MARYLAND PSYCHIATRIC SOCIETY

March 27, 2023

Jourdan Green, Director
Office of Regulation and Policy Coordination
Maryland Department of Health

Via email to mdh.regs@maryland.gov

RE: Proposed Regulations:
Subtitle 63 Community-Based Behavioral Health Programs and Services, and
Subtitle 09 MEDICAL CARE PROGRAMS *10.09.16 Behavioral Health Crisis Services*

The Maryland Psychiatric Society (MPS) is the state medical organization whose 800 physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. We appreciate the opportunity to provide feedback on the above regulations proposed in the February 24, 2023 *Maryland Register*. We support the addition of crisis services to the continuum of care available in our state and the funding that is essential to their success. We hope these new services will help meet the need for additional urgent outpatient care so that behavioral health problems are addressed sooner and do not escalate to the level of acute care (with associated wait times for beds) and incarceration. We support the concerns submitted by the Fund MD988 Campaign. Please also consider the following:

(11) The program shall make documented attempts to contact and follow-up with all individuals who initially presented, or were later evaluated, as a danger to self or others within 72 hours after discharge. **We recommend a follow-up within 48 hours.**

.21 Behavioral Health Crisis Stabilization Center Program (BHCSC).
Initial evaluations by the psychiatrist or psychiatric nurse practitioner within 6 hours or sooner if clinically indicated, which may be rendered via telehealth if compliant with the telehealth requirements specified in COMAR 10.63.03.21; **We recommend that the crisis evaluation be performed in person, except as a last resort, and ideally performed by the psychiatrist.**

Bringing emergency petition (EP) patients to BHCSCs must be based on discretion that is not reflected in the proposed regulations. They do indicate that the psychiatrist will collaborate with local emergency departments (ED), but if a patient is too aggressive or unstable, the patient should proceed directly to the ED. Given that EDs will then be responsible for a disproportionate share of the most difficult EPs, there should be some additional ED funding to support that extra load.

Has consideration been given to the location of BHCSCs? Could they be co-located within or very near hospitals to leverage ED and other hospital staff? On the other hand, if there is no institutional overlap, will there be unintended consequences, such as "cherry-picking" easier patients yet still maximizing payments if they are located near a hospital? Location will be one of the primary factors in whether there is sufficient patient volume for financial success based on the fee schedule and geographic area served.

Very little specificity is given in the proposal for children, adolescents, and other vulnerable groups. These are the patients who have been most difficult to place, and they are a main factor in ED boarding. BHCSCs should be required to accept those patients too, at least offering some minimum services, or there should be funding for establishing or expanding the services elsewhere, perhaps in separate crisis centers. National models like Roadmap to the Ideal Crisis System specifically include child and adolescent services – often in the context of a Crisis Hub.

Please email heidi@mdpsych.org with any questions. We appreciate your consideration.

Sincerely,

Jessica V. Merkel-Keller, M.D., M.Sc.
President