. SOR crisis beds are used to stabilize patients, conduct an assessment, start buprenorphine treatment, and provide care coordination. Peer Recovery Specialists are embedded in these facilities or work with the facilities to support patients. The funding for these beds comes from a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), which began in 2018. Before the SOR grant, the availability of SUD crisis services was limited. Locations: Allegany, Anne Arundel, Baltimore City, Mid-Shore, and Carroll Counties.
- **Safe Stations**: Safe stations are Fire and Police Stations that act as 24-hour access hubs for entry into the treatment system (similar to walk-in centers, described above). Locations: Anne Arundel, Wicomico, and Worcester Counties.
- **Crisis Intervention Teams:** Specialized police that are trained in behavioral health intervention and de-escalation to respond to behavioral health crises. These teams are funded in every jurisdiction in the state. Some jurisdictions partner to create regional programs.

MDH, OOCC, and HSCRC are actively working to increase the availability of crisis services across the State. Recently implemented and planned initiatives related to crisis services include the following:

- **Regional Partnerships:** The HSCRC has made $79.1 million available for the 5-year period between 2021 and 2024 to support three regional partnerships focused on crisis services. These programs, which reach eight counties, will expand mobile crisis units, create crisis stabilization centers, and establish care traffic control systems. The purpose of this funding is to implement evidence-based programs that assist in reducing unnecessary emergency department and hospital utilization. TRIBE, the regional partnership on the lower Eastern Shore, will open a new crisis stabilization center in January 2022, and important new resource in an underserved area of the State.
- **Hospital Diversion Program with Sheppard Pratt:** BHA is working with Sheppard Pratt to develop a 16-bed residential crisis program in Baltimore City, in a building donated by GBMC. This program will be used to divert individuals who need residential, but not inpatient hospital, level care from hospitals.

- **24-hour regional crisis centers:** Under the recently announced Master State Facilities Plan, MDH plans to open four 24-hour regional crisis centers across the state between 2022-2026. These crisis centers will provide alternatives to hospital emergency rooms for individuals in crisis. Site selection (in Western Maryland, Baltimore, Southern Maryland, and the Eastern Shore) will occur in FY 2022.
- **Outpatient Mental Health Clinic to Crisis Stabilization Facility Transformation Project**: In 2020, MDH was awarded a competitive grant from the Opioid Operational Command Center (OOCC) to implement the Outpatient Mental Health Clinic (OMHCs) to Crisis Stabilization Facility (CSF) Transformation Program. The purpose of this program is to support OMHCs in transitioning to provide the full compendium of CSF services. In Program Year One, MDH conducted research on current regulatory and payment structures for OMHCs and CSFs; the payment and regulatory levers that other states have used to create and fund CSF systems; as well as a review of crisis service providers in Maryland; with the aim of determining the challenges, as well as potential solutions, as Maryland seeks to support OMHCs expanding to provide CSF services. In Year Two, MDH is implementing a Small Grants program to provide technical and financial support for OMHCs interested in expanding to provide CSF services.
- **Medicaid Crisis-Planning Grant:** CMS awarded a Medicaid Crisis Services Planning Grant to Maryland in September 2021. This funding will be used to develop a Medicaid state plan amendment, section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services.
- **Maryland Crisis System Work Group:** The State of Maryland is working to develop a Comprehensive Crisis System that integrates public and private entities to provide 24/7 behavioral health (mental health and addiction) access, including access to hotline, crisis walk-in, mobile crisis team and stabilization services that will provide care in the most effective, least restrictive, person and family focused manner.
- **Assertive Community Treatment (ACT):** ACT provides intensive treatment provided by a multidisciplinary team. Teams are available 24/7 to assist individuals who participate in ACT services who are experiencing a mental health crisis. There are 25 teams statewide and Maryland is going to use block grant funding to expand services in Southern and Western Maryland by early 2022.

Some workgroup members noted that there are promising practices that the State might consider adopting. These include implementation of Certified Community Behavioral Health Clinics (CCBHCs), which provide a comprehensive approach to crisis services as well as ongoing support services; intensive care management for high-cost users at the community provider level, and value-based payment approaches that allow flexibility in service delivery and reward outcomes.

Help People in Emergency Departments and Hospitals

As noted above, regardless of the amount of community and crisis services available, some patients will need hospital care. Patients deserve to receive timely and appropriate care. Several new or soon to be implemented behavioral health initiatives in the State are focused on improving hospital psychiatric services availability while appropriately reducing hospital utilization (some of these programs are discussed in an earlier section of this report, on pages 5-6 above). These initiatives include the following:

- **State Health Plan for Acute Psychiatric Hospital Services:** Effective as of August 2021, the Maryland Health Care Commission updated the State Health Plan Chapter on Acute Psychiatric Hospital Services (COMAR 10.24.17). The State Health Plan is the set of regulations that govern MHCC's review of applications for certificates of need.[36] Private and State psychiatric hospitals and psychiatric units in general acute hospitals require a CON to be established, to relocate, to add beds, or to introduce programming to serve an age group that they have not been authorized to serve in the past. Changes in the regulations are intended to encourage the development of acute psychiatric beds for historically underserved groups, specifically children, adolescents, patients with mental disorders and one or more developmental disabilities, and patients with mental disorders and a secondary diagnosis of substance abuse disorder.
- **New Inpatient Hospital Facility Projects:** Health facilities in Maryland continue to invest in inpatient psychiatric hospital capacity.
    - **Luminis Health J. Kent McNew Family Medical Center:** In March of 2020, Luminis Health System opened the J. Kent McNew Family Medical Center, which provides 16 beds for adult inpatient psychiatric treatment.
    - **Doctors Community Hospital:** In September of 2021, the Maryland Health Care Commission approved a certificate of need to allow Luminis Health, Doctors Community Medical, to build a 16-bed adult inpatient behavioral health unit.
    - **Peninsula Region Medical Center:** PRMC will establish a 15-bed inpatient psychiatric unit for the treatment of children and adolescents (adjacent to the existing 13 bed adult psychiatric unit). This project is to be completed by 2023.
    - **University of Maryland Medical Center:** The University of Maryland Medical Center is adding new acute inpatient psychiatric services for adolescents (ages 13-18), as part of a project that also relocates its inpatient child psychiatry beds to new, renovated quarters in the hospital. The proposed unit will have 8 beds each for both children and adolescents and will manage them as separate populations.

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- **Nexus Montgomery Regional Partnership**: All six acute care hospitals in Montgomery County work together in a hospital-led collaborative that aims to reduce readmissions and unnecessary hospital use in the county.
- **Maryland Readmission Reduction Program:** This is a new initiative from BHA which is scheduled to start in early 2022. This program targets individuals who have serious mental illness or a co-occurring mental illness and substance use disorder and who are either high utilizers of emergency departments or who have had one psychiatric hospital admission. A team of case managers will provide 24/7 care coordination and psychosocial support to individuals over a 30-to-60-day period. The case managers will ensure warm handoff to treatment and other supportive services.
- **SBIRT in Hospitals:** SBIRT, an early intervention to help individuals with non-dependent substance use, is utilized statewide in more than 30 hospital EDs. This program connects people to services that can help prevent their substance use from becoming a reason for a future ED visit. The State has extended the contract that supports implementation, reporting, & quality improvement of the ED-based SBIRT intervention for 2 more years.
- **Local Care Teams:** For children and youth, local care teams exist to support hospitals in helping with referrals and placements for patients who are impact by long ED wait times or inpatient overstays. These teams particularly focus on patients who are involved with DHS or Developmental Disabilities Administration and older kids. Local care teams bring together all the relevant agencies and family peer navigators to help find a solution. In the Winter of 2020/2021, BHA worked closely with MHA and hospital discharge planners to ensure local care teams were used effectively to place children and youth in hospitals in more appropriate settings. BHA is currently conducting retraining with a small number of hospitals on this model. These teams work with patients regardless of their source of payment for services. Training for these teams is supported by the Maryland's Children's Cabinet.
- **Adolescent Hospital Overstay Grant Program (AHPGP):** This program is described on page 5.
- **ASO/BHA review of high utilizer/high length of stay cases:** Optum and BHA conduct a weekly review of pediatric behavioral health cases that are high utilizers of services and/or have high lengths of stay in a hospital to brainstorm solutions that directly impact the specific patient's needs.

Progress has also been made in reimbursement and payment for hospital psychiatric services.

- **Rate increase for Sheppard Pratt:** In September 2021, the HSCRC increased rates for Sheppard Pratt. This increased rate was approved for the purpose of protecting access to services by protecting the hospital's financial stability. Because Sheppard Pratt is a specialty hospital, this increase only applies to commercially-insured rates. Medicaid has traditionally followed HSCRC's set rates for Sheppard Pratt.
- **Medicaid IMD Exclusion Waiver Request:** This program is described on page 6.

Remaining Challenges

Significant work is underway to improve the care delivery system for people with behavioral health conditions in Maryland. In addition to the work described in this report, the workgroup recognizes that challenges remain. Key challenges include the following:

1. **Data Availability**: Data necessary to understand the problems identified in this report and guide solutions is not readily available. The workgroup was interested in identifying a data element to use as a baseline measure, to return to over time to measure progress. However, the workgroup was not able to identify an easily available and appropriate data measure for this purpose. Realtime data on the number of patients boarding in the ED, the length of stay of those patients, and the reason they have not been discharged to another setting would be helpful to allow the state to better manage these patients. MHA and BHA will continue to work to collect this data moving forward, to build on the 8-week study conducted in the fall of 2021. In addition, workgroup members were interested in data that is not available at this point in time, including data on community supports for behavioral health and post-discharge metrics such as care plan adherence and connection to community supports for patients who are discharged from a hospital.
2. **Sustainable funding:** Behavioral health services are funded through a mix of grant funding (from State agencies, federal agencies, and other sources), reimbursements from payers (such as Medicaid, Medicare, and Commercial insurers), and other sources. Grant funding is often short term: grants come with varying requirements and target populations. Grants may expire without a path for sustainable funding for the program or initiative in the future. For example, MDH has received recent federal funds for crisis services, but those funds are short term. Multiple State agencies are working together to try to develop an approach for sustainable funding of crisis services in the State. Other grants have been flat funded for years, while the costs of providing services and the demand for services has increased. Different payers have different benefits—Medicaid provides the broadest coverage of behavioral health services, while commercial insurance and Medicare are more limited. This means that individuals with commercial insurance or Medicare may not have access to services that are available to Medicaid enrollees.
3. **Strengthen Primary Behavioral Healthcare Model & Integration of Behavioral Health into Primary Care**: Community-based behavioral health does not have the same level of investment as primary medical care. Increasing investment in this basic level of care, which plays an important role in helping people stay stable, is important. In addition, behavioral health could be improved in primary care settings, including care management, psychiatric consultations, and evaluations to determine if patients are improving, worsening, or staying stable. Often primary care providers are in the best position to identify behavioral health issues early, provide a brief intervention, and direct

patients to the appropriate resources. MDPCP has made good progress in this area, but additional progress is needed for patients who are not reached by the MDPCP program.

4. **Legal Issues:** Legal issues can be a factor in moving a patient to an appropriate setting, particularly with children and youth under DHS supervision and individuals with legal charges (such as sex offenses, arson, or other criminal behavior). The responsible agencies, including MDH, collaborate closely to resolve these issues. Relatedly, sometimes courts order treatment services that payers do not consider medically necessary, creating a challenge for reimbursement for the services.
5. **Support to Maintain and Expand the Behavioral Health Workforce:** BHA reports that the topic of most concern raised in regional stakeholder engagement meetings is the ongoing workforce shortage, which makes it difficult to meet increasing demand for services. The workforce shortage impacts all levels of care. Low salaries and high educational requirements for some roles (and related educational debt) are a challenge to recruiting and retaining workforce. Some suggestions for addressing this problem include:
    a. **Funding**: Increasing funding for incentives for providers to help pay educational loans. Federal funding available from the U.S. Health Resources and Services Administration (HRSA) for these sorts of incentives is limited and too narrow to meet the need.
    b. **Education**: Universities should review their curriculums to ensure that students are getting up-to-date, accurate information on best practices, including medication assisted treatment for substance use disorder.
    c. **Reducing barriers to entering the workforce**: The Professional Boards should consider the impact of their decisions on the workforce as a whole, not just the providers they certify and license. For example, broad scope of practice regulations can unnecessarily prevent lower-level staff from providing care. Limitations on telehealth can also impact workforce availability. Fees and tests for certification can be barriers. For example, BHA is currently paying peers to get certification to increase the peer support workforce.

Conclusion

The Health and Government Operations Committee of the Maryland General Assembly requested that the HSCRC convene a workgroup on solutions to address long ED wait times and hospital overstays for behavioral health patients. This problem is multifaceted and complex and has existed for many years. The impact of this problem is worse on patients with complex needs and patients who are under age 18. No single intervention will solve these problems.

MDH is making progress on implementing the bed registry and referral system required by HB 1121 and the related pilot program, as well as other initiatives that should help to impact ED boarding and hospital

overstays for behavioral health patients. In addition, many State agencies, including MDH, OOCC, MHCC, and HSCRC, are actively engaged in implementing and planning projects and programs that 1) help keep people stable in the community, so they do not need acute psychiatric services; 2) increase the availability of community based services for people in crisis, which divert people from the ED to other, more appropriate, settings of care, and 3) address issues with throughput in the ED.

While much good work is being done to address the problem of ED wait times and hospital overstays for behavioral health patients, many challenges remain. These challenges include data availability, the sustainability of existing funding streams, legal issues (particularly related to children under DHS supervision), and a shortage of workforce. The State Agencies contributing to this report look forward to continuing to work with the legislature to address these challenges.

Appendix:

The following is an excerpt from the August 2021 Feasibility Study, describing the three vendor solutions described in that study.

OpenBeds

OpenBeds (part of Appriss Health) is a comprehensive behavioral health capacity management and referral technology solution. The solution provides real-time visibility of treatment provider availability, evidence-based service capacity, secure two-way digital provider communication, data aggregation and analytics, clinical decision support and crisis management. OpenBeds also provides a public facing view that allows the public to see availability and create referrals.

It is currently used or being implemented in 10 states with contracts to implement in 2 more. The core system is basically the same for all of the states. The naming conventions may vary, but the system is able to adapt to accommodate that. Customization work is identified early and can happen quickly, based on previous experiences.

The system has decision support tools and reporting built in. The provider system report is customized by the state. Most states have requested the report monthly. The system also has the ability to have a state dashboard and a public facing report. The system has the capability for single sign-on. OpenBeds is in the process of developing integration with both EPIC and Cerner, is currently connected to the HIE in New Mexico and has a customer relationship management (CRM) integration in the works as well which will allow the system to work with platforms like Salesforce and others.

Costs of the system are based on the unique number of intake sites. There is no cost for referral sites or number of state staff. Fees are all inclusive annual subscriptions that include implementation, training, ongoing updates, and reporting tools.

The average time for implementation of OpenBeds is three to six months, depending on the contracting process and pre-work to support adoption by providers.

Juvare

Juvare's EMTrack solution is capable of tracking individuals across a variety of different environments, integrates with related technologies and operates most effectively in real-time situations. The input we received from Colorado was that the funding that had been allocated for their bed registry effort in legislation was pulled due to COVID and so they were forced to use this system, which was already procured for use by a sister agency for physical health bed information, EMS, and emergency room data. The system is not designed for the purposes outlined here and based on the experience of Colorado this solution was not evaluated further.

Behavioral Health Link

Behavioral Health Link's Bed Track solution is part of its suite of Crisis Now software solutions. BHL was originally developed for the state of Georgia and has only limited implementation elsewhere. Its core product is a call center system that feeds an outpatient scheduling module, GPS enabled crisis response and a live bed registry. The entire suite is designed to be a single point of entry for a state's crisis system and for state's 988 system. Implementation is typically 90-120 days with training based on the train-the trainer model for both state staff and providers.

With the live bed registry, the state can include any type or number of providers. The system can be configured with any number of different admission criteria including prior authorizations which serve as the system gate keeper. The system interfaces with provider EMRs and cannot accommodate other types of provider inputs. Standard reports with standard core metrics are included.

Implementation cost is based on the number of providers participating. Ongoing operations and maintenance are sold as a software-as-a-service product with cost determined by the number of state residents and input gathered from a discovery call with BHL. There are three levels of technical support offered.

BHL's differentiating feature is that this is a mature product that has been developed and used in Georgia for 25 years.