

**The Maryland Department of Health's Responses to the DLS FY 2020  
Behavioral Health Administration Budget Analysis  
February 27, 2019 (House) and March 1, 2019 (Senate)**

**Policy Questions**

***MDH should comment on the timeline for this reorganization, the budgetary implications, and how this reorganization will benefit the department's response to the opioid crisis. (pg. 27)***

The Department decided to streamline and more clearly define the MDH opioid program management responsibilities in support of the Opioid Operational Command Center's (OCCC) opioid response mission. The basic objective behind this reorganization is to house harm reduction, data analysis, and prevention-type programs within the Public Health Services (PHS) and treatment and recovery programs and services with the Behavioral Health Administration (BHA). Effective February 4, 2019, the following units were re-assigned from BHA to PHS:

- The Prescription Drug Monitoring Program (PDMP)
- Substance Use Disorder Prevention
- Selected programs within the Office of Early Intervention and Wellness
- All tobacco-related projects

There is no impact to the overall MDH budget as the funds will move between the two administrations within the Department. The budgets for these programs will transition effective July 1, 2019. The estimated funds that would move between the two administrations in FY 2020 would be \$2.5 million in general funds and \$16 million in federal funds.

***The department should comment on why it elected to use different measurement techniques when evaluating the private versus the public sector; what difference, if any, exists between operational and licensed beds for private psychiatric hospitals; and its recommendation as to how to best determine and uniformly measure inpatient psychiatric capacity and demand throughout the State. (pg. 39)***

The Department used different measurement techniques based on (1) establishing a comparable analysis and (2) the availability of information.

The Joint Chairmen's Report (JCR) requested data on inpatient psychiatric bed "capacity" in the State. While licensed beds (available from the Maryland Health Care Commission) show the overall potential capacity, operational beds are capacity that can be used or that are currently in use. While the Department regularly reports on the operational capacity of state hospitals, acute care and private psychiatric hospitals regularly make internal business decisions on whether or not to operate their licensed beds. Discrepancies between licensed beds and hospital beds are either the result of temporary decisions (staffing for example) or a more permanent condition preventing operation of the bed.

Second, the Department was limited to public data as well as the data provided by the private sector. The Department requested data from the Maryland Hospital Association (MHA) and

included its response (see enclosed Report on Inpatient Psychiatric Bed Capacity, p. 10) for full transparency. Unfortunately, MHA provided data from an internal MHA study without sufficient details to evaluate the findings or to make comparisons to the BHA study results during the writing of the report. The Department could not use the insufficient MHA data in its analysis.

Either a statewide bed registry or additional data sharing between the Department and hospitals would improve the quality of operational bed capacity data and subsequent analysis to make specific recommendations regarding bed capacity across the State.

***Given the high use of leave throughout the State-run psychiatric facilities, the agency should comment on its confidence in the ability to adequately staff the facilities with its current resources and other measures being taken to reduce overtime expenditures. (pg. 41)***

The Department is working closely with facility leadership to develop strategies aimed at reducing overtime as well as ensuring adequate staffing levels within the MDH psychiatric hospital system. The Department is exploring options to increase scheduling efficiencies and augment the pool of available staff to ensure that direct care clinicians and staff are available to cover shifts when assigned staff report off work. In addition, the Department is looking at the feasibility of cross-campus staffing opportunities for direct care positions.

***BHA should comment on which of these recommendations are currently underway, what recommendations are being initiated, and what recommendations are being considered. Further, BHA should comment on the resources being committed to these recommendations, steps being taken to meet the service gaps identified, and performance measures being used to track progress in addressing service needs identified in this report. (pg. 45-46)***

BHA is implementing several strategies to address workforce shortages within the public behavioral health system. This includes the following:

- 1. Expanding telemedicine services.** Expansion of telemedicine services for the delivery of medication assisted treatment (MAT), particularly in rural areas. This is being accomplished through the establishment of partnerships with primary care. Treatment of some individuals with a substance use disorder in primary care settings is both appropriate and efficient. Several efforts are underway to integrate primary care and specialty addictions treatment providers to support patients in their varying stages of recovery. Examples include the following:
  - BHA established the Maryland Addictions Consultation Service (MACS), which is operated by the University of Maryland School of Medicine to provide expert consultation to physicians and other prescribers about buprenorphine induction and maintenance. In addition, MACS performs outreach to rural providers to encourage them to receive the credentials to prescribe buprenorphine. Through these efforts, BHA has been successful in increasing the number of prescribers of buprenorphine, which will increase the number of patients that are able to receive treatment for opioid use disorder

in office based settings. This initiative will continue to be supported with State Opioid Response (SOR) funds.

BHA proposes to expand the scope of the Maryland Addictions Consultation Service to include working intensively with prescribers to move toward initiating practice with patients with opioid use disorders and/or expanding their practice with this patient population. This will be accomplished through intensive technology transfer to include assisting providers with setting up electronic health record, billing work flows, and developing policies and procedures to work with patients with opioid use disorders. These additional elements will be funded through Federal Block Grant funds.

- Buprenorphine prescribers are linked to several rural jurisdictions to prescribe this medicine through telepsychiatry through a service being implemented by the University of Maryland School of Medicine. This has been successful in Washington, Frederick, Garrett, and Caroline Counties where patients in substance use treatment programs are being prescribed buprenorphine through physicians located at the University of Maryland downtown campus. The clinical services are reimbursable through Medicaid, and BHA has provided funds for the purchase of the telepsychiatry equipment.
- BHA has established an in-patient telemedicine program at the Thomas B. Finan Hospital Center in Cumberland, MD. This program is operated in collaboration with the University of Maryland School of Medicine. Patients receive direct psychiatric care via telemedicine. Psychiatric consultation is also provided to nursing staff on the unit to address clinical care issues and to complete treatment planning for patients. This physician extender service has assisted the hospital in addressing the shortage of psychiatrists within Western Maryland. Twenty-two patients are currently receiving psychiatric care using this technological approach to service delivery.
- Mobile van services are being expanded throughout the state. BHA contributed funding toward a mobile van that is providing telemedicine (buprenorphine prescribing) in Caroline, Talbot, and Queen Anne's counties. The van was purchased in December of 2018, equipment purchased in January 2019, and first patients were seen in February 2019.
- Expanding Telemedicine in Pediatric Primary Care: BHA has an established the Behavioral Health Integration in Pediatric Primary Care (B-HIPP ) program created in partnership with both the University of Maryland and Johns Hopkins University Bloomberg School of Public Health. See this link for details:  
<http://www.mdbhipp.org/resources.html>.

The program provides direct consultation and support to pediatricians, family practice specialists, and other pediatric primary care providers to strengthen their capacity to meet the needs of youth and families both in their own practices and through appropriate referral to specialty services in their communities. Primary care specialists also have access to training designed to assist them better meet the needs of children and families with behavioral health conditions.

In addition, the program provides a number of additional innovative components including an effort being implemented in conjunction with Salisbury State University. Through this specialized program, social work interns are placed in pediatric practices both on the Eastern Shore and in Western Maryland. This project directly supports patients by providing care coordination and direct clinical intervention. This approach both addresses current workforce shortages and provides a potential career trajectory in public sector service for future social workers. In addition, specialized telemedicine pilot projects have been established through B-HIPP in most rural areas of the State where the shortage of child psychiatrists is most acute. These pilot projects provide greatly expanded and integrated access to psychiatric care in a number of pediatric groups located in counties that do not have a practicing Child Psychiatrist.

**2. Utilizing Incentives Provided through the Federal Health Professional Shortage Area Financial Assistance program.** This opportunity is available to providers who are willing to work in Health Professional Shortage Area (HPSA) to help develop capacity. The federal government made grants available to professionals who were willing to work in HPSA areas. Health professionals had to apply directly to the federal government for these grants. Information was provided to health care professionals by BHA. Grants were not made through BHA.

**3. Encouraging collaboration with public and private providers to establish regional service delivery options.** BHA works with the Core Service Agencies (CSAs), Local Addiction Authorities (LAAs) Local Behavioral Health Authorities (LBHAs) to establish collaborations with both public and private providers to address service delivery needs. Providers are engaged in the development of the local behavioral health plans, identifying gaps and needs and coordinating care in the community and transitions from institutional and hospital-based to community-based services.

**4. Addressing the Transportation Needs of Individuals in Rural Communities.** In addition to increasing mobile and crisis support services, BHA is providing funding to support transportation to and from clinical care through the Maryland Opioid Rapid Response (MORR) grant and Substance Abuse Treatment Outcome Partnership (STOP) funds.

**Other Strategies Under Development/Consideration:**

- BHA is considering telemedicine options in all new projects including medical patient engagement and the development of a “hub and spoke” model to support individuals with substance use disorders.
- BHA is creating a statewide needs assessment survey to identify gaps and understand the needs of the treatment system regarding workforce issues.

**Performance Measures.** BHA will track the following data to determine the degree to which identified gaps in services and workforce capacity issues are addressed:

- Number of people linked to ongoing care within 7 days of discharge
- Reductions in Emergency Department visits for drug/alcohol related problems
- Increases in the number of people served in the behavioral health system
- Increases in the number of buprenorphine prescribers
- Increases in recruitment and retention as a result of the workforce development strategies implemented.

***The department should comment on the status of the interim [Hope Act] report, any substantive changes from the draft report, and progress toward meeting the December 1, 2019 deadline. (pg. 46)***

The Department will not meet the December 1, 2019 deadline of the HOPE Act, Section 5. The Department has not submitted any interim reports to date. Any materials generated regarding HOPE Act rate study were internal draft work plans to meet the requirements of the HOPE Act, which met with logistical challenges as noted below. The Department intends to submit the interim report at the earliest possible opportunity with a working alternative.

Chapter 571 (House Bill 1329, 2017), Section 5, laid out a report that:

- (1) Details outcome measures that reasonably can be collected for each treatment modality offered by community providers for which the rate of reimbursement would be adjusted under [Section 2 of the HOPE Act]; and
- (2) Includes recommendations regarding how reimbursement rates can be tied to outcomes, such as:
  - (i) different payment for implementation of, and adherence to evidence-based and promising practices;
  - (ii) differential payment based on outcomes;
  - (iii) payments made to align incentives with the goals of the State's all-payer model contract; and
  - (iv) any other financial payment system linking reimbursement to outcomes.

The Department made an initial effort to obtain cost reporting data in the summer of 2018 from various substance use disorder (SUD) providers. However, some provider groups were not prepared to handle the administrative burden of submitting cost information. As such, the Department does not have any rate data to analyze at this point.

For comparison purposes, Chapter 648 (House Bill 1238, 2014), which mandated an independent, cost-driven, rate-setting study for the Development Disabilities Administration (DDA), included specific statutory requirements for a community provider to provide their costs (under Health General Article § 7-306.3). The study was largely completed by Fall 2017 and submitted to the General Assembly on November 3, 2017. The report's rate setting recommendations are currently anticipated to be implemented in the FY 2021 DDA rates.

The scope of the study requested by the HOPE Act is larger than the report required by Chapter 648 (DDA Rate setting). As such, the Department is currently reviewing internally what type of statutory authority or language would be most useful to fulfill the intent of the HOPE Act,

Section 5 requirement and potential legislative vehicles in the 2019 Session. The Department is further determining what action items would need to be done in terms of a study budget, potential consultant, and other operational details.

### **Budget Questions**

***In order to get a better understanding of trends in SUD residential treatment, DLS recommends adding language requiring BHA to report monthly on the number of individuals relapsing or being readmitted to residential treatment, the average length of stay for individuals in SUD residential treatment, and the rate of individuals completing the treatment program by July 1, 2020. (pg. 3, 25, 47)***

The Department respectfully disagrees with the recommendation. Instead of submitting formal reports to the Joint Chairmen each month, the Department would prefer to add requested data to the MDH Virtual Data Unit that is already available for shared use with the Department Legislative Services (DLS) and the Department of Budget and Management (DBM). Additionally, the Department would like to collaborate with DLS and DBM to decide on performance measures that are available would be of value to the Department, DLS, and DBM regarding SUD residential services that can be extracted from the Public Behavioral Health System.

***Due to the uncertainty in the out-year spending, DLS recommends adding language to the budget bill that restricts the appropriations that fund behavioral health services to be used only for that purpose. (pg. 3, 25-26, 47-48)***

The Department concurs with the recommendation.

MARYLAND DEPARTMENT OF HEALTH

# Behavioral Health Administration FY 2020 Budget Presentation

Robert R. Neall, Secretary

**Barbara J. Bazron, Ph. D.**  
**Deputy Secretary, Behavioral Health Administration**

February 27 and March 1, 2019

# **BHA Core Functions**

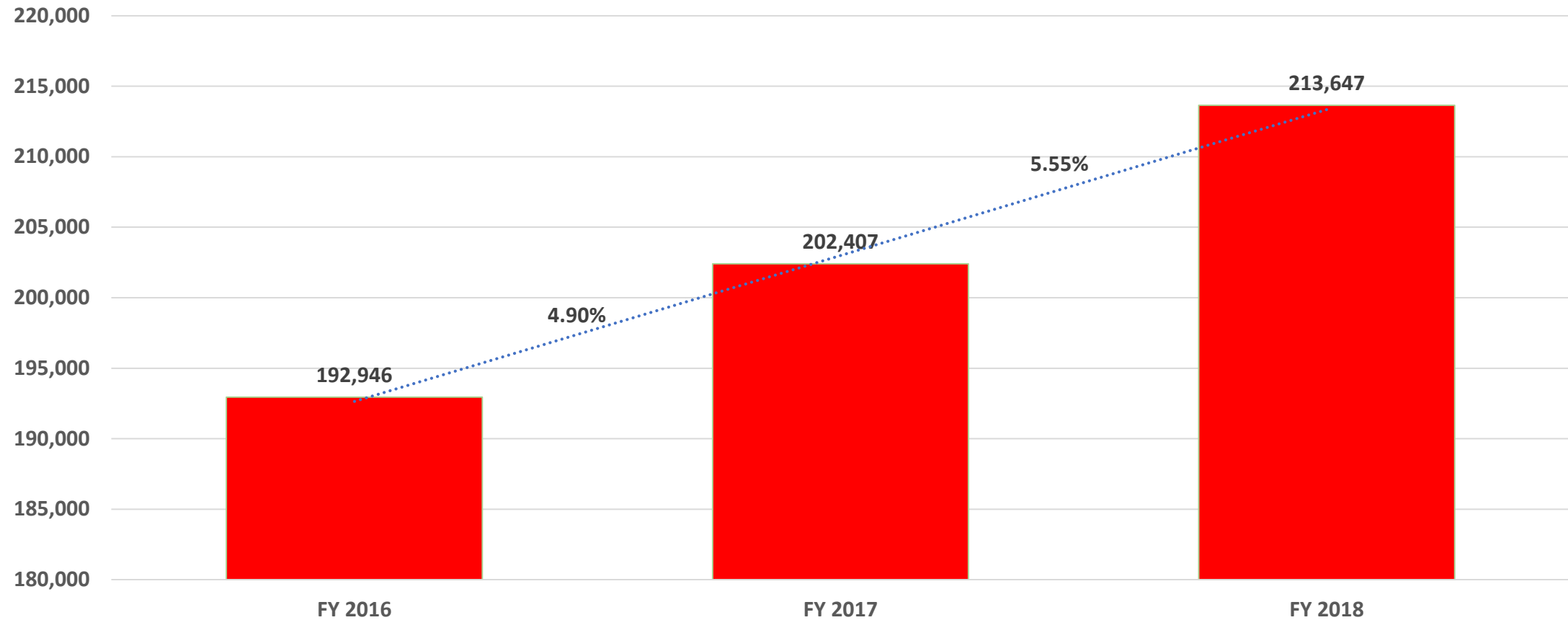
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1. Develop/manage the state system of care
2. Licensure and accreditation
3. Provider network development
4. Training and technical assistance
5. Program/service innovations
6. Evaluation and monitoring
7. Funding of Core Service Agencies (CSAs), Local Addiction Authorities (LAAs) and Local Behavioral Health Authorities (LBHAs)
8. Operate psychiatric hospitals and Regional Institutes for Children and Adolescents



# Behavioral Health Administration Overview

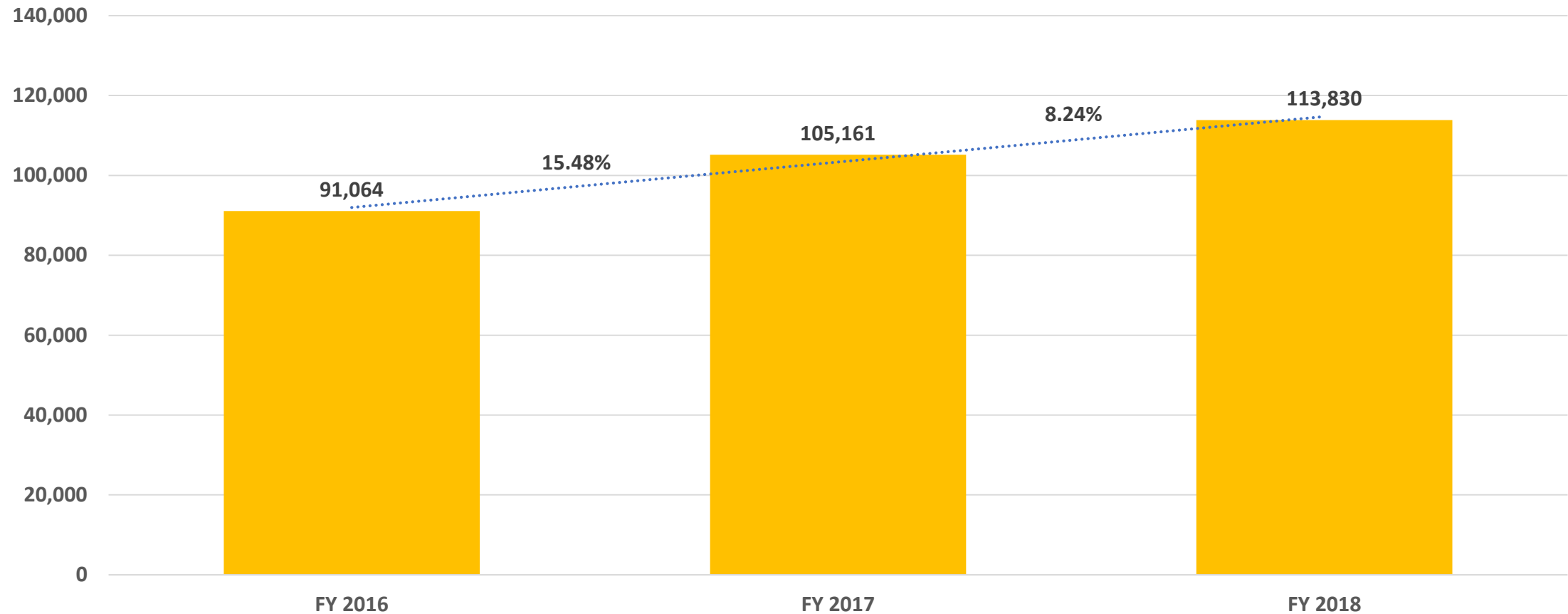
## Number of Individuals Receiving Mental Health Services by Fiscal Year



**Note:** 1. Based on claims paid through November 30, 2018  
2. FY 2018 is incomplete as providers have 12 months from service date to submit claims for payment.

# Behavioral Health Administration Overview

## Number of Individuals Receiving Substance Use Services by Fiscal Year



**Note:** 1. Based on claims paid through November 30, 2018

2. FY 2018 is incomplete as providers have 12 months from service date to submit claims for payment.

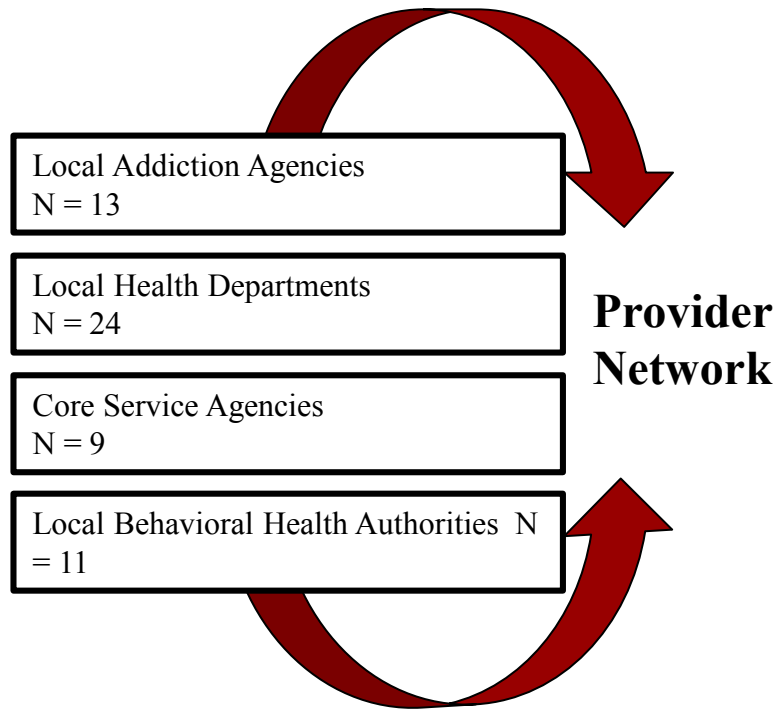
3. In FY 2017, SUD ambulatory services for the uninsured was transitioned from being grant funded to fee for service.

4. In FY 2018, SUD residential services was transitioned from being grant funded to fee for service.

# Service Delivery System

## Outpatient Service System

- 24 jurisdictions



## Inpatient Service System

- Five State Psychiatric Hospitals (adult)
- Two State Residential Treatment Center (children/adolescents)
- 47 General Acute Care Hospitals
- Two Psychiatric Institutes for Mental Disease (IMDs):
  - Brooklane
  - Sheppard Pratt

# Treatment and Recovery

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## **Mental Health**

- Inpatient Services
- Health Services
- Targeted Case Management
- Psychiatric Rehabilitation Services
- Residential Rehabilitation Services
- Residential Treatment Services (RTC's)
- Mobile Treatment
- Assertive Community Treatment
- Traumatic Brain Injury
- Respite Services
- Supported Employment
- Crisis Services
- Permanent Supported Housing
- Data Link
- Wellness and Recovery Centers

## **Substance Use Disorders**

- Recovery Housing
- Recovery Community Centers
- Residential Treatment Facilities
- Withdrawal Management
- Medication Assisted Treatment
- Adolescent Clubhouses

## **Mental Health and Substance Use Disorders**

- Individual Practitioners
- Outpatient Services
- Intensive Outpatient Services
- Partial Hospitalization
- Lab Services (behavioral health-related disorders)
- Health Homes
- Care Coordination

# Access to Crisis Services



Maryland Crisis  
Hotline



Mobile Crisis Teams  
Crisis Intervention  
Teams



Walk-In  
Centers/Safe  
Stations



Crisis Stabilization  
Center



Short Term Crisis  
Beds  
Residential Crisis  
Beds



Care Coordination  
Peer Recovery  
Support



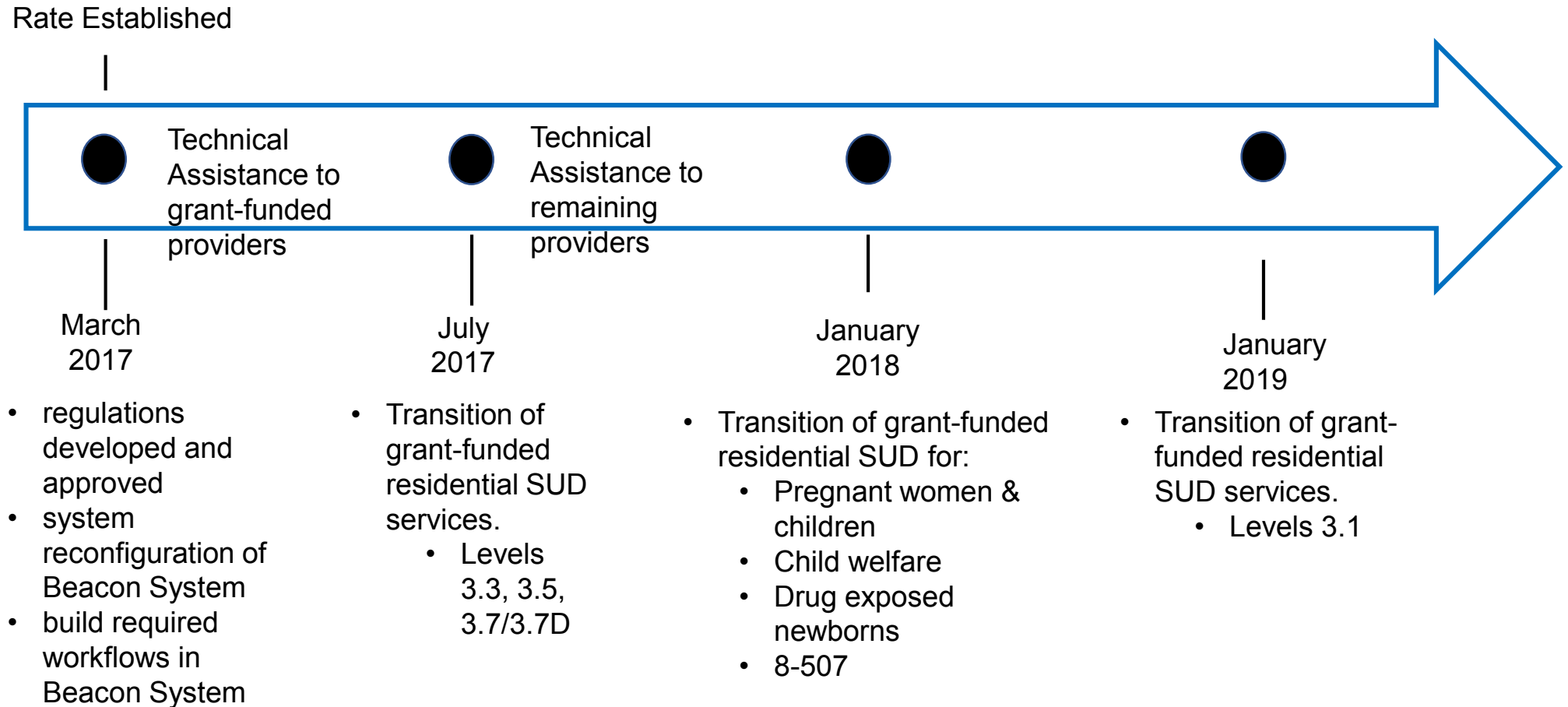
# Increasing Access: Telehealth Programs

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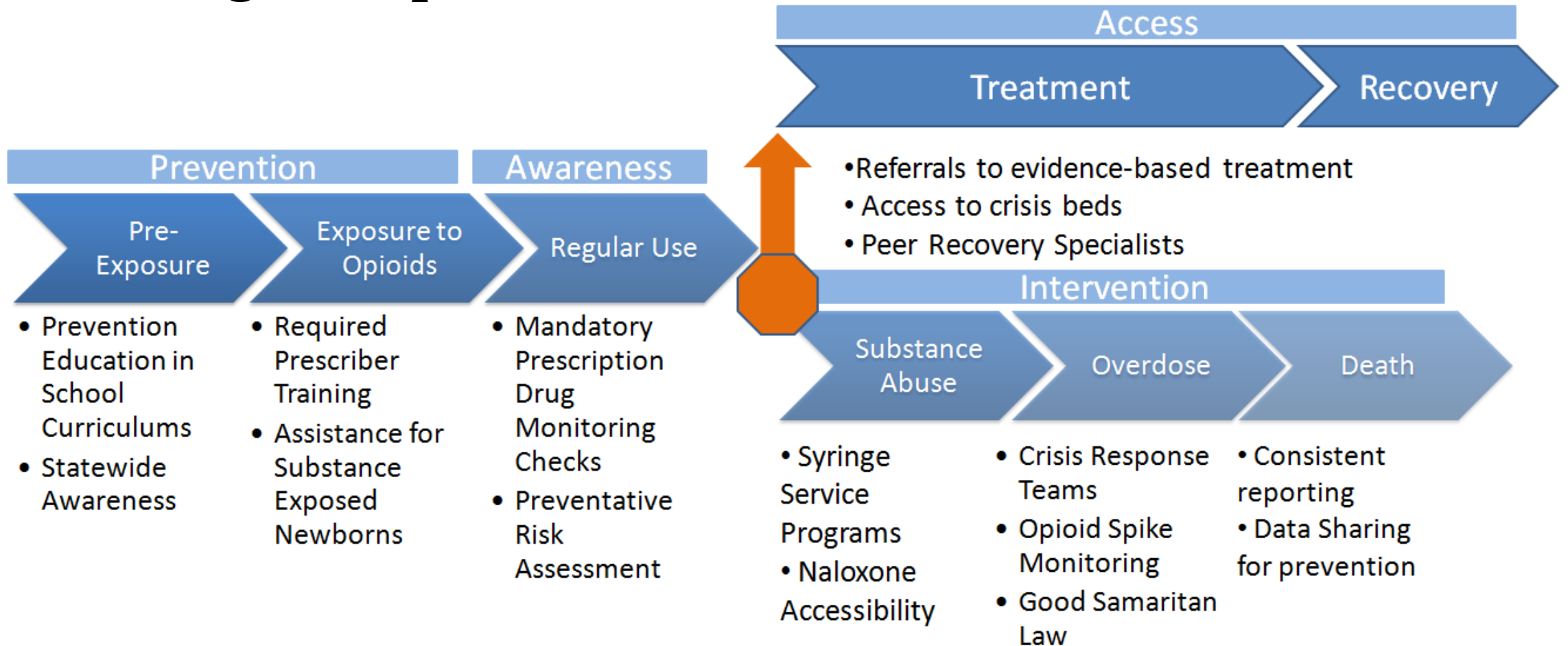
- **Behavioral Health Integration in Pediatric Primary Care** provides consultation to children with mental health issues and their families.
- **Tele-health Program at Finan Center:** In-patient psychiatric care provided by University of MD psychiatrist.
- **Mobile Van** offers buprenorphine prescribing via tele-medicine.
- **Maryland Addictions Consultation Service (MACS)** provides consultation to physicians and other prescribers about buprenorphine induction and maintenance.



# Increasing Access: Moving Substance Use Disorder Services to Medicaid Fee-for-Service



# Addressing the Opioid Crisis

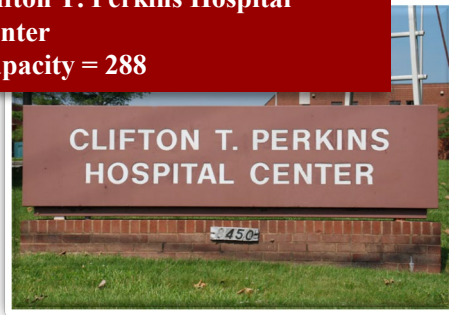




# State Psychiatric Hospitals

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**Clifton T. Perkins Hospital  
Center**  
Capacity = 288



**Springfield Hospital Center**  
Capacity = 220



**Thomas B. Finan Center**  
Capacity = 66



**Eastern Shore Hospital Center**  
Capacity = 80



**Spring Grove Hospital Center**  
Capacity = 347



# Court-Ordered Placement

## Centralized Admissions Office Mission

The Maryland Department of Health (MDH) has created a Centralized Admissions Office that will process all court orders that commit patients to MDH for evaluation or treatment services for substance use disorders or mental health issues.

The Centralized Admissions Office will serve as the single point of contact for submitting all court orders to MDH and making any inquiries on such orders. Send all court orders by e-mail or fax.

## CONTACT INFORMATION

Centralized Admissions Office Main Number: 410-402-8422

E-mail: [mdh.admissions@maryland.gov](mailto:mdh.admissions@maryland.gov)

Fax: 443-681-1035

## Questions:

Michele Fleming, LCSW-C

Director, Central Admissions Office: 410-916- 1215 (cell)



- Centralized MDH forensic services
- Decreased wait time for hospital placement. 8 days for Title 3 and 10 days for 8-507 SUD placements
- Increased bed capacity by 95 beds
- Increased provider capacity (704 MH, 507 SUD, and 253 Co-occurring programs)
- Expanded availability of crisis services
- Increased education to reduce stigma through the *Anti-Stigma Campaign* implemented beginning in 2017.



# Accessing Behavioral Health Services

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- <https://www.mdcrisisconnect.org/>
  - Click the button for mental health services or substance use services.
  - The **SUD button** takes you to the **BeforeItsTooLate** website <http://beforeitstoolate.maryland.gov/> where you can click on the button "For Family and Love Ones" or "For Yourself".
  - Go to Find Treatment search engine, which links you to the **SAMHSA Treatment Locator**. If you enter your zip code or address a list of specific treatment programs, by type appear.
    - The MH button takes you to a list of services such as crisis counseling, grief counseling.
- **211-Press 1.** Individuals can also be connected to services by calling the line, using the chat or text features. *This database resides on the "211" platform.* <https://211md.org/>
- <http://maryland.networkofcare.org> This site has a treatment locator for MH, SUD and Veterans' services.
- **Beacon: Administrative Service Organization:** A toll-free number for assistance or to answer questions 24 hours a day, 7 days a week. **Call 1-800-888-1965.**



# MARYLAND Department of Health

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

December 10, 2018

Hon. Edward J. Kasmeyer, Chair  
Senate Budget and Taxation Committee  
3 West Miller Senate Office Building  
Annapolis, MD 21401

Hon. Maggie McIntosh, Chair  
House Appropriations Committee  
121 House Office Building  
Annapolis, MD 21401

**Re: Joint Chairmen's Report, p. 84—Inpatient Psychiatric Bed Capacity**

Dear Chairs Kasmeyer and McIntosh:

Pursuant to the Joint Chairmen's Report, p. 84, the Maryland Department of Health respectfully submits the attached report on behalf of the Behavioral Health Administration detailing inpatient psychiatric bed capacity in Maryland.

If you have any questions regarding this report, please contact Webster Ye, Deputy Chief of Staff, at (410) 767-6480 or [webster.ye@maryland.gov](mailto:webster.ye@maryland.gov).

Sincerely,

Robert R. Neall  
Secretary

## **Report on Inpatient Psychiatric Bed Capacity**

Submitted by the Maryland Department of Health  
December 10, 2018

2018 Joint Chairmen's Report (p. 84)

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## **I. Executive Summary**

As evidenced in the data contained herein, psychiatric bed capacity has remained relatively stable between FY13 and FY17 in state and private hospital sectors, while there was a modest increase in psychiatric bed capacity in the acute care hospital sector of approximately 5% over this period. Bed occupancy rates varied considerably across the sectors with the state facilities operating at near 100% occupancy, while the average bed occupancy in acute general and private psychiatric hospitals was considerably lower at 61% and 69% respectively.

## **II. Introduction**

The fiscal 2019 budget includes additional funding to expand capacity at the state-run psychiatric facilities as well as both of the Regional Institutes for Children and Adolescents (RICAs). According to p. 84 of the 2018 Joint Chairmen's Report, the committees remain concerned about the adequacy of inpatient psychiatric bed capacity for both adults as well as children and youth across all sectors (state-run, private hospitals, and acute general hospitals) as well as for both civil and forensic admissions.

As a result, the 2018 Joint Chairmen's Report requests that the Behavioral Health Administration (BHA) submit a report on inpatient psychiatric bed capacity in both private and public facilities across Maryland and provide recommendations on the appropriate inpatient psychiatric bed capacity by sector.

## **III. Data**

The Joint Chairmen's Report specifically requests details on the (A) extent of current inpatient psychiatric bed capacity in Maryland and the changes to that capacity by sector since January 1, 2013, and (B) demand for inpatient psychiatric beds in each sector including historical data since January 1, 2013. This report compiles data from a number of sources, including the State Hospital Management Information System (HMIS), Maryland Health Care Commission (MHCC), and Health Services Cost Review Commission (HSCRC) hospital inpatient data. As of the writing of this report, the most recent complete data relating to both inpatient bed capacity and utilization of psychiatric inpatient services is FY17.

To calculate bed capacity, this report references "licensed beds" and "operational beds." For the purpose of this report, "licensed beds" are beds in a facility that are licensed and *capable of being staffed*. Licensed beds most accurately reflect the capacity at private and acute care hospitals because the facility has direct control over its ratio of beds licensed, the number of employees it hires, and where the employees work. Therefore, in a private or acute care hospital, a licensed bed without staff can become staffed through the autonomy of the facility and best reflects its true capacity.

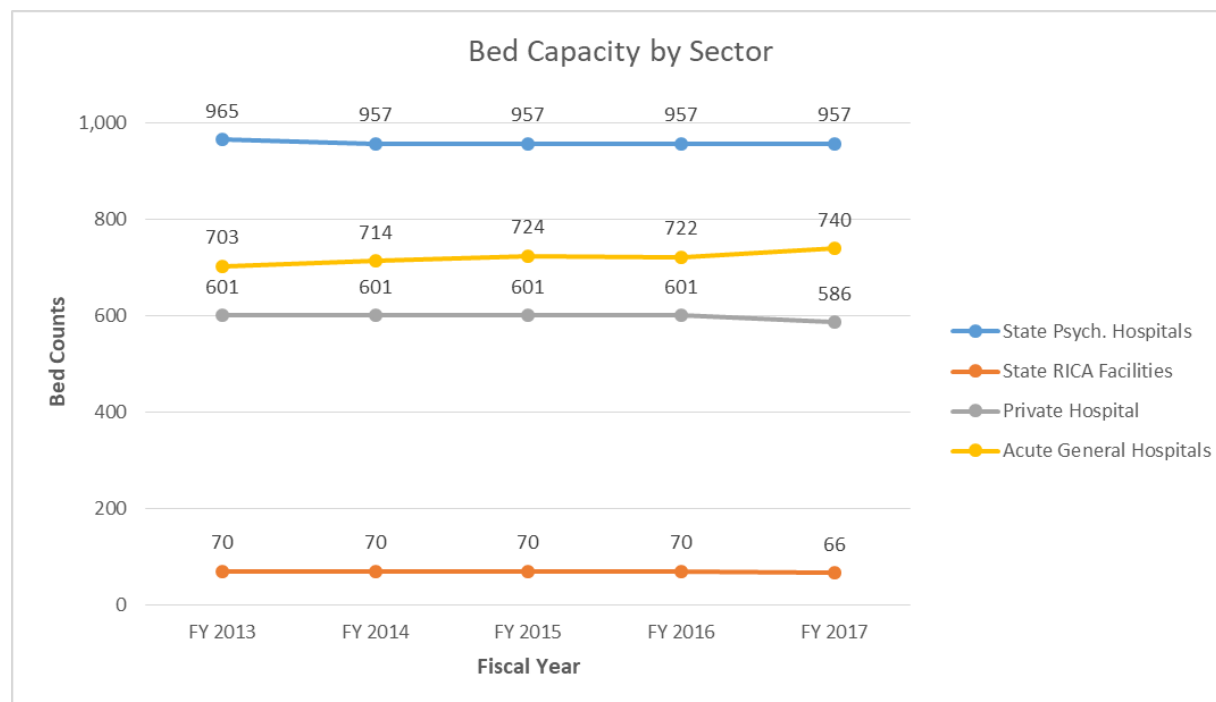
"Operational beds" are beds in a facility that are licensed and *are staffed*. The bed capacity of a state hospital is most accurately reflected by beds that are staffed because the facility does not have independent authority over staff hiring and placement. For example, a state hospital may have beds licensed in a building that is not operational, which means the beds cannot be staffed.



Therefore, in a state facility, a licensed bed without staff is not operational and cannot reflect true capacity.

### A. Inpatient Psychiatric Bed Capacity

Figure 1: Psychiatric Facilities Bed Capacity by Sector, FY13 to FY17



**Source:** Maryland Health Care Commission (MHCC), State Hospital Management Information System (HMIS).

**Note:** Bed counts for the state Psychiatric facilities include the two RICAs and reflect the operational bed capacity. The licensed bed capacity is displayed for Acute Care Hospitals and Private Psychiatric facilities. Adventist Behavioral Health Eastern Shore temporarily delicensed their 15 beds in 2016.

Figure 1 displays the number of psychiatric beds by facility type (*i.e.*, sector) between FY13 and FY17. In FY17, statewide, there were a total of 39 hospitals that provided psychiatric inpatient treatment services, of which 29 were acute care hospitals, five private psychiatric facilities, and five state psychiatric hospitals. In addition to the five state-run psychiatric hospitals, the State also operates two RICAs, which has a combined bed capacity of 66 in FY17. Of the 39 acute, private-IMD, and public inpatient facilities, 13 provided inpatient psychiatric services to children, adolescents, and adults and the remaining 26 provided inpatient services to adults only. Combined, these facilities (acute, private, and state) had a total bed capacity of 2,349 beds in FY17. Overall bed capacity increased from 2,339 in FY13 to 2,349 in FY17, representing a 10-bed increase in bed capacity across all sectors. The state facilities account for the largest proportion (43.5%) of bed capacity in FY17 while the acute care hospitals and private psychiatric hospitals account for 31.5% and 26% of bed capacity, respectively.

As shown in Figure 1, the operational bed capacity in the state-operated hospitals remained relatively stable since FY13, decreasing by a total of eight beds over this period, while State RICA facilities decreased by four beds. The bed capacity in acute care hospitals increased from 703 in



FY13 to 740 in FY17, reflecting a 5.3% increase. Over the same period, the private psychiatric hospitals had a 2.5% (15 bed) decrease from 601 in FY13 to 586 in FY17. According to the MHCC, this decrease is largely due to the temporary delicensing of 15 beds at Adventist Behavioral Health – Eastern Shore in 2016, which were later reinstituted in FY18.

### **State Psychiatric Facilities**

As shown in Figure 1, in FY17, operational bed capacity across the state psychiatric hospitals was 957, while the two RICAs accounted for a total an additional 66 beds. The number of operational beds varied substantially across the State hospitals from a low of 60 beds at Eastern Shore Hospital to 355 at Spring Grove Hospital. (See Appendix A, Table 3).

### **Acute Care Hospitals<sup>1</sup>**

A total of 29 acute care hospitals provided psychiatric treatment services across the state. As of FY17, the licensed bed capacity ranged from 6 beds (Holy Cross Germantown Hospital) to 108 beds (Johns Hopkins Hospital). See Appendix A, Table 4. Between FY13 and FY17, total bed capacity in acute care hospitals increased from 703 to 740, representing a 5.3% (37 bed) increase from FY13. This increase in bed capacity was largely driven by an increases in psychiatric beds at MedStar Franklin Square Hospital and Northwestern Hospital with both adding 16 beds since FY13. See Appendix A, Table 4.

In acute care hospitals, “licensed beds” were used in this report rather than “operational beds” in order to assess the potential capacity available at each hospital, even if all the licensed beds are not being utilized given current staffing resources. In FY17, licensed and operational bed counts for acute care hospitals did not differ substantially. In 19 out of 29 acute care hospitals, licensed and operational beds counts were either the same or operational beds were higher. Across all hospitals, there were a total of 53 more licensed beds compared to operational beds. It is recognized that using licensed beds will marginally inflate the bed capacity that is available at each of these facilities.

### **Private Hospitals**

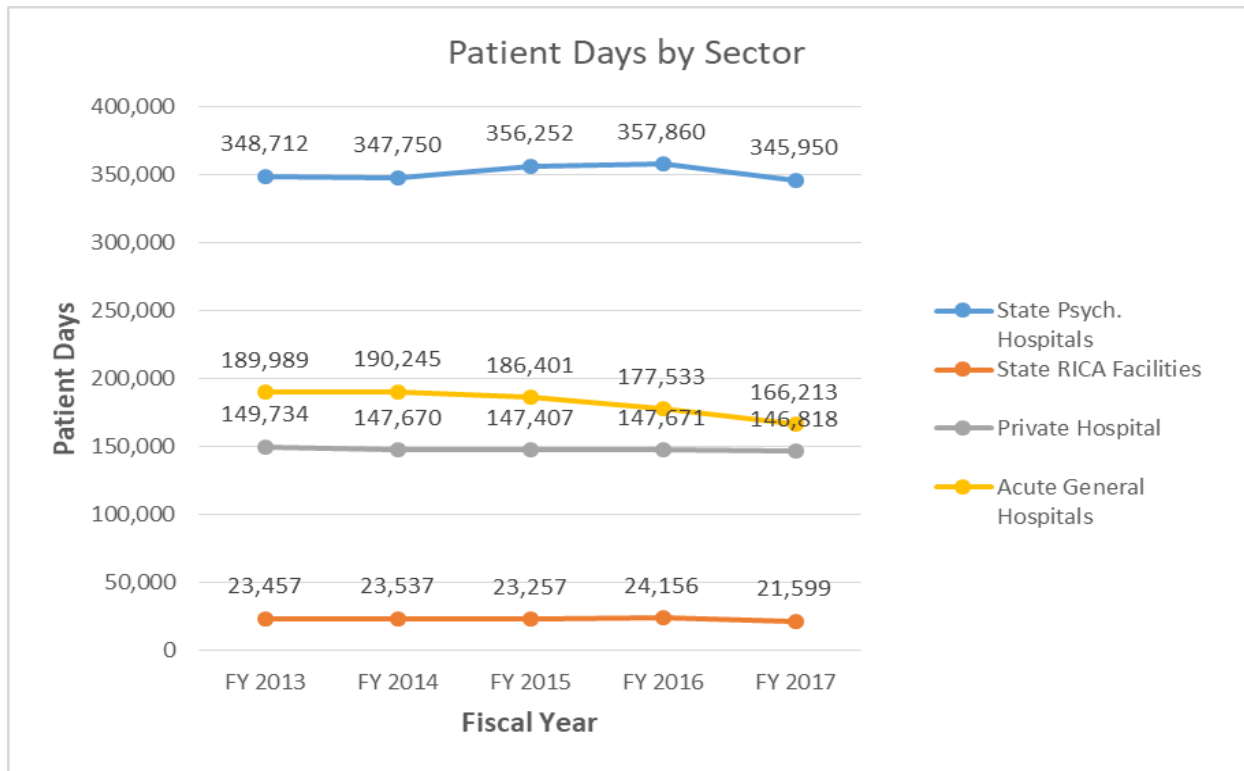
Statewide, the five private psychiatric specialty hospitals had a combined licensed bed capacity of 586 beds in FY17. Between FY13 and FY17, the number of beds declined from 601 to 586, representing a 2.5% (15 beds) decline over the time period. This decrease is a result of Adventist Behavioral Health-Eastern Shore delicensing 15 beds in 2016. In FY17, the bed capacity in the four remaining facilities ranged from 65 at Brooklane Health Services to 322 at Sheppard Pratt Hospital. See Appendix A, Table 2.

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<sup>1</sup> The Joint Chairmen’s report instructs BHA to consult with appropriate stakeholders, which are local community hospitals. Therefore, on August 7, 2018, the Deputy Secretary of Behavioral Health met with the Maryland Hospital Association to illicit input from key stakeholders on data collected for this report on acute general hospital psychiatric capacity and utilization. See Appendix A, Table 4. The Maryland Hospital Association submitted a letter on September 5, 2018. See Appendix B.

## B. Demand for Inpatient Psychiatric Bed Utilization

Figure 2: Total Psychiatric Patient Days by Sector



Source: Health Service Cost Review Commission (HSCRC) Inpatient data; HMIS

In FY17, a total of 680,580 psychiatric patient days were used across all sectors. As shown in Figure 2, the state hospitals had substantially higher numbers of patient days compared to private psychiatric and acute general hospitals, which is largely driven by fewer discharges and longer average length of stays. In FY17, average lengths of stay for the state hospitals were 199 days and 149 days for the RICA facilities compared to 6 and 11 days for the acute general hospitals and private psychiatric hospitals respectively. See Appendix A, Table 1.

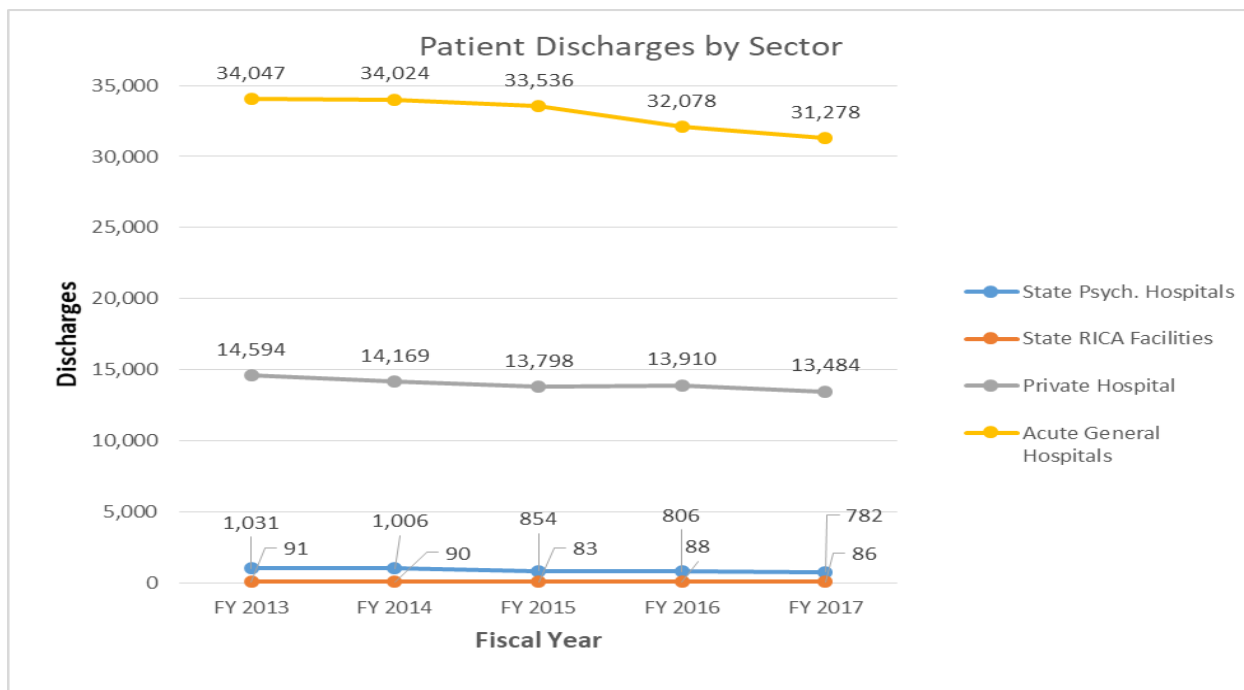
As shown in Appendix A, occupancy rates in FY17 varied across sectors and hospitals, with state hospitals and RICA Facilities maintaining almost 100% occupancy rates. Comparatively, acute general hospitals and private hospitals had average occupancy rates of 61% and 69% respectively. The average occupancy rate across all hospital sectors was 79%.

As shown in Figure 2, the number of psychiatric patient days remained relatively stable for State Psychiatric Facilities and Private Psychiatric Hospitals between FY13 to FY17, while showing a steady decline in acute care hospitals from 189,989 to 166,213 over the same period. A study on bed demand in acute care hospitals, conducted by the Maryland Hospital Association (MHA), estimated that the 29 acute care hospitals provided approximately 245,000 inpatient days, reflecting nearly 80,000 more inpatient days than reported in this analysis. See Appendix B. MHA's counts of patient days are based on patients with a primary behavioral health diagnosis admitted to acute care hospitals licensed to provide psychiatric care. This approach will likely

overestimate the actual patient days since some individuals may be assigned a primary behavioral health diagnosis but not receive behavioral health treatment services. In the current report, psychiatric patient days were obtained from the HSCRC inpatient files and included all patients who were reported by the hospitals to have had one or more days of psychiatric care over a given fiscal year.

Given that the current methodology likely excludes some patients that receive psychiatric care while being treated in emergency rooms or while receiving care on non-psychiatric medical units within these hospitals, the patient days provided in this report likely represent a conservative estimate of the actual demand for psychiatric services within acute care hospitals.

Figure 3: Discharges from Psychiatric Services by Sector, FY13 to FY17



Source: HSCRC Inpatient data; HMIS

Figure 3 displays psychiatric patient discharges by hospital type (i.e., sector) between FY13 and FY17. As shown in Figure 3, the overall volume of psychiatric patients seen in the acute care hospitals was substantially higher compared to private psychiatric hospitals and state facilities. These higher discharge rates are largely a result of lower average length of stay in these facilities compared to hospitals in other sectors.

The average length of stays for the acute care hospitals was five days in FY17 compared to 11 days in private psychiatric hospitals, 199 days in state hospitals and 149 days in state RICA facilities. See Appendix A. The lower number of discharges and high average length of stays in the state hospitals is attributable to high numbers of court-ordered and forensic patients. As shown in Figure 3, the number of psychiatric discharges declined in each sector between FY13 and FY17. While the acute care hospitals and private psychiatric facilities exhibited similar declines of approximately 8%, discharges at the state facilities declined by 23% since FY13.

## **Recommendations**

As mentioned, the 2018 Joint Chairmen's Report requests recommendations on the appropriate amount of inpatient psychiatric bed capacity by sector. Based on the discussions surrounding the appropriate accounting method for bed capacity and occupancy rate in the acute care hospital and private psychiatric hospitals, the Department must first determine whether existing bed capacity is consistently availability and utilized before making further recommendations. The Department is currently considering additional paths forward to improve bed capacity information and how those beds might be utilized as part of Maryland's overall behavioral health system.

## APPENDIX A

### Hospital Capacity and Utilization Detail Tables

Table 1: Statewide Sector Capacity and Utilization

	Total Number of Psych. Discharges		Total Psych. Day		Avg. Length of Stay		Beds		Occupancy Rate	
	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17
Acute General Hospitals	34,047	31,278	189,989	166,213	5	6	703	740	74%	61%
Private Psychiatric Hospitals	14,594	13,484	149,734	146,818	10	11	601	586	68%	69%
State Psychiatric Facilities	1,122	868	372,169	367,549	184	195	1,035	1,023	99%	99%
<b>GRAND TOTAL</b>	<b>49,763</b>	<b>45,630</b>	<b>711,892</b>	<b>680,580</b>	<b>14</b>	<b>15</b>	<b>2,331</b>	<b>2,349</b>	<b>84%</b>	<b>79%</b>

Source: HSCRC, HMIS, and MHCC.

Table 2: Private Psychiatric Hospital Capacity and Utilization

	Total Number of Psych. Discharges		Total Psych. Day		Avg. Length of Stay		Beds		Occupancy Rate	
	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17
Sheppard & Enoch Pratt Hospital - Ellicott	2,854	2,624	20,682	22,523	7	9	92	92	62%	67%
Sheppard & Enoch Pratt Hospital - Towson	6,878	6,015	83,006	81,811	12	14	322	322	71%	70%
Brook Lane	1,761	1,237	12,966	10,312	7	8	65	65	55%	43%
Adventist Behavioral Health - Eastern Shore*	335	101	2,976	963	9	10	15	0	54%	
Adventist Behavioral Health - Mont Co	2,766	3,507	30,104	31,209	11	9	107	107	77%	80%
<b>GRAND TOTAL</b>	<b>14,594</b>	<b>13,484</b>	<b>149,734</b>	<b>146,818</b>	<b>10</b>	<b>11</b>	<b>601</b>	<b>586</b>	<b>68%</b>	<b>69%</b>

Source: HSCRC, MHCC.

Notes: \*Adventist Behavioral Eastern Shore temporary delicensed their 15 beds in 2016, which affected the occupancy rate.

Table 3: State Psychiatric Facility Capacity and Utilization

	Total Number of Psych. Discharges		Total Psych. Day		Avg. Length of Stay		Beds		Occupancy Rate	
	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17
Clifton T. Perkins	93	91	87,360	92,027	364	264	238	248	100%	102%
Eastern Shore	68	52	21,458	22,305	172	196	60	60	98%	102%
Spring Grove	477	292	130,227	128,414	159	158	366	355	97%	99%
Springfield	316	284	85,010	79,612	156	199	235	228	99%	96%
Thomas B. Finan	77	63	24,657	23,592	169	180	66	66	102%	98%
RICA - Baltimore	49	42	12,900	10,956	157	154	38	34	93%	88%
RICA - Montgomery	42	44	10,557	10,643	153	144	32	32	90%	91%
<b>GRAND TOTAL</b>	<b>1,122</b>	<b>868</b>	<b>372,169</b>	<b>367,549</b>	<b>184</b>	<b>195</b>	<b>1,035</b>	<b>1,023</b>	<b>98%</b>	<b>98%</b>

**Source:** MHCC, HMIS.

**Notes:** Discharges reflect all discharges within each fiscal year. The average length of stay is based on those patient days used within each fiscal year divided by the total number of individuals served in the year.

Table 4: Acute General Hospital Psychiatric Capacity and Utilization<sup>2</sup>

	Total Number of Psych. Discharges		Total Psych. Day		Avg. Length of Stay		Beds		Occupancy Rate	
	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17	FY13	FY17
Bon Secours Hospital	1,690	1,287	8,864	6,798	5	5	32	24	76%	78%
Calvert Health Medical Center	674	581	3,076	2,756	5	5	11	9	77%	84%
Carroll Hospital Center	1,312	857	4,603	3,855	3	5	20	20	63%	53%
Frederick Memorial Hospital	1,072	1,001	6,818	6,158	6	6	21	21	89%	80%
Holy Cross Hospital-Germantown <sup>±</sup>		393		1,557		4		6		71%
Howard County General Hospital	1,026	847	5,405	5,328	5	6	20	20	74%	73%
Johns Hopkins Bayview Medical Center	887	700	6,133	6,345	7	9	20	20	84%	87%
Johns Hopkins Hospital	2,801	2,554	32,863	32,005	12	13	108	108	83%	81%
MedStar Franklin Square	1,239	2,200	6,150	916	5	5	24	40	70%	6%
MedStar Montgomery Medical Center	1,437	1,109	4,744	-	4	4	25	20	52%	
MedStar Southern Maryland Hospital Center	1,024	1,346	4,280	-	4	5	25	25	47%	
MedStar St. Mary's Hospital	558	821	2,139	-	4	4	12	12	49%	
MedStar Union Memorial Hospital	1,971	536	7,755	1,946	4	6	26	26	82%	21%
Meritus Medical Center	1,028	1,146	4,575	5,275	4	5	18	18	70%	80%
Northwest Hospital Center	941	1,366	5,746	9,518	6	7	14	30	112%	87%
Peninsula Regional Medical Center	846	725	3,704	3,805	4	5	10	12	101%	87%
Sinai Hospital	1,327	1,170	8,055	7,375	6	6	24	24	92%	84%
Suburban Hospital	1,401	1,224	6,889	7,194	5	6	24	24	79%	82%
UM-Baltimore Washington Medical Center	986	924	5,276	4,795	5	5	14	14	103%	94%
UM-Harford Memorial Hospital	1,384	1,235	7,083	7,349	5	6	27	26	72%	77%
UM-Laurel Regional Hospital	812	770	3,512	3,608	4	5	14	18	69%	55%
UMMC Midtown Campus	1,498	1,047	9,281	7,924	6	8	28	28	91%	78%
UM-Prince George's Hospital Center	1,369	1,139	7,398	7,782	5	7	28	28	72%	76%
UM-Shore Regional Health at Dorchester	683	580	-	-	5	7	16	24		
UM-St. Joseph Medical Center	712	820	5,449	5,862	8	7	19	19	79%	85%
Union Hospital of Cecil County	734	510	-	2,411	3	5	7	11		60%
University of Maryland Medical Center	1,694	1,116	15,359	12,857	9	12	56	56	75%	63%
Washington Adventist Hospital	1,738	1,475	9,752	7,965	6	5	40	39	67%	56%
Western Maryland Regional Medical Center	1,203	1,059	5,080	4,829	4	5	20	19	70%	70%
<b>GRAND TOTAL</b>	<b>34,047</b>	<b>30,538</b>	<b>189,989</b>	<b>166,213</b>	<b>6</b>	<b>5</b>	<b>703</b>	<b>740</b>	<b>74%</b>	<b>61%</b>

Source: HSCRC, MHCC.

± Holy Cross Hospital – Germantown did not report data for FY2013.

<sup>2</sup> BHA shared this table with the Maryland Hospital Association for consultation. The Maryland Hospital Association submitted a letter in response. See Appendix B.

## APPENDIX B

### Maryland Hospital Association Letter



Maryland  
Hospital Association

September 5, 2018

Barbara Bazron, PhD  
Deputy Secretary, Behavioral Health Administration  
Maryland Department of Health  
201 West Preston Street  
Baltimore, Maryland 21201

Dear Dr. Bazron,

On behalf of the 63 hospital and health system members of the Maryland Hospital Association, I appreciate the opportunity to provide input on inpatient psychiatric bed capacity, as required by the 2018 Joint Chairmen's Report.

The Behavioral Health Administration's analysis of Acute General Hospital Psychiatric Capacity and Utilization (attached), is limited in its ability to truly capture Maryland's behavioral health treatment capacity and demand. The analysis, which draws on Maryland Health Care Commission and Health Services Cost Review Commission data, calculates occupancy based on *licensed* beds, a method that overstates actual capacity. Any analysis of inpatient psychiatric occupancy should instead use the number of *staffed* beds available to each facility. Staffed beds, defined by the Maryland Health Care Commission, are "the number of beds regularly maintained (set up and staffed for use) for inpatients." Numerous hospitals are unable to treat patients due to staffing shortages, patient characteristics, and other factors that are unrelated to the raw number of licensed beds.

In addition, to fully measure the state's demand for treatment, any analysis must capture more than just inpatient psychiatric services, as a significant portion of treatment is now conducted in other inpatient units and outpatient settings.

MHA has conducted an internal analysis to measure demand for inpatient behavioral health services in the 29 Maryland hospitals licensed to provide inpatient psychiatric services in fiscal 2017. Claims data were used to identify patients with a behavioral health primary diagnosis, including those with substance use disorders. Through this analysis, MHA estimates that these 29 hospitals provided approximately 80,000 more inpatient days of care, bringing the total to approximately 245,000. Please note that this analysis covers all units for the 29 hospitals with inpatient psychiatric services; however, because the analysis excludes hospitals without psychiatric units that may be treating behavioral health patients admitted to the hospital through the emergency department, we believe it is still conservative.

Currently, MHA is completing a study to identify the primary factors for discharge delays in inpatient psychiatric units, to better understand the behavioral health needs of Maryland's communities. We would be happy to share a preview of these findings.

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6820 Deerpath Road, Elkridge, MD 21075 • 410-379-6200 • [www.mhaonline.org](http://www.mhaonline.org)

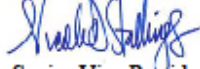


Dr. Barbara Bazron  
September 5, 2018  
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Thank you again for the opportunity to provide feedback. I look forward to continuing to work together on this important issue.

Sincerely,

Nicole Stallings



Senior Vice President, Government Affairs