The Hilltop Institute

UMBC

report

Outpatient Mental Health Centers: Expansion to Provide Comprehensive Crisis Stabilization Center Services. An Environmental Scan.

April 22, 2021

Suggested Citation: Tan B., Mouslim, M. C., Williams, T., & Idala, D. (2021). *Outpatient mental health centers: Expansion to provide comprehensive crisis stabilization center services. An environmental scan.* Baltimore, MD: The Hilltop Institute, UMBC.

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Acknowledgements

The Hilltop Institute would like to thank the staff of the Maryland Department of Health's Behavioral Health Administration, Behavioral Health System Baltimore, Catholic Charities of Baltimore, the Colorado Department of Human Services, the Georgia Department of Behavioral Health and Developmental Disabilities, Grassroots Crisis Intervention Center, the Klein Family Harford Crisis Center, the Mental Health Association of Frederick County, the Tri-County Behavioral Health Engagement partnership, and the Vermont Department of Mental Health. This report would not have been possible without their valuable input.

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**Outpatient Mental Health Centers:
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Executive Summary

Background

Maryland Medicaid (the Maryland Department of Health, or the Department) received a competitive grant from the Opioid Operational Command Center (OOCC) with the aim of expanding the crisis response infrastructure by increasing the capacity of outpatient mental health centers (OMHCs) to provide comprehensive crisis stabilization center (CCSC) services as defined by the Crisis Now model. The process of increasing the capacity of OMHCs to provide CCSC services will require a multi-year, phased approach with the first year of funding (FY 2021) focused on scoping and planning. The Department has contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to conduct an environmental scan to 1) identify regulatory and licensing barriers to OMHC expansion, 2) describe the development and implementation experiences of crisis providers in Maryland, and 3) describe the development and implementation of wider crisis services systems in other states that have undertaken similar initiatives. This environmental scan is based on a thorough review of government reports and regulatory databases, as well as interviews with staff and representatives of various agencies and organizations in Maryland and other states.

Regulatory and Licensing Requirements and Barriers

Maryland's OMHCs are licensed and overseen by the state's Behavioral Health Administration (BHA). CCSCs are currently not licensed, and to license them would require an expansion of the current regulations. This report provides a detailed discussion of current OMHC licensing and payment regulations, expansion needs, and anticipated challenges. Table E1 provides a summary of these factors.

Table E1. Current OMHC Regulations, Expansion Needs, and Anticipated Challenges

Regulation	Key Points	Expansion Needs	Anticipated Challenges
Licensing Regulations			
10.63.03.02	Lists the community-based behavioral health programs that require an accreditation-based license, including OMHCs	Modify regulations to include CCSCs in the list	Need to have approved accreditation organizations capable of accrediting CCSCs
10.63.03.05	Lists the basic requirements for OMHCs	Modify this regulatory section or add a new section to address requirements for CCSCs	Need to determine requirements for CCSCs
Payment Regulations			
10.21.25.01-.13	Fee schedule for mental health services provided by community-based programs	Modify to include fees for services provided by CCSCs	Need to determine appropriate fees
10.09.59.07	Medicaid will not reimburse OMHC services delivered to a participant with a primary diagnosis of SUD, unless the claim reflects a secondary mental health diagnosis	Must allow reimbursement for some SUD treatment services provided at CCSCs	Determine which SUD treatment services should be eligible for reimbursement

CCSC = comprehensive crisis stabilization center; OMHC = outpatient mental health center; SUD = substance use disorder

The Maryland Experience

This section describes the crisis provider landscape in Maryland, through an overview of funding, billable services, patient access, hours of operations, services offered, and staffing requirements of select crisis providers. The inclusion of these providers was based on feedback from stakeholders and the Department.

Crisis providers in Maryland are primarily funded by grants and are either unable to bill for services or only able to bill for a limited number of services. Interviews with stakeholders consistently identified funding and current billing structure as the two greatest challenges to expansion of the current crisis system in Maryland.

Although minimum staffing requirements for OMHCs are established by BHA regulations, staffing for crisis services other than those within the scope of OMHCs, such as inpatient or residential offerings, vary greatly and are largely dependent on hours of operation, community need, and

utilization. This situation highlights the potential need for expanding current regulations to set minimum staffing requirements for an array of crisis services outside the scope of OMHCs.

Crisis Systems in Other States

This section explores the functioning and implementation of crisis services systems elsewhere in the United States, for the purpose of better understanding the steps necessary to build a successful, comprehensive crisis system in Maryland. A detailed discussion of the crisis systems in four other states (Colorado, Arizona, Georgia, and Vermont) can be found in this section, and Table E2 on the following page summarizes select characteristics of each state's systems.

Table E2. Funding Sources, Regulatory Changes, Billable Services, and Staffing and Licensing Requirements of Crisis Services in Maryland Compared to Four Other States

Characteristics	MARYLAND	ARIZONA	COLORADO	GEORGIA	VERMONT
Funding Source(s)	Current crisis programs are primarily grant-funded.	State funds, Medicaid, RBHA. RBHA covers all services in first 24 hours for Medicaid enrollees; first 72 hours for non-Medicaid enrollees.	Almost entirely state-funded, although some initial costs were covered by a marijuana tax fund.	Primarily state general funds (approximately 75 percent); remainder from Medicaid budget.	Mix of state funds and Medicaid investment funds.
Notable Regulatory Changes	In 2020 legislation was passed, allowing OMHCs to be recognized as alternative emergency destinations.[1] Need changes to the regulations for community-based behavioral health programs and to create sustainable funding through reimbursement from all payers for crisis services.	Arnold v. Sarn settlement in 2014. Creation of H0030 for behavioral health hotline service, effective June 2020.	SB 13-266 (2013). SB 17-207 (2017). ATU and Community Clinic licensing/ designation by DPHE and DHS, but efforts to centralize are underway.	2010 settlement with U.S. Department of Justice.	Transitioning to value-based purchasing for state-funded mental health providers (currently case rate/PMPM).
Covered Billable Services	Current crisis programs are either not be able to bill for services or can only bill for limited services such as therapeutic services or professional fees.	Observation and stabilization <23 hours, 59 minutes. Cannot be readmitted <2 hours after discharge, except in certain circumstances.	CSU licensed as ATU or Community Clinic; provides up to 5 days treatment. Residential and in-home respite: up to 14 days, voluntary.	CSU gets 1/12 drawdown, which mostly covers infrastructure. CSU uses H0018 per diem code. CSU with ≥ 16 beds (i.e., IMD) cannot bill Medicaid.	Minimum for PMPM billing by stabilization center is completion of intake. Required to document one encounter per day until discharge.

[1] 2020 Md. Laws Ch. 173.

Characteristics	MARYLAND	ARIZONA	COLORADO	GEORGIA	VERMONT
Covered Billable Services *continued*		Facility crisis codes S9484 (hourly, 5 or fewer hours) and S9485 (per diem); other codes depend on setting. Hotline code H0030 (per 15 minutes). Transport to crisis provider and medical transportation to another level of care or location after observation and stabilization unit discharge.	Most services based on capacity model (1/12 drawdown), with occasional FFS or per diem arrangements. Services not covered by insurance are billed to state crisis fund.	CSC bill as usual for assessments, evaluations, etc., prior to referral or admission to other care. Respite apartments use H0045 per diem code but cannot bill Medicaid. BHCC can contain CSC and CSU.	
Staffing/Licensing Requirements	Minimum staffing requirements for OMHCs as described below. Crisis services are staffed based on estimated need and may vary by provider.	Observation and stabilization in any facility authorized and provided according to rules for outpatient treatment centers. Facility-based services provided by BHP and/or BHT/BHPP and supervised by BHP. Mobile and hotline: BHP or BHT supervised by BHP.	Walk-in Crisis: 24/7/365 staff; minimum 2 staff at all times; skilled and licensed staff; if unskilled, must have skilled staff available within 30 minutes; ability to provide peer support. CSU: same as walk-in, but needs prescriber and a clinician to administer meds.	DBHDD certifies CSUs; new CSUs certified by invitation only. CSU: Physician, nursing administrator (RN), 24/7 RN, peer specialist if part of BHCC. CSC: BH clinician; CPS; physician, APRN, or PA; RN; other requirements may vary by contract. Respite apartments: varies by provider and contract (no requirements). CSU exempt from certificate of need.	Varies by provider, but typically mix of QMHPs and peer specialists.

APRN = Advanced Practice Registered Nurse; ATU = acute treatment unit; BHCC = behavioral health crisis center; BHP = Behavioral Health Practitioner; BHPP = Behavioral Health Paraprofessional; BHT = Behavioral Health Technician; CPS = Certified Peer Specialist; CSC = crisis service center; CSU = crisis stabilization unit; DBHDD = Department of Behavioral Health and Developmental Disabilities; DHS = Department of Human Services; DPHE = Department of Public Health & Environment; IMD = Institution for Mental Disease; PA = Physician Assistant; PMPM = per member per month; QMHP = Qualified Mental Health Professional; RBHA = Regional Behavioral Health Authority

Conclusion

The expansion of a select number of OMHCs into CCSCs could significantly improve Maryland's behavioral health crisis network and allow individuals with behavioral health crises to receive treatment outside the emergency department (ED). This initiative represents a more generally unified vision of crisis care and behavioral health care than what currently exists in the state. OMHCs currently provide individual, group, and family therapy, as well as medication management. They will need funding and assistance with expanding their services to include the short-term observation and crisis stabilization services needed by "walk-ins" and "drop-offs" from first responders, which are required for CCSCs.

The numerous potential barriers to OMHCs expanding to offer CCSC services can be broadly categorized as either financial or regulatory. There will be substantial initial costs associated with these expansions, including possible infrastructure renovations and/or additions, as well as the ongoing costs of increased staffing. The crisis providers in Maryland who were interviewed for this report consistently described concerns about relying on grants and philanthropic support as the primary sources of funding. However, they explained that their options were limited, because they were unable to bill for many of the services they provided. Additionally, these providers reported that the high cost associated with having staff available 24 hours a day, seven days a week (24/7) was their largest expense. In other states, funds are allocated by the state specifically for crisis services, an arrangement that Maryland's crisis providers claimed would be immensely helpful.

The importance of reliable and sufficient funding is a point that was made repeatedly in conversations with Maryland-based providers as well as providers in other states, but it is equally important that these funds are spent wisely and efficiently. It will be vital that systems are put in place to collect and analyze data regarding the need for and use of healthcare services, not just behavioral health services, so that all the health needs of people seeking crisis stabilization services can be addressed. Regardless of how crisis services are delivered, their effectiveness relies heavily on establishing local relationships so that the unique needs of the communities in which crisis providers are located can be addressed. This will involve significant outreach efforts to area first responders to help clarify the referral and admissions process, as well as to other local providers to build networks for care coordination and transitions.

Another potential barrier observed in other states is that crisis service providers may not share a single electronic health records system, which also occurs in Maryland. The lack of consistent data can negatively impact the treatment of patients and coordination of care. Some states have been able to innovate and more successfully use crisis utilization data. For example, Georgia collects crisis system utilization data from across the state and has used these data to develop an algorithm that helps officials identify areas of the state that would most benefit from the establishment of a CCSC. This system illustrates a possible approach Maryland could use for crisis system data collection.

There are few clear solutions to the regulatory barriers identified in this report. Services provided by OMHCs and CCSCs tend to overlap, but not entirely. These differences suggest that the proposed CCSCs might require a reconsideration of the current OMHC licensing and accreditation framework. Adding crisis services to existing OMHCs is akin to an existing provider adding a new service line but would still require accreditation and licensing for the crisis services.

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Introduction

In the United States, the responsibility for treating people experiencing acute crises related to behavioral health conditions, including substance use, has historically fallen to hospital emergency departments (EDs). However, the complex and chronic nature of behavioral health conditions necessitates specialized care that traditional hospital EDs are simply unable to provide to a person experiencing a behavioral health crisis. Unfortunately, the lack of community-based alternatives means that EDs often serve as the de facto safety-net crisis provider.[2] Individuals experiencing behavioral health crises tend to utilize ED services more often than others, and there is consistent evidence that the number of all behavioral health (mental health- and substance use-related) visits has increased rapidly over the past three decades, with some estimates that such visits accounted for more than 10 percent of all ED visits in 2015 and 2016.[3-4]

ED Utilization for Behavioral Health Crisis

Behavioral health visits to the ED are typically longer than visits for other conditions. In addition, when a person experiencing a behavioral health crisis requires more intensive care than an ED can provide, the shortage of inpatient psychiatric beds and specialist providers often means they remain in the ED for hours or even days until a bed becomes available or they can be transferred to another facility.[5-6] The lack of inpatient space is compounded by a lack of community-based spaces for crisis care. Even after successful stabilization, treatment, and discharge from the ED, patients with behavioral health conditions may not have a clear plan for follow-up treatment and

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[2] Larkin, G.L., Beautrais, A.L., Spirito, A., Kirrane, B.M., Lippman, M.J., & Milzman, D.P. (2009). Mental health and emergency medicine: A research agenda. Academic Emergency Medicine, 16, 1110-1119. https://dx.doi.org/10.1111%2Fj.1553-2712.2009.00545.x

[3] Larkin, G.L., Claasen, C.A., Emond, J.A., Pelletier, A.J., & Camargo, C.A. (2005). Trends in U.S. emergency department visits for mental health conditions, 1992 to 2001. *Psychiatric Services, 56*(6), 671-677.

[4] Theriault, K.M., Rosenheck, R.A., & Rhee, T.G. (2020). Increasing emergency department visits for mental health conditions in the United States. *J Clin Psychiatry, 81*(5). https://doi.org/10.4088/jcp.20m13241

[5] Pearlmutter, M.D., Dwyer, K.H., Burke, L.G., Rathlev, N., Maranda, L., & Volturo, G. (2017). Analysis of emergency department length of stay for mental health patients at ten Massachusetts emergency departments. *Annals of Emergency Medicine, 70*(2), 193-202. http://dx.doi.org/10.1016/j.annemergmed.2016.10.005

[6] Nordstrom, K., Berlin, J.S., Nash, S.S., Shah, S.B., Schmelzer, N.A., & Worley, L.L.M. (2019). Boarding of mentally ill patients in emergency departments: American Psychiatric Association resource document. *Western Journal of Emergency Medicine, 20*(5), 690-695. https://doi.org/10.5811/westjem.2019.6.42422

aftercare. This may be due to a lack of options for such services or poor care coordination. This situation increases the likelihood of a return visit to the ED or an inpatient admission.[7]

A 2017 Joint Chairmen's Report (JCR) on ED Overcrowding in Maryland found that one of the key challenges to alleviating the state's overburdened EDs was a rise in the number of patients seeking behavioral health treatment in the ED setting.[8] The report concluded that state psychiatric facility closures and the opioid epidemic contributed to the higher number of patients with behavioral health disorders seeking treatment in an ED, and the frequent need for enhanced supervision of these patients strained hospital resources. A white paper from the Maryland Hospital Association (MHA) provided evidence for these conclusions, citing a decrease in the number of state-operated psychiatric beds from 4,390 in 1982 to 950 in 2016.[9] The MHA paper also found that behavioral health ED visits increased by 18 percent between 2013 and 2015, whereas non-behavioral health visits declined by five percent over the same time. In 2015, there was an average occupancy rate of 99.7 percent for staffed inpatient psychiatric beds. A 2019 follow-up to the 2017 JCR stated that most of the issues regarding the use of ED services by patients with behavioral health conditions persisted, and that efforts were underway to gather data and other information from stakeholders to determine a course of action.[10]

Crisis Now Model

The National Action Alliance for Suicide Prevention developed the Crisis Now model to provide a framework for a more comprehensive and effective crisis care system to address the current gaps in crisis care. In 2020 the Substance Abuse and Mental Health Services Administration (SAMHSA) released The National Guidelines for Crisis Care –A Best Practice Toolkit.[11] These guidelines are intended to help state and local entities design, develop, and implement the Crisis Now model. There are three major components of the system: regional crisis call center, crisis mobile team response, and crisis receiving and stabilization facilities. Regional crisis call centers should be available 24/7 and provide crisis intervention capabilities through phone, text, and

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[7] Wise-Harris, D., Pauly, D., Kahan, D., de Bibiana, J.T., Hwang, S.W., & Stergiopoulos, V. (2017). "Hospital was the only option": Experiences of frequent emergency department users in mental health. *Adm Policy Ment Health, 44,* 405-412.

[8] Maryland Institute for Emergency Medical Services Systems, & Health Services Cost Review Commission. (2017). *Joint Chairmen's Report on emergency department overcrowding.* https://www.miemss.org/home/Portals/0/Docs/LegislativeReports/MIEMSS-HospitalED-Overcrowding-Report_12-2017-FINA.pdf?ver=2018-01-11-145527-537

[9] Maryland Hospital Association. (2017). *Emergency department diversions, wait times: Understanding the causes.* https://www.mhaonline.org/docs/default-source/Resources/ED-Diversions/ed-diversions-wait-times---understanding-the-causes.pdf?sfvrsn=2

[10] Maryland Institute for Emergency Medical Services Systems, & Health Services Cost Review Commission. (2019). *Emergency department overcrowding update.* https://www.miemss.org/home/Portals/0/Docs/LegislativeReports/miemss-ed-overcrowding-update-10-31-19.pdf?ver=2019-11-19-174743-763

[11] SAMHSA (2020). National guidelines for behavioral health crisis care – A best practice toolkit: Knowledge informing transformation. https://www.mamh.org/assets/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

chat. Crisis mobile teams should be available to reach any person in the service area experiencing a crisis in a timely manner at their home or any community-based location. Lastly, the crisis system should include crisis stabilization facilities to provide short-term observation and crisis stabilization services to all referrals. CCSCs serve this role in their ability to operate like a hospital ED. This entails accepting individuals experiencing a behavioral health crisis through walk-ins and drop-offs from first responders, as well as providing crisis stabilization services.

Community-Based Crisis Services Providers

Multiple community-based crisis services facilities have opened in Maryland over the past several years with the aim of addressing the unmet needs of persons in crisis in a community-setting tailored to their needs. Notable examples include the Tuerk House crisis stabilization center in Baltimore, the Klein Family Harford Crisis Center in Bel Air, Catholic Charities' Baltimore Child & Adolescent Response System (BCARS), the Grassroots Crisis Intervention Center in Columbia, and the Mental Health Association of Frederick County. These facilities provide a range of important services but typically do not offer all services as described in the Crisis Now Model. Furthermore, these facilities are exceptions rather than the rule and their limited reach has left large geographic gaps in crisis service availability across Maryland.

Additionally, there are important barriers to overcome for these facilities to expand, and for similar facilities to be successfully established in Maryland. Currently, crisis providers are not able to bill payers for services outside of the scope of those offered by a traditional outpatient mental health center (OMHC). As such, these community-based crisis service providers rely mainly on grants, typically federally- or state-funded, to function. Given the transient nature of grant funding, a first step in the expansion of crisis services in Maryland will be restructuring the payment structure for crisis services to allow for reimbursement of all services offered in a manner that allows crisis providers to be financially viable.

Leveraging Provider Networks to Increase Crisis Infrastructure: Competitive Grant

Approximately 42 percent of all behavioral health visits by Maryland Medicaid enrollees took place at an OMHC in 2018, representing more than 121,000 unique Medicaid enrollees who received services. This high utilization, combined with the expertise, diverse service offerings, and existing infrastructure of the more than 260 OMHCs in Maryland, presents an opportunity not only to strengthen the state's behavioral health crisis network, but to significantly improve the lives of hundreds of thousands of residents and their families. To reach this goal, the Maryland Department of Health (the Department) has developed a five-year plan to guide the planning, implementation, and long-term support for expanding the capacity of pilot OMHCs to provide CCSC services. The appendix provides an outline of this plan. The Department received a grant from the OOCC in 2020 to begin the first part of this multi-year plan, including planning and scoping.

As part of this competitive grant, the Department contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to conduct an environmental scan for the purpose of 1) identifying regulatory and licensing barriers to OMHC expansion, 2) describing the development and implementation experiences of crisis providers in Maryland, and 3) describing the development and implementation of wider crisis services systems in other states that have undertaken similar initiatives. It was hypothesized that key barriers to expansion would include federal and state regulations that affect service reimbursement and credentialing and licensing restrictions that could hinder hiring new staff and physical facility expansion.

Organization of the Environmental Scan

This report begins by explaining the methods Hilltop used to develop the environmental scan. It describes OMHCs and CCSCs, including the regulatory environment in which they currently operate, and discusses barriers to transitioning from an OMHC to a CCSC. It outlines the array of services offered by Maryland's crisis service providers and presents operational information for several of these providers. A brief analysis of OMHC capacity in Maryland is followed by a summary of the paths taken and challenges faced by four other states in establishing successful crisis services networks. Maryland is currently working towards building state-wide all-payer crisis services infrastructure, and OMHCs that choose to add CCSC services may play an integral role in that work.

Methods

Although the methodology for conducting environmental scans in the context of public health remains largely undefined, Hilltop broadly followed the framework presented by Wilburn, Vanderpool, and Knight in their 2016 paper, *Environmental Scanning as a Public Health Tool: Kentucky's Human Papillomavirus Vaccination Project*. This framework consists of 1) assigning team leads and determining capacity, 2) outlining the scope of work, 3) creating a timeline and setting goals, 4) outlining information to be collected, 5) identifying and engaging stakeholders, 6) analyzing and synthesizing results in a report, and 7) disseminating results to stakeholders. The appendix presents a detailed description of the methodology in the context of that framework.

Outpatient Mental Health Centers

Regulatory and Licensing Requirements

In Maryland, OMHCs are licensed by the Behavioral Health Administration (BHA), which is part of the Department. At a minimum, OMHCs provide individual therapy, group therapy, family therapy, and medication management, and they may include family psychoeducation and other adjunctive treatment services.[12] After the integration of Maryland's behavioral health system in

[12] Behavioral Health Administration. *Office of Treatment Services*. https://bha.health.maryland.gov/Pages/Treatment-and-Recovery-Services-Unit.aspx

2016, all eligible community-based behavioral health programs, including OMHCs, were required to be licensed by the BHA by 2018.[13]. OMHCs must receive accreditation from an approved accreditation organization (four OMHC accrediting organizations are recognized in Maryland) as a precondition for licensure.[14,15] OMHCs must also obtain a written agreement with the local addiction authority (LAA), core service agency (CSA), or local behavioral health authority (LBHA) in each jurisdiction in which services will be offered.[16] If an OMHC offers behavioral health and substance use disorder (SUD) treatment services, an Agreement to Cooperate must be in place with both the CSA and LAA in jurisdictions that do not have an LBHA.[17]

After receiving accreditation and an Agreement to Cooperate, OMHCs are eligible to submit a licensing application to the BHA. To become licensed, an OMHC must offer regularly scheduled outpatient mental health treatment services in a community-based setting and provide, at a minimum, individual, group, and family therapy and medication management. OMHCs must employ a medical director who is a psychiatrist or psychiatric nurse practitioner. The medical director has overall responsibility for clinical services and is on-site at least 20 hours per week. To bill Medicaid, an OMHC must also have a program director who is a licensed mental health professional or has earned a master's degree in a relevant field and is responsible for administrative oversight of the OMHC. Additionally, OMHCs must employ a licensed, multidisciplinary, clinical treatment staff composed of three different mental health professions.[18] Medicaid requires that this staff should include representatives of two different mental health professions, both of whom are represented on-site 50 percent of the OMHC's regularly scheduled hours.[19]

All licensed community-based behavioral health programs must comply with any inspection requests from the Department or its designees, which include BHA and LBHAs, perform an appropriate criminal background investigation of potential employees and volunteers, and comply with all applicable state and federal laws, including the Health Insurance Portability and Accountability Act and the Confidentiality of Alcohol and Drug Abuse Patient Records regulations. Community-based behavioral health programs may not exclude or discriminate against an individual on the basis of the individual receiving opioid treatment services.[20] New OMHCs—and OMHCs that open new locations—need to apply for a National Provider Identifier

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[13] Behavioral Health Administration. *Introduction to accreditation and licensing*. https://bha.health.maryland.gov/Documents/Introduction%20to%20Accreditation%20and%20Licensing%20Requirements.pdf

[14] COMAR 10.63.02.02(A)(5).

[15] Maryland Department of Health. *Approved accrediting organizations*. https://bha.health.maryland.gov/Documents/MDH%20Approved%20AOs%20list%20updated%209.27.17%20(1).pdf

[16] Counties that have integrated behavioral health and SUD services have a LBHA and counties that have not integrated services yet have both a LAA and CSA.

[17] COMAR 10.63.01.05(E).

[18] COMAR 10.63.03.05.

[19] COMAR 10.21.20.10.

[20] COMAR 10.63.01.05.

(NPI) and a Medicaid provider number to become eligible to receive reimbursement from the Department for services delivered.[21]

The accreditation standards for OMHCs are derived from the regulations at COMAR 10.21.20, which detailed the requirements for OMHCs prior to the integration of Maryland's behavioral health system in 2016. The approved accreditation organizations were originally required to correlate their standards with the requirements of COMAR 10.21.20 et al, although the standards may vary slightly among the organizations. A summary of these regulations effectively serves as a summary of the accreditation standards for OMHCs.

Programs that are currently approved as other types of community health programs and group practices with experience providing mental health services are eligible to become OMHCs.[22] Clinical services must only be provided by licensed mental health professionals.[23] Services must be available at least 40 hours a week, with some weekend and evening hours, and for emergency coverage.[24] An OMHC facility must be publicly accessible, not located in a private residence, contain a secure area for records, and be compliant with all federal, state, and local laws and regulations.[25] An OMHC may provide short-term intensive outpatient services, but those services must be delivered by a multidisciplinary team for a minimum of three hours of therapeutic services per day, and include at least two group therapy sessions and physician services as needed.[26]

Referral and Intake

The accreditation requirements originally derived from COMAR 10.21.20 generally require that, upon referral to an OMHC, an individual must receive a screening assessment by a licensed mental health professional to assess the individual's goals for recovery, strengths, available resources, and treatment needs. Individuals determined to be clinically appropriate for services are then provided with services. After the assessment is performed, the OMHC and patient develop an individual treatment plan that includes a description of the patient's diagnosis and current condition, as well as necessary treatment and goals. The OMHC must provide evaluative treatment and support services. Evaluative services include assessment and diagnosis, co-occurring substance use screening assessment, and review of somatic status. There must be a primary diagnosis of mental health for a patient to be eligible for treatment through an OMHC. Treatment services should include mental health treatment, psychological evaluation and testing, co-occurring substance use treatment, and medication services. On-call and crisis-

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[21] BHA (2017, February 16). *Application process steps for accreditation-based licenses.* https://bha.health.maryland.gov/Documents/bh%20regs%20application%20process%20steps%20amended%202-16-17.pdf

[22] COMAR 10.21.20.03.

[23] COMAR 10.21.20.04(B).

[24] COMAR 10.21.20.04(C).

[25] COMAR 10.21.20.04(D).

[26] COMAR 10.21.20.04(E).

intervention services must be provided face-to-face during the OHMC's open hours and by telephone 24/7 during the hours the OMHC is closed, either through the OMHC or a partner organization to individuals enrolled in the OMHC. In addition to treatment services, the OMHC must be equipped to provide support services, such as education regarding prescribed medications, case-coordination services, and referrals to psychiatric rehabilitation, somatic care, occupational therapy, self-help organizations, and substance use services. An OMHC must have a staff that is sufficient in size and qualifications to provide clinically-appropriate services to the individuals served; however, accreditation standards vary with regard to standardized staffing ratios.

Payment Structure

OMHCs must comply with the regulations of COMAR 10.09.59 to receive reimbursement from Medicaid for services delivered to Medicaid participants. The majority of OMHCs are structured to receive Medicaid reimbursement. General requirements for all behavioral health providers include having clearly defined and written patient-care policies and adequate documentation of each contact with a person, including the date of service, reason for visit, description of services provided, and signature of provider.[27] OMHCs specifically must comply with the staffing requirement in COMAR 10.63.03.05, as described above. Medicaid should reimburse OMHCs for medically-necessary specialty mental health services delivered to Medicaid participants.[28] However, Medicaid will not reimburse OMHCs for services delivered to a Medicaid participant with a primary diagnosis of SUD, unless the claim reflects a secondary mental health diagnosis.[29]

Comprehensive Crisis Stabilization Centers

Requirements

CCSCs provide short-term observation and crisis stabilization services to individuals. They operate like a hospital ED that accepts people experiencing a behavioral health crisis through walk-ins and drop-offs from first responders. According to guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA), crisis-receiving and stabilization services centers must at a minimum:[30]

- Provide 24-hour crisis-receiving and stabilization facilities
- Accept all referrals

[27] COMAR 10.09.59.03(C);(D).
[28] COMAR 10.09.59.06(A).
[29] COMAR 10.09.59.07(I).
[30] SAMHSA (2020). *National guidelines for behavioral health crisis care – A best practice toolkit: Knowledge informing transformation*. https://www.mamh.org/assets/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

- Offer assessment and support for medical stability while in the center, without requiring medical clearance prior to admission
- Design their services to address mental health and substance use crisis issues
- Have the capacity to assess physical health needs and deliver care for most minor physical health challenges, with an identified pathway to transfer the individual to a higher level of medical care, if needed
- Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, including:
    - Psychiatrists or psychiatric nurse practitioners (telehealth is allowed)
    - Nurses
    - Licensed and/or credentialed clinicians capable of completing assessments in the region
    - Peers with lived experience similar to that of the population served
- Offer walk-in and first responder drop-off options and be capable of accepting all referrals at least 90 percent of the time, with a no-rejection policy for first responders
- Screen for suicide risk and complete more comprehensive suicide risk assessments and planning when clinically indicated
- Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated
- Incorporate intensive support beds into a partner program, either within the CCSC's own program or with another provider to support flow for individuals who need additional support
- Offer sobering support services
- Coordinate ongoing care for their patients

Payment Structure

CCSC funding varies greatly from state to state and may be blended with multiple payers, which can make it more difficult for CCSC to receive consistent and adequate funding.[31] SAMHSA notes that a funding model similar to the one used for firefighting and emergency medical services, known as the "firehouse model," might be the optimal approach for funding some crisis stabilization services.[32] Mental health crisis care has similarities to emergency medical services. Both services are essential and could be needed by anyone in the community; the need is

[31] Ibid.

[32] Firehouse Model as described in the SAMHSA (2020). *National guidelines for behavioral health crisis care – A best practice toolkit: Knowledge informing transformation*. (page 37 of 80). https://www.mamh.org/assets/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

predictable over time, but the timing of individual crisis events is not. Effective crisis response is lifesaving and potentially less costly than the consequences of inadequate care. Since funding for physical health emergency services already exists, this model could be applied to mental health crisis care. Further, if CCSCs can bill individual's insurance plans for services, this could shift expenses for crisis care from local communities to health insurance plans. This strategy would help establish sustainable funding streams for crisis care.

Another important aspect in the development of a payment structure for CCSCs is establishing a common definition for crisis services to ensure consistent use of crisis service codes across different providers. Coding of crisis services must be standardized to support reimbursement for crisis hotlines, mobile crisis units, and CCSC services. SAMHSA proposes the following healthcare common procedure coding system (HCPCS) codes for crisis services:[33]

- S9484 - Crisis Intervention Mental Health Services per Hour
- S9485 - Crisis Intervention Mental Health Services per Diem[34]

Current procedural terminology (CPT) codes for medications, and professional evaluation and treatment services may be billed separately or bundled into reimbursement rates.[35]

[33] SAMHSA (2020). *National guidelines for behavioral health crisis care – A best practice toolkit: Knowledge informing transformation*. https://www.mamh.org/assets/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[34] Ibid.
[35] Ibid.

OMHC Expansion to Provide CCSC Services

Table 1 displays the current services provided by OMHCs in Maryland and the additional services that would be needed for OMHCs to expand to provide CCSC services.

Table 1. Comparison of OMHC and CCSC Services

Current OMHC Services	Additional Services for CCSC
Regularly scheduled outpatient mental health treatment	Accepts walk-ins, first responder drop-offs, and emergency petitions (involuntary admissions)
Individual, group, and family therapy	Staffed 24/7
Medication management	Crisis observation chairs
	Subacute crisis beds
	Sobering center capacity

CCSC = comprehensive crisis stabilization center; OMHC = outpatient mental health center

CCSCs do not neatly fit into Maryland's current regulatory structure. Table 2 presents key regulations for OMHCs and how these regulations would need to be adapted in order for OMHCs to expand into CCSCs. The regulations regarding community-based behavioral health programs at COMAR 10.63.01 et al. would need to be modified to include CCSCs as a community-based behavioral health program. The fee schedule for behavioral services at COMAR 10.21.25.01-.13 would also need to be modified to include fees for services provided by CCSCs. Because community-based behavioral health programs generally require accreditation from an approved accreditation organization, Maryland would also need to identify accreditation organizations capable of accrediting CCSCs (see Table 2 for additional information).

Table 2. Current OMHC Regulations, Expansion Needs, and Anticipated Challenges

Regulation	Key Points	Expansion Needs	Anticipated Challenges
Licensing Regulations			
10.63.03.02	Lists the community-based behavioral health programs that require an accreditation-based license, including OMHCs	Modify regulations to include CCSCs in the list	Need to have approved accreditation organizations capable of accrediting CCSCs
10.63.03.05	Lists the basic requirements for OMHCs	Modify this regulatory section or add a new section to address requirements for CCSCs	Need to determine requirements for CCSCs

Table 2. cont.

Regulation	Key Points	Expansion Needs	Anticipated Challenges
Payment Regulations			
10.21.25.01-.13	Fee schedule for mental health services provided by community-based programs	Modify to include fees for services provided by CCSCs	Need to determine appropriate fees
10.09.59.07	Medicaid will not reimburse OMHC services delivered to a participant with a primary diagnosis of SUD, unless the claim reflects a secondary mental health diagnosis	Must allow reimbursement for some SUD treatment services provided at CCSCs	Determine which SUD treatment services should be eligible for reimbursement

CCSC = comprehensive crisis stabilization center; OMHC = outpatient mental health center; SUD = substance use disorder

Potential Barriers to Expanding an OMHC to Provide CCSC Services

To function as a CCSC, an OMHC would need to provide the following expanded services: accept walk-ins, provide 24-hour staffing, have crisis-observation chairs, have emergency petition capacity, have subacute crisis beds (24-72 hours), and have sobering center capacity. There are several potential barriers to an OMHC expanding to provide CCSC services, including staffing, limited resources, accreditation, regulations, reimbursement and start-up capital. Providing these expanded services would require OMHCs to hire additional staff, which would in turn increase expenses. Hours of operation would also need to be expanded for OMHCs. Furthermore, OMHCs would need additional supplies including medical supplies and durables such as furniture to support the new CCSC services. As OMHCs expand, it is likely they will need additional space. This can be achieved either by expanding their current space or finding a new location; both methods of expansion would require additional funds and resources. Additionally, programs that provide behavioral health and/or SUD services may find it challenging to move to a new location that is convenient for its target population, in a community willing to accept a CCSC, and while being able to satisfy any zoning requirements.

Funding is also an important barrier to OMHC expansion. OMHCs would need initial funding to begin the expansion process and implement the necessary changes, such as increased staffing and expanded space. Finally, billing systems and agreements would need to be restructured. After successful expansion into CCSCs, centers need to be able to bill both private and public insurance for reimbursement of services.

The Maryland Experience

Crisis Providers in Maryland

The purpose of this section is to describe the behavioral health crisis provider landscape in Maryland outside of legislation and regulation. It provides an overview of select crisis providers in Maryland focusing on: 1) hours of operation, staffing, and services offered; and 2) funding sources, billable services, and patient access to crisis services. A literature review and semi-structured interview with key informants were used to provide the basis for this section.

Hours of Operation, Staffing, and Services Offered

Outside of traditional OMHC services, providers commonly offer access to a crisis hotline and/or mobile crisis team; care coordination with access to residential services (either in-house or from another provider); and transportation. Hours of operation seem to vary according to service type. Crisis hotlines and mobile crisis teams are typically offered on a 24/7 basis. Residential crisis services are also 24/7 services. Alternatively, walk-in and outpatient services tend to have limited hours.

Staffing varies with service type, hours of operations, capacity, and utilization. However, OMHCs need to meet minimum staffing requirements as set by COMAR. While OMHCs may individually decide to exceed the requirements, having a minimum staffing threshold limits variation and ensures that a minimum standard of care will be met. It also enables OMHCs to estimate their minimum personnel costs.

Any 24/7 service will have to meet staffing requirements that satisfy its hours of operations. This has significant hiring and cost implications. If there were minimum standards for CCSC services, then providers would have to carefully consider any staffing requirements against cost implications. For example, when interviewed, many crisis providers emphasized that having a psychiatrist onsite 24/7 would impose a significant cost burden, which might not be financially viable. As policy makers draft minimum staffing requirements for crisis services with expanded hours, they may consider hybrid models, which allow high-cost staff to be available on an on-call, or telehealth basis as opposed to fully onsite. Another important consideration in determining staffing needs is utilization over time. Utilization not only varies by locality but also by time of year, day of the week, and time of day.

More generally, policy makers could approach staffing requirements using one of two broad strategies:

1. Set minimum requirements with low-utilization providers in mind; and
2. Set flexible staffing requirements that allow for variation based on utilization.

Table 3 on the following page compares hours of operation, staffing, and services offered by each crisis provider.

Table 3. Comparison of Hours of Operations, Services Offered, and Staffing Requirements among Crisis Service Providers in Maryland

Crisis Provider	Hours of Operation	Crisis Services	Minimum Staffing Requirements
Catholic Charities' Baltimore Child & Adolescent Response System (BCARS)	**24/7 services:** Crisis hotline; Crisis stabilization (DSS) program) **Limited hours:** Crisis stabilization (traditional program): Monday-Friday from 8:30 a.m. to 7 p.m.; OMHC: Monday-Friday from 8:30 a.m. to 7 p.m.	▪ Crisis hotline ▪ OMHC[36] ▪ Crisis stabilization services[37] ▪ Transportation	▪ **Crisis hotline:** operated by outside company ▪ **OMHC**: minimum staffing requirements set by COMAR ▪ **Crisis stabilization services**: Same staff as OMHC.[1]
Frederick Mental Health Association	**24/7 services:** Crisis hotline **Limited hours:** OMHC: by appointment only Walk-in crisis services: Monday-Friday from 10 a.m. to 10 p.m. and Saturday-Sunday from 10 a.m. to 6 p.m.	▪ Crisis hotline ▪ OMHC ▪ Walk-in crisis services[38]	▪ **Hotline:** 2+ counselor 24/7 ▪ **OMHC**: minimum staffing requirements set by COMAR ▪ **Walk-in:** 2+ staff on every shift during business hours.
Grassroots Crisis Intervention Center	**24/7 services:** Crisis hotline; SUD screening program; walk-in counseling **Limited hours:** MCT: daily 8 a.m. to 11 p.m.	▪ Crisis intervention hotline ▪ MCT ▪ SUD screening program ▪ Walk-in counseling	▪ **Hotline:** 1+ counselor 24/7 ▪ **MCT:** 1+ licensed clinician 24/7 ▪ **SUD screening program:** 1+ NP, 50 hours/week onsite and on-call 24/7; 1+ RN 24/7; 1 program director 24/7 on-call; 1+ LCSW, 24/7; 2+ peer specialists, 24/7 ▪ **Walk-in counseling:** share staff with SUD screening program ▪ All in-person services: security (unarmed): 24/7
Klein Family Harford Crisis Center	**24/7 services:** Crisis hotline; MCT; residential crisis services **Limited hours:** Walk-in urgent care: daily from 9 a.m. to 9 p.m.; OMHC: by appointment only	▪ Walk-in urgent care ▪ Crisis hotline ▪ MCT ▪ OMHC ▪ Residential crisis services[39]	▪ **Walk-in urgent care:** 1+ RN, 1+ LCSW, 1+ prescriber and security. Daily from 9 a.m. to 9 p.m. ▪ **OMHC:** minimum staffing requirements set by COMAR ▪ **Residential crisis services:** 1+ NP, 24/7; 1+ Intake staff, 24/7, 1+ security, 24/7, 1 medical director, 20 hours/week
Tuerk House crisis stabilization center	All services 24/7	▪ Crisis-receiving and stabilization services[40] ▪ Transportation	1 + CAN, 24/7; 1+ LPN, 24/7; 1+ NP, 24/7; 1+ peer specialist, 24/7; 1+ LCSW, 16 hours a day, 7 days a week

BHA = Behavioral Health Administration; CAN = certified nursing assistant; DSS = Department of Social Services; LPN = licensed practical nurse; LCSW = licensed certified social worker; OMHC = outpatient mental health center; RN = registered nurse (RN): SUD: substance use disorder; MCT = mobile crisis team; NP = nurse practitioner

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[36] BCARS is designated as an OMHC but offers services beyond the traditional OMHC model. Services offered are in line with that of a behavioral health urgent care clinic.

[37] These services include community-based crisis services, initial assessments, short-term intensive individual and family therapy, psychiatric rehabilitation services, psychiatric assessment and medication management, and crisis response to Baltimore City Public Schools. There are no inpatient services. If inpatient services are needed, patients are either referred to the emergency department or to direct admission via a psychiatrist.

[38] These services include suicide intervention, mental health, urgent psychiatric medication evaluations, as well as, crises related to family, financial, and employment matters.

[39] These services include assessment and treatment, access to residential beds for short-term stays, group psychotherapy, individual psychotherapy, care coordination, and peer recovery support.

[40] These services include secondary triage by medical staff to ensure patients meet admission criteria, biopsychosocial assessment, evaluation for medication-assisted treatment (MAT) or buprenorphine induction, treatment plan and treatment referral, access to a crisis bed, and counseling through a peer specialist.

Funding Sources, Billable Services, and Patient Access

Funding was commonly identified as the most important barrier to expanding OMHC services. Most of the crisis services that go beyond the scope of what a traditional OMHC would offer are primarily or entirely grant-funded, an inherently unstable, non-sustainable source of capital which tends to require substantial administrative oversight to complete reporting, and renewals. Grant sources vary, but most are either federal or state grants. Given the limitations of grant funding, policy makers may consider shifting away from grants by restructuring the payment structure for crisis services to allow for reimbursement of all services offered in a manner that allows crisis providers to be financially viable.

Maryland Medicaid currently reimburses a limited number of providers for a limited number of crisis services. The same is true for other payers operating in the state. In some instances, this means that crisis service providers are solely grant funded and cannot bill for services, in other instances, it means that providers must restrict access to serviced based on insurance type. For example; BCARS is restricted to Medicaid participants under the age of 18, with some latitude to accept uninsured patients, depending on grant funding availability. Meanwhile, the Klein Family Harford Crisis Center bills insurance if possible, but provides its crisis services to anyone in need regardless of insurance status. Table 4 compares funding sources, billing capabilities, and patient access among these four crisis providers.

Table 4. Comparison of Funding Sources, Billable Services, and Patient Access among Crisis Service Providers in Maryland

Crisis Provider	Funding Source	Billing Capabilities	Patient Access
Catholic Charities' Baltimore Child & Adolescent Response System (BCARS)	Grants: Combination of federal and state grants	OMHC Medicaid covered Therapeutic services only	Hotline available to everyone free of charge, other services restricted to Medicaid patients Some access to uninsured patients, dependent on available grant funding
Frederick Mental Health Association	Grants Philanthropy	Medicaid, Medicare,[41] and sliding scale based on income and ability to pay for OMHC therapeutic services	Hotline and walk-in crisis services available to everyone free of charge OMHC restricted to Medicaid and Medicare patients
Grassroots Crisis Intervention Center	Grant: State Opioid Response (SOR) grant Philanthropy	Unable to bill for services	Available to all patients, regardless of insurance status
Klein Family Harford Crisis Center	Grants (mostly state and county) Private support and philanthropy	Professional fees. Able to bill most insurances for walk-in behavioral health urgent care services Bill a limited set of providers for residential crisis beds at a bundled rate	Available to patients regardless of health insurance status
Tuerk House crisis stabilization center	Grants: Combination of federal and state grants	Unable to bill for services	Available to all patients, regardless of insurance status

[41] Note: As of the writing of this report, was only able to bill Medicare for medication. Private insurance is being explored as a future option.

CCSC Initiatives in Other States

This section explores the functioning and implementation of crisis services systems elsewhere in the United States, for the purpose of better understanding the steps necessary to build a successful, comprehensive crisis system in Maryland. A detailed discussion of the crisis systems in four other states (Colorado, Arizona, Georgia, and Vermont) follows, and Table 5 summarizes select characteristics of each state's systems at a high-level. These states were chosen in part because their crisis systems have a reputation for being efficient, effective, wide-reaching, and, as demonstrated by Table 5, utilizing varied approaches. For example, Colorado has multiple facility-based modalities where people experiencing a behavioral health crisis typically receive several days of stabilization services. By contrast, Arizona's crisis system emphasizes the use of hotlines and mobile units, while facility-based crisis stabilization is largely limited to 23-hour observation services. After this observation period, the appropriate level of traditional inpatient or outpatient follow-up care is determined, and transitions are coordinated by facility staff and insurance payers. Observed similarities across the states include a heavy reliance on public funding sources.

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Table 5. Funding Sources, Regulatory Changes, Billable Services, and Staffing and Licensing Requirements of Crisis Services in Maryland Compared to Four Other States

Characteristics	MARYLAND	ARIZONA	COLORADO	GEORGIA	VERMONT
Funding Source(s)	Current crisis programs are primarily grant-funded.	State funds, Medicaid, RBHA. RBHA covers all services in first 23 hours for Medicaid enrollees; first 72 hours for non-Medicaid enrollees.	Almost entirely state-funded, although some initial costs were covered by a marijuana tax fund.	Primarily state general funds (approximately 75 percent); remainder from Medicaid budget.	Mix of state funds and Medicaid investment funds.
Notable Regulatory Changes	In 2020 legislation was passed, allowing OMHCs to be recognized as alternative emergency destinations.[42] Need changes to the regulations for community-based behavioral health programs and to create sustainable funding through reimbursement from all payers for crisis services.	Arnold v. Sarn settlement in 2014. Creation of H0030 for behavioral health hotline service, effective June 2020.	SB 13-266 (2013) SB 17-207 (2017) ATU and Community Clinic licensing/ designation by DPHE and DHS, but efforts to centralize are underway.	2010 settlement with U.S. Department of Justice.	Transitioning to value-based purchasing for state-funded mental health providers (currently case rate/PMPM).
Covered Billable Services	Current crisis programs are either not be able to bill for services, or can only bill for limited services such as therapeutic services or professional fees.	Observation and stabilization <23 hours, 59 minutes. Cannot be readmitted <2 hours after discharge, except in certain circumstances.	CSU licensed as ATU or Community Clinic; provides up to 5 days treatment. Residential and in-home respite: up to 14 days, voluntary.	CSU gets 1/12 drawdown, which mostly covers infrastructure. CSU uses H0018 per diem code. CSU with ≥ 16 beds (i.e., IMD) cannot bill Medicaid.	Minimum for PMPM billing by stabilization center is completion of intake. Required to document one encounter per day until discharge.

[42] 2020 Md. Laws Ch. 173.

Characteristics	MARYLAND	ARIZONA	COLORADO	GEORGIA	VERMONT
Covered Billable Services *continued*		Facility crisis codes S9484 (hourly, 5 or fewer hours) and S9485 (per diem); other codes depend on setting. Hotline code H0030 (per 15 minutes). Transport to crisis provider and medical transportation to another level of care or location after observation and stabilization unit discharge.	Most services based on capacity model (1/12 drawdown), with occasional FFS or per diem arrangements. Services not covered by insurance are billed to state crisis fund.	CSC bill as usual for assessments, evaluations, etc., prior to referral or admission to other care. Respite apartments use H0045 per diem code but cannot bill Medicaid. BHCC can contain CSC and CSU.	
Staffing/Licensing Requirements	Minimum staffing requirements for OMHCs as described below. Crisis services are staffed based on estimated need and may vary by provider.	Observation and stabilization in any facility authorized and provided according to rules for outpatient treatment centers. Facility-based services provided by BHP and/or BHT/BHPP and supervised by BHP. Mobile and hotline: BHP or BHT supervised by BHP.	Walk-in Crisis: 24/7/365 staff; minimum 2 staff at all times; skilled and licensed staff; if unskilled, must have skilled staff available within 30 minutes; ability to provide peer support. CSU: same as walk-in, but needs prescriber and a clinician to administer meds.	DBHDD certifies CSUs; new CSUs certified by invitation only. CSU: Physician, nursing administrator (RN), 24/7 RN, peer specialist if part of BHCC. CSC: BH clinician; CPS; physician, APRN, or PA; RN; other requirements may vary by contract. Respite apartments: varies by provider and contract (no requirements). CSU exempt from certificate of need.	Varies by provider, but typically mix of QMHPs and peer specialists.

APRN = Advanced Practice Registered Nurse; ATU = acute treatment unit; BHCC = behavioral health crisis center; BHP = Behavioral Health Practitioner; BHPP = Behavioral Health Paraprofessional; BHT = Behavioral Health Technician; CPS = Certified Peer Specialist; CSC = crisis service center; CSU = crisis stabilization unit; DBHDD = Department of Behavioral Health and Developmental Disabilities; DHS = Department of Human Services; DPHE = Department of Public Health & Environment; IMD = Institution for Mental Disease; PA = Physician Assistant; PMPM = per member per month; QMHP = Qualified Mental Health Professional; RBHA = Regional Behavioral Health Authority

Colorado

In 2013, as part of Governor John Hickenlooper's "Strengthening Colorado's Mental Health System: A Plan to Safeguard All Coloradans" initiative, Colorado legislators passed Senate Bill (SB) 13-266. This law required the state's Department of Human Services to release a request for proposals to organizations to create a behavioral health crisis network that would reach every community in the state.[43] Nearly $20 million was appropriated to implement SB 13-266. The crisis network that would eventually be created was required to include at least five major components:[44]

1. A 24-hour crisis hotline[45]
2. Walk-in crisis services and crisis stabilization units[46]
3. Mobile crisis services[47]
4. Residential and respite crisis services[48]
5. A public information campaign[49]

Colorado Crisis Services (CCS) was also created in 2013 to oversee this newly bolstered crisis treatment network, which eventually developed over several years to include all five of these components. [50]

Funding of Crisis System

In 2017, Colorado lawmakers passed SB 17-207, which appropriated more than $7 million to expand CCS even further. It also ended the practice of using jails and other detention centers as holding places for individuals experiencing behavioral health emergencies.[51] An additional $2.6 million was provided from general appropriations for training law enforcement and other first responders on how to interact with someone having a behavioral health crisis. This training included determining when it is appropriate to direct the individual to community crisis and treatment providers rather than EDs or incarceration. SB 17-207 also included language encouraging crisis service providers to extend their reach into rural areas, something that SB 13-

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[43] 2013 Colo. Sess. Laws page no. 1105.

[44] 2013 Colo. Sess. Laws page no. 1108.

[45] 2013 Colo. Sess. Laws page no. 1105; Colo. Rev. Stat. § 27-60-103(1)(b)(I).

[46] 2013 Colo. Sess. Laws page no. 1105; Colo. Rev. Stat. § 27-60-103(1)(b)(II).

[47] 2013 Colo. Sess. Laws page no. 1105; Colo. Rev. Stat. § 27-60-103(1)(b)(III).

[48] 2013 Colo. Sess. Laws page no. 1105; Colo. Rev. Stat. § 27-60-103(1)(b)(IV).

[49] 2013 Colo. Sess. Laws page no. 1105; Colo. Rev. Stat. § 27-60-103(1)(b)(V).

[50] Colorado Office of Behavioral Health. (2018, May 1). *Expansion of the Colorado crisis system report*. https://cdpsdocs.state.co.us/ccjj/Resources/Leg/Mandates/2018-05-01_BHCrisisSystemReport.pdf

[51] 2017 Colo. Sess. Laws page no. 760.

266 did not do.[52] Nearly $1 million was provided for a rural enhancement contract to support crisis services in the Western part of the state.

To ensure that these service expansions and training programs would continue, SB 17-207 created a marijuana tax cash fund from which initial and future appropriations would be drawn, although much of the funding for crisis services comes from the state's general budget.[53]

Regulatory and Licensing Structures of CCSCs

Several provisions were included in SB 17-207 that outline the general reach and scope of services that crisis providers would be expected to offer. Perhaps most importantly, it stipulated that, "Components of the crisis response system must reflect a continuum of care from crisis response through stabilization and safe return to the community, with adequate support for transitions to each stage."[54] The law does not require that each individual provider offer the full continuum of services, although another provision does mandate that facilities licensed as crisis walk-in centers, acute-treatment units, and crisis stabilization units, "must be able to adequately care for an individual" who arrives there voluntarily or involuntarily, regardless of facility licensure.[55] Additionally, all mobile-response units must be able to respond to a crisis in under two hours anywhere in the state, although it does allow for this response to be via telehealth, when necessary.[56]

Crisis stabilization services in Colorado are currently divided into seven regions, with services in each region managed by one of four administrative services organizations (ASOs). The ASOs are responsible for ensuring that the crisis services network in their region includes mobile units, walk-in treatment, crisis stabilization facilities, and respite crisis services, with a statewide crisis hotline overseen separately by a third-party contractor.

To manage services in a region, an ASO must contract with the Colorado Office of Behavioral Health (OBH), the state agency overseeing the CCS, and agree to abide by certain state regulations and federal guidelines. These contracts include additional operational requirements for facilities beyond those codified in law, such as the required admissions process for each facility, from screening to referral, including the specific screening tools to be used.[57] Because each region is different, ASOs are permitted to provide additional crisis services that are deemed necessary to meet the needs of their region's population, though Colorado Department of

[52] 2017 Colo. Sess. Laws page no. 760; Colo. Rev. Stat. § 27-60-104(4);(5).

[53] 2017 Colo. Sess. Laws page no. 760; Colo. Rev. Stat. § 39-28.8-501(2)(b)(IV)(C);(D).

[54] 2017 Colo. Sess. Laws page no. 760; Colo. Rev. Stat. § 27-60-104(1)(b).

[55] 2017 Colo. Sess. Laws page no. 760; Colo. Rev. Stat. § 27-60-104(1).

[56] 2017 Colo. Sess. Laws page no. 760; Colo. Rev. Stat. § 27-60-104(2).

[57] Colorado Crisis Services. (2020). *Statement of work and contract with regional administrative services organization*.

Human Services (CDHS) staff reported that the most common regional differences related to payment arrangements rather than the availability of services.

Billable Services and Staffing Requirements

State funding for services at most crisis facilities in Colorado is based on a capacity model. The OBH determines an annual budget for each ASO based on the previous year's costs and patient volume. Each ASO then receives 1/12th of their budget monthly, and they in turn pay their contracted providers 1/12th of the providers' yearly budget each month per modality offered. These funds primarily cover the costs of infrastructure and staffing, though ASOs do occasionally agree to a fee-for-service or per diem arrangement with some providers depending on the availability of other funding sources. For example, one ASO may use the capacity model to fund their crisis stabilization units (CSUs), while another ASO pays a per diem for beds used at a CSU in their catchment area that is already fully funded through donations or federal grants. Service reimbursement for people with private insurance varies based on the payer but anything not covered by a private insurer is typically billed back to the state's crisis fund.

Service offerings and staffing requirements differ according to facility licensure. The lowest level of licensure is for walk-in centers which as the name suggests, these are public-facing facilities where people experiencing a behavioral health crisis can enter voluntarily. Walk-in centers offer very short-term (i.e., hours, not days) stabilization, are required to be open 24/7/365, and must have always at least two staff members available. Colorado's CSUs must abide by the same access and staffing guidelines as walk-in centers, but they must also have staff who can prescribe and dispense medication.

Barriers to Implementation

In the year after SB 17-207 was passed, the OBH finalized numerous contracts that implemented the service expansions mandated by the legislation. Several new facilities and programs were opened, and specialized staff members were hired to manage the expected increase in patient complexity and volume.[48] Despite the careful planning, persistent barriers have hindered CCS from expanding crisis treatment to the extent intended by SB 13-266 and SB 17-207. These barriers can be categorized as logistical, education/outreach, and regulatory, which is typical of the other states profiled in this report.

Logistical Barriers

Logistical barriers have tended to be the most difficult to overcome in Colorado, particularly staffing shortages. Many of the positions in crisis facilities require individuals with specific licenses or credentials, which are earned by meeting standards of education and experience. Finding individuals who meet these minimum requirements has been challenging; some individuals with experience in the crisis services field are not willing to work the irregular hours these positions often require. Because some of Colorado's crisis facilities were not equipped to treat all crisis cases, transportation had to be made readily available to bring individuals to

facilities that were better equipped. Shortages of staff and facilities can be particularly difficult to overcome in rural and frontier areas, where demand for facility-based services may not be consistent enough to justify the required investment.

The Transportation Pilot Program (TPP) began in February 2018 to facilitate the transportation of individuals placed on voluntary or involuntary 72-hour treatment holds in rural areas to appropriate crisis stabilization units. These individuals typically require the highest levels of crisis stabilization treatment. Historically, these individuals would have been incarcerated or wait for hours to days for an available hospital bed in a psychiatric ward. A 2019 evaluation by the OBH included qualitative reports of high satisfaction with the TPP from various stakeholders, although the authors conceded there was little quantitative evidence to support the conclusions.[58] Furthermore, Colorado Department of Human Services (CDHS) staff noted concerns about the feasibility of operating such a program in rural areas, where transportation services might only be required a few times per month but were always expected to be available.

A shortage of qualified behavioral health professionals is not a problem unique to Colorado. Several adjustments have already been made or are underway in the state to overcome these obstacles in crisis facilities. Notably, there has been a shift in messaging to encourage utilization of the statewide hotline and mobile crisis units rather than facility-based services; they can serve a much larger area than facilities and require significantly less investment in staff and capital. These services help individuals where they are, and staff can make determinations in the field regarding when it is necessary to direct a person to a higher level of care. By reaching people in their communities, hotlines and mobile crisis units can prevent individuals from seeking treatment in an ED, which is one of the primary goals of specialized behavioral health crisis services. Another advantage of these services is that they can help mitigate the shortage of crisis stabilization facilities in rural and frontier areas. Colorado also is reevaluating the requirements for working in crisis stabilization facilities, in an effort to address the staff shortage.

Staff members are expected to quickly and accurately assess the nature and severity of a behavioral health crisis and determine the most appropriate next step, whether it be offering peer support or initiating admission to a 72-hour stabilization unit. However, this assessment does not always occur in practice. Anecdotal reports from CDHS staff indicated that some employees might be uncomfortable interacting with individuals experiencing exacerbated symptoms of their SUD or MH condition. In addition, there are no concrete criteria for determining when someone is too heavily intoxicated for admission; therefore, decisions to turn individuals away and refer them elsewhere (e.g., an ED or withdrawal management facility) could be made arbitrarily.

One specific part of the current requirement reevaluation effort is exploring the feasibility of allowing staff from Withdrawal Management facilities, more colloquially known as “detox” facilities, to screen new arrivals at crisis facilities. The rationale is that these employees may not

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[58] Colorado Office of Behavioral Health. (2019, July 19). *Transportation Pilot Program evaluation: A summary of findings FY 2019.* http://drive.google.com/open?id=1-eNSkblyonLUFNRDcO3C8PUyESf_UnKr

have the required credentials to work in a crisis unit, but they do have significant experience providing services to individuals in crisis who have co-occurring SUD and MH conditions. These employees would likely only require modest procedural training. Crisis stabilization units and walk-in centers also are required to make peer specialists available at least during peak hours, which helps decrease reliance on licensed providers and other skilled professionals who can be more difficult to find and expensive to employ.[55]

Staff at CDHS reported that accurate data collection remains an issue. All crisis stabilization facilities are required to submit data on metrics such as the number of individuals admitted and discharged, including the demographics of these individuals. However, these data are aggregated at the monthly and facility levels, which are frequently inconsistent with the individual-level data that some facilities also report to the state. According to CDHS staff, crisis services providers do not share a single electronic health records system. This situation affects metric collection and reporting and hinders providers' ability to share relevant patient information. The OBH is working to create a single data system for all crisis providers who receive state funding, but this and other efforts to remedy these issues are ongoing.

Educational/Outreach Barriers

A more intangible barrier to crisis services uptake in Colorado has been the perception of these services held by the community members they are intended to serve. CDHS staff reported that it is common for some individuals to be distrustful of crisis stabilization facilities because they believe seeking treatment could result in legal consequences or that they could be locked into the facilities against their will. Staff believed that the word "crisis" carried a strong negative connotation and might dissuade some individuals from seeking services if they were not certain their symptoms were severe enough to be considered a crisis. The shift toward emphasizing mobile crisis units and hotline utilization stemmed in part from a desire to assuage these concerns, and marketing efforts have characterized crisis facilities as safe and less stressful alternatives to EDs. In fact, crisis facilities were sometimes even framed as places where legal consequences might be avoided, although it is important to note that no guarantees were made in this regard.

In addition to public perception, crisis services providers also found that law enforcement and other first responders in some communities were hesitant to divert individuals away from traditional emergency medical services. Various reasons were cited, including concerns about the liability first responders might face if a patient they brought to a crisis facility (instead of an ED) subsequently died or experienced another negative health outcome. CDHS staff also noted that there were numerous reports of law enforcement bringing someone to a crisis facility, only to be told that they needed to be taken to an ED instead. In some areas, this situation left little incentive for law enforcement to divert individuals away from EDs and soured the relationship between first responders and crisis facilities. Millions of dollars have been allocated to train first responders to determine when an individual is an appropriate candidate for crisis stabilization. Although CDHS staff reported that participation in these programs generally has been high, their overall effectiveness has varied. A more reliable factor in determining first responders'

willingness to bring individuals to crisis facilities appears to be the relationship between first responders and the facilities.

Regulatory Barriers

Behavioral health crisis services in Colorado operate under the principle that everyone who needs crisis stabilization treatment will receive it, which is also referred to as a "no wrong door" policy. As a result, crisis treatment providers must be prepared to offer a wide range of services, which in turn requires numerous layers of regulation. Staff at CDHS reported that the facility licensing process currently involves numerous competing entities, such as insurance carriers, ASOs, and state offices both within and outside CDHS and OBH. Other requirements, such as agreements on the required referral and transportation protocols between certain facilities and local emergency services, and specialized crisis-related training for staff, might not be directly tied to licensing, but they are critical to facility operation and can add to administrative burden. According to CDHS staff, the licensing process for crisis stabilization facilities is currently undergoing an extensive overhaul, and there is a push to bring it all under the purview of a single, cabinet-level office.

Perhaps surprisingly, CDHS staff noted that little effort was required to adapt the payment structure to the redesigned crisis system, because crisis-enhanced versions of billing codes for behavioral health services already existed. However, there is constant communication among the various agencies that oversee crisis services, Colorado's Medicaid program, and private insurers to ensure that payers are covering what they are required to cover. To limit out-of-pocket costs and make services available, crisis stabilization services that are not reimbursed by public or private insurance are billed back to the state and paid by CCS.

In a 2018 the Colorado Crisis Services Steering Committee, a workgroup of stakeholders assembled to provide recommendations for the state's crisis stabilization services authored a report. The group recommended that mental health and SUD services be better integrated within crisis stabilization units so individuals presenting with co-occurring conditions could be more seamlessly treated, with the services reimbursed.[59] Crisis facilities that provide higher levels of care must admit individuals with co-occurring conditions, but Colorado regulations still do not allow stabilization units to admit someone who, "has acute withdrawal symptoms, is at risk of withdrawal symptoms, or is incapacitated due to a substance use disorder."[60] Even though crisis facilities are required to admit nearly everyone, first responders are not required or even encouraged to bring individuals to crisis facilities under the current regulations. In addition to the previously mentioned liability concerns, which could also be considered a regulatory issue,

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[59] Colorado Department of Human Services. (2018, June). *Colorado Crisis Steering Committee: Final report and recommendations.* http://mediad.publicbroadcasting.net/p/kunc/files/201807/colorado_crisis_steering_committee_recommendations_report_final_061518.pdf

[60] Colo. Code Regs. § 21.290.51(E)(5).

CDHS has heard from first responders that it is not always clear when someone should be transported to a crisis facility, so they often default to bringing them to the ED.

Arizona

Regulatory and Licensing Structures of CCSCs

Crisis stabilization services have been available in Arizona for decades, but a concerted effort to reform and streamline the system began only recently – and only after a major event drew attention to the shortcomings of the existing system. In 1981, a class action suit, *Arnold v. Sarn,* was filed against the state of Arizona. The Arizona Supreme Court ruled that the state had failed to provide community-based mental health treatment services to residents of Maricopa County with severe mental health conditions, as required by state law.[61] The state subsequently agreed to a detailed remediation plan, but never implemented it. A final settlement reached in 2014 bound the Arizona Department of Health Services to, "maintain a Crisis System, … which provides timely and accessible services and is available 24 hours per day, 7 days per week, to [Maricopa County adults with severe mental health conditions] experiencing a behavioral health crisis, including a crisis due to substance use."[62] The settlement stated that the crisis system should include at least a hotline, mobile crisis units, and crisis stabilization services that can be provided for up to 72 hours in licensed facilities or nontraditional settings such as homes or apartments, where viable. Because the case of *Arnold v. Sarn* concerned access to all behavioral health services for residents with severe mental health conditions, not just crisis services, the settlement also called for significant expansion of patient capacity in supportive housing and employment, the creation of new Assertive Community Treatment (ACT) teams, and other improvements to various community-based services.[60]

Under Arizona regulations, an outpatient treatment center that is authorized to provide crisis services must comply with the same licensing requirements as an outpatient treatment center that is authorized to provide behavioral health services in addition to crisis service-specific regulations.[63] Behavioral health services must be delivered by appropriately licensed behavioral health professionals. A behavioral health assessment must be completed before treatment begins, counseling must be provided by a behavioral health professional according to the frequency and duration identified in the assessment, and each counseling session must be documented. In addition to these requirements, an outpatient treatment centers providing crisis services must ensure that crisis services are available during clinical hours of operation and a qualified behavioral health technician is present in the outpatient treatment center during clinical hours of operation.[64] A behavioral health professional, medical practitioner, and

[61] Arizona Center for Law in the Public Interest. 2014. "Arnold v. Sarn." https://www.centerforpublicrep.org/court_case/arnold-v-sarn/

[62] *Arnold v. Sarn* Final Settlement. https://www.centerforpublicrep.org/wp-content/uploads/2017/06/Stipulation-on-Termination.final_.doc

[63] Ariz. Admin. Code § R9-10-1011;1016.

[64] Ariz. Admin. Code § R9-10-1016.

registered nurse also must be available to provide crisis services during clinical hours of operations.

Experiences with Crisis Stabilization Services

The final settlement reached in *Arnold v. Sarn* required the development of a more robust crisis system in Maricopa County. To this end, the county utilized partnerships between behavioral health providers and law enforcement to minimize the role and responsibility of law enforcement in managing individuals experiencing a behavioral health crisis whenever possible. Law enforcement officers (LEOs) are trained to identify individuals experiencing a behavioral health crisis who should receive care in a crisis stabilization facility, and LEOs are assured that anyone they bring to a facility will be quickly accepted.[65] These partnerships also extend to the "upstream" aspects of the crisis network; including the emergency dispatch system and the crisis-response system; in that both are geared toward early intervention and de-escalation via a hotline and mobile units.[66]

The state's Crisis Response Network (CRN) operates the crisis hotline and mobile crisis units for central and northern Arizona and has been working with law enforcement in Phoenix since 2001 to assist with possible crisis calls when requested. As part of a 2020 pilot program, both law enforcement and a mobile crisis team were sent to the scene of 911 calls involving a behavioral health crisis. This program was well-received by LEOs, but CRN plans to take this a step further and bypass law enforcement by having 911 dispatchers route these calls directly to CRN staff in cases in which a law enforcement response is considered unnecessary. Liability concerns have been cited as the primary reason this process has not been formally implemented.[64]

The crisis services network in Arizona is based on the three components of the Crisis Now model:

- Coordination among statewide and regional call centers;
- Mobile crisis units available 24/7 to provide community stabilization and transportation to crisis stabilization facilities; and
- Facilities that provide short-term (i.e., less than 24 hours) observation to stabilize individuals in crisis and coordinate subsequent care transfer.[67]

There are three RBHAs in Arizona, each of which is responsible for providing these crisis services to their respective region. Prior to October 2018, RBHAs administered the majority of behavioral

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[65] Vestal, C. (2020, February 21). *"Arizona Model" for behavioral health crisis care gains attention from other states*. https://www.azcentral.com/story/news/local/arizona-health/2020/02/21/other-states-copy-arizona-model-behavioral-health-crisis-care/4794168002/

[66] Beck, J., Reuland, M., & Pope, L. (2020, November). *Case study: Robust crisis care and diverting 911 calls to crisis lines*. https://www.vera.org/behavioral-health-crisis-alternatives/robust-crisis-care-and-diverting-911-calls-to-crisis-lines

[67] National Action Alliance for Suicide Prevention: Crisis Services Task Force. *Crisis now: Transforming services is within our reach*. https://theactionalliance.org/sites/default/files/crisisnow.pdf

health services for enrollees in the state's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). However, a statewide shift toward integrating physical and behavioral health care significantly narrowed the scope of services and populations for which RBHAs were responsible.[68] Regardless, contracts between the RBHAs and the AHCCCS specifically state that RBHAs are, "responsible for the provision of a full continuum of crisis services to all individuals, within their [regions]."[69] Additionally, RBHAs must provide these services for the first 23 hours of a crisis episode for Medicaid enrollees and for the first 72 hours for non-Medicaid enrollees. Responsibility for services provided to Medicaid members after the initial 23 hours falls to the members' managed care plan, although RBHAs are required to inform the plan of the crisis episode and coordinate necessary follow-up care.[70]

Arizona's crisis system focuses on providing rapid, community-based stabilization; avoiding facility-based treatment when possible; and never turning down an individual who seeks care, regardless of referral source. Contracts between the RBHAs and the AHCCCS require that an array of short-term crisis services be available, including crisis stabilization units with access to certain drugs used for medication-assisted treatment, so that individuals experiencing any type of crisis can access appropriate services. In Arizona, 23-hour, facility-based stabilization can be offered by facilities already licensed as outpatient behavioral health treatment centers, provided they meet certain staffing and building requirements to do so.[71] Because crisis stabilization units (CSUs) are expected to treat individuals for less than 24 hours and rarely, if ever, turn away individuals seeking care, CSUs coordinate care with an extensive and diverse provider network to ensure that individuals are smoothly transitioned to appropriate long-term treatment when necessary.

Beginning in the third quarter of FY 2019 (April to June), quarterly reports from AHCCCS to CMS note that enhancements are being made to the state's crisis policy that will, "outline specific requirements for mobile crisis response teams, as well as telephone crisis call centers."[72] Subsequent reports state that this work continues, but do not identify the enhancements, and a search of proposed and implemented changes to the AHCCCS medical policy manual provided no additional details. The current AHCCCS medical policy manual already includes the required qualifications for mobile and telephone crisis personnel, but it provides little detail regarding how these services should be structured and established, so it is possible the proposed

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[68] Arizona Health Care Cost Containment System. *AHCCCS complete care: The future of integrated care.* https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/

[69] Arizona Health Care Cost Containment System. *AHCCCS contract amendments, RBHA, Title XIX/XXI RBHA contract amendments*. https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html

[70] Arizona Health Care Cost Containment System. *AHCCCS complete care crisis services FAQ*. https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf

[71] Ariz. Admin. Code § 9-10-1012.

[72] Arizona Health Care Cost Containment System. *AHCCCS quarterly report: April 1, 2019 – June 30, 2019*. https://www.azahcccs.gov/Resources/Downloads/QuarterlyProgressReports/2019/CMSQuarter3ProgressReportAprJun2019.pdf

enhancements are related to this topic.[73] Some notable mobile and telephone crisis policies were implemented in 2020, although it is unclear whether they are the result of these enhancement efforts.

The state activated a new HCPCS code (H0030) on July 1, 2020, specifically for "Behavioral Health Hotline Service," to replace the "Case Management" code that was previously used. New policies regarding which entities are responsible for providing and paying for crisis-related transportation became effective on October 1, 2020.[74] These policies state that RBHAs are responsible for, "crisis related non-emergency medical transportation (NEMT), including transportation provided by mobile teams, [and] transportation for [non-Medicaid] individuals," whereas, "emergent transportation to and from a crisis services provider and NEMT from the crisis service provider to another level of care, or other location, is the responsibility of the [Medicaid] member's plan of enrollment, regardless of the timing within the crisis episode."[74]

Georgia

Regulatory and Licensing Structures of CCSCs

In its 1999 ruling in *Olmstead v. L.C.*, the United States Supreme Court held that keeping people with mental health conditions and/or developmental disabilities in a residential or inpatient psychiatric treatment facility when they would be better served in community-based treatment constitutes a violation of the Americans with Disabilities Act. The Supreme Court mandated that public entities, including state and local governments,

> *"are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."*[75]

This landmark decision resulted in systematic changes in how services were provided to people with mental health conditions and developmental disabilities across the country, and undoubtedly it influenced the crisis systems of each state discussed in this report. It is described in this section; however, because the plaintiffs filed the case after being held in a psychiatric unit

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[73] Arizona Health Care Cost Containment System. *AHCCCS medical policy manual: Section 310-B – Title XIX/XXI behavioral health service benefit*. https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf

[74] Arizona Health Care Cost Containment System. *AHCCCS complete care crisis services FAQ*. https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf

[75] Olmstead v. L.C., 527 U.S. 581 (1999).

of a state-run hospital in Georgia for several years after clinicians there determined they could be safely discharged to community-based services.[76]

Despite being "ground zero" as a catalyst for significant reconsideration of the country's behavioral health system, issues continued to plague Georgia's state psychiatric hospitals for several years after the *Olmstead* ruling. The U.S. Department of Justice eventually launched an investigation and in 2009 released a report detailing "significant and wide-ranging deficiencies" in the care state hospitals provided, which caused "additional, preventable harm" to patients.[77] To settle the matter, Georgia entered into an agreement with the federal government in 2010 to overhaul the state's behavioral health and developmental-disabilities system of care.[78] The agreement required Georgia to greatly improve the availability of community treatment options for people with mental health conditions by creating and maintaining funding for ACT teams, thousands of supportive housing beds, supported employment, peer support services, and other case-management services.[78] Other notable provisions of the agreement included ceasing admissions to state psychiatric hospitals for people with developmental disabilities, waivers to transition those currently institutionalized back to the community, and support for home and community-based services (HCBS) for these individuals.[78] All of these changes were expected to take place in phases between 2011 and 2015; an extension agreement allowed the work to continue to this day.

Most relevant to this report were the provisions of the settlement agreement that required Georgia to establish a variety of behavioral health crisis services programs across the state. Crisis services had been available for decades prior, but they were largely fragmented and varied widely in quality and accessibility. To address these problems, the settlement agreement bound Georgia to establish crisis service centers (CSCs) to provide 24/7, walk-in assessments and referrals, as well as CSUs for short-term residential treatment; maintain 35 all-purpose crisis beds in community hospitals; create a statewide crisis hotline; establish a mobile crisis service that could respond to calls in all 159 counties in one hour or less, 24/7; and provide crisis apartments as community alternatives to other stabilization modalities.[78] The Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD) website states that approximately $256 million "new dollars" went into expanding crisis services between 2011 and 2018. A mandatory independent review of the crisis system in 2015 found that the state had largely met the terms of the settlement agreement, which included opening specified numbers

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[76] United States Department of Justice, Civil Rights Division. *Olmstead: Community integration for everyone*. https://www.ada.gov/olmstead/olmstead_about.htm

[77] United States Department of Justice, Civil Rights Division. (2009, December 8). *Investigation of the state psychiatric hospitals*. https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/Georgia_Psychiatric_Hospitals_findlet_12-08-09.pdf

[78] United States of America v. The State of Georgia Settlement Agreement, (N.D. Ga. 2010) https://dbhdd.georgia.gov/document/document/settlement-agreement-united-states-america-v-state-georgia/download

of each of the aforementioned crisis facilities. The only significant shortcoming noted was the inability of people with developmental disabilities to access some crisis services.[79,80]

The transformation of Georgia's crisis services system spurred by the 2010 settlement agreement is evidenced by the higher number of facilities, as well as the standardization and streamlining of other system functions. Georgia is divided into six regions, each of which has a field office responsible for administering public behavioral health services to the counties in their region, and a regional advisory board tasked with identifying relevant priorities. These field offices serve as the primary point of contact for residents who seek services and have questions about services in their area. They also develop and expand services, investigate complaints, and oversee the implementation of new statewide initiatives.[81] While the field offices handle what could be considered the day-to-day, routine functions of the behavioral health system in each region, the DBHDD ensures the system is operating smoothly statewide.

For Georgia's crisis system, the regional field offices and regional boards serve in advisory roles, whereas the DBHDD certifies crisis providers, grants permission for the opening of new crisis units and facilities and manages all provider contracts for state-funded services. Staff at the DBHDD explained that crisis services are generally considered part of the behavioral health safety net. Since Georgia has not elected to expand Medicaid eligibility under the Patient Protection and Affordable Care Act, most people served by crisis providers are uninsured. Therefore, approximately 75 percent of crisis services in Georgia are funded with state money from DBHDD. The state's CSUs receive a 1/12 drawdown of their yearly budget each month, although DBHDD staff reported that these funds primarily pay for infrastructure costs and do not fully cover other costs related to staffing and service provision. Because CSUs are considered residential facilities, payment for services there is further limited by federal regulations that bar the use of Medicaid funds for residential mental health treatment at facilities with 16 or more beds, which includes most CSUs in Georgia.

Regardless of the payer, CSUs are only permitted to bill an all-inclusive code (HCPCS H0018) for each day of service, with some modifiers allowed as appropriate. Medicaid still pays for nearly all the remaining 25 percent of crisis services not covered by the DBHDD, and much of this is collected by CSCs, which provide short-term services such as evaluations, brief interventions, and referrals on a walk-in basis. In contrast to CSUs, services at CSCs bill individually, just as if they were being provided at any other outpatient facility, although there are some restrictions on the types of services and the number of daily units for which they can bill.

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[79] Georgia Department of Behavioral Health and Developmental Disabilities. *ADA settlement agreement*. https://dbhdd.georgia.gov/organization/be-informed/reports-performance/ada-settlement-agreement

[80] Baron, S. T. (2015, September 12). *Review of crisis services*. https://dbhdd.georgia.gov/document/document/review-crisis-services/download

[81] Georgia Department of Behavioral Health and Developmental Disabilities. *Regional field offices*. https://dbhdd.georgia.gov/regional-field-offices

Their almost total reliance on state funds means that CSUs are subject to additional DBHDD oversight. All behavioral health services are required to meet minimum requirements for staffing, infrastructure, documentation, etc., but CSUs are unique among crisis modalities in Georgia in that they must be specially certified by the DBHDD and can only apply for this certification upon the department's invitation. According to DBHDD staff, opening a new CSU – either as a standalone facility or by expanding a current facility's service offerings – requires a substantial initial investment. Furthermore, certified CSUs are required to accept nearly all referred patients, so the invitation-only system is necessary to preserve scarce state funds that would be rapidly depleted if standards for new facility openings were relaxed.

Candidate sites for new CSUs are selected in part by using data collected from the state's crisis telephone hotline, the Georgia Crisis and Access Line (GCAL). GCAL is a statewide service that functions like any other crisis hotline: residents call a toll-free number and are connected to a trained specialist who screens the call and determines whether the caller can be stabilized during the call or requires a referral to a higher level of care. What makes GCAL unique; however, is the robust online referral database that allows every crisis provider in the state to see in real time who the hotline's staff has referred to crisis care, when they were referred, where the person is located, and which facility is closest, among other information. This system generates massive amounts of data, and, because most crisis referrals come through GCAL, these data are a valid approximation of overall crisis-system utilization across the state. Since 2015, the DBHDD has used this data to develop an algorithm that helps officials identify areas of the state that would most benefit from the establishment of a CSU. This algorithm is complex and was developed by a specialized programming team, so DBHDD staff were not able to provide details on its inputs.

Experiences with Crisis Stabilization Services

The pace with which new, state-funded CSUs can be opened is limited by practical factors, such as the budget, length of the certification process, and, most recently, the COVID-19 pandemic. However, the DBHDD establishes one new facility per year on average, with plans for no fewer than eight future CSUs already underway as of this writing. DBHDD staff reported that the demand for CSUs and other crisis stabilization services has been high for many years, and they have had little trouble finding providers who are willing and able to expand to offer such services. In addition, they stated that efforts to expand crisis services in general have received widespread support from state residents and other community stakeholders. Overall, DBHDD staff reported few nonfinancial barriers to community-based crisis services. The state's centralized regulatory structure streamlines certification and licensing processes in many cases, which makes the common issue of staff shortages less of a hindrance to crisis-system functioning.

As seen in Table 5 (page 24 of this report) staffing requirements for crisis facilities are fairly standard. Facilities must employ a mix of physicians/prescribers, nurses, behavioral health specialists, and peer support specialists. In some cases, Georgia's regulations allow staff to move between crisis modalities that are housed within the same facility. For example, physician

coverage may be shared by a CSC and CSU if coverage requirements are still met for both facilities. Registered nurses also are allowed to float between CSCs and temporary observation units, which are lower-level CSUs that must be associated with a CSC or CSU.[82] Flexible policies such as these allow for the establishment of behavioral health crisis centers (facilities that offer CSU, CSC, and other crisis services in the same location).

Vermont

Regulatory and Licensing Structures of CCSCs

Vermont's crisis system is unlike the systems of other states described in this report. The state's crisis system was not created after a specific tragedy, nor was it revamped under pressure from a court order. Rather, staff from the state's Department of Mental Health (DMH), within the Agency of Human Services, reported that the current structure of the crisis system is essentially the same as it has been for decades. Public mental health services and other related functions in Vermont are provided directly by one of ten private designated agencies (DAs), each of which has a catchment area spanning one to three counties.[83] DAs are required to meet minimum standards to receive their DA designation, including offering crisis services, and are subject to periodic recertification to maintain it. However, DMH staff explained that DAs develop delivery systems based on the unique needs of the residents in their catchment areas, and there are few, if any, laws that establish statewide parameters for crisis services. In other words, referring to Vermont's "crisis system" is somewhat misleading, because it implies a greater level of uniformity than actually exists across the state.

Every DA is mandated to at least offer "Emergency Care and Assessment Services."[84] This term describes various types of screening, evaluation, and outreach intended to determine the appropriate treatment needs of residents with severe mental health conditions, either acute or chronic, or who are experiencing a mental health crisis. These services must be made available 24/7 both via telephone and in-person in an office or other community setting.

Even though there are no other requirements, DMH staff reported that each DA provides additional crisis services, often well beyond these minimums. For example, two DAs have dedicated mobile crisis teams, and the state's capital of Burlington has a mobile team that provides targeted outreach to at-risk populations, such as people who are homeless. The team also offers links to community resources and raises awareness of crisis service availability, all of

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[82] Georgia Department of Behavioral Health and Developmental Disabilities. *Provider manual for community behavioral health providers, fiscal year 2021, quarter 3*. http://dbhdd.org/files/Provider-Manual-BH.pdf

[83] Vermont Agency of Human Services, Department of Mental Health. *Designated and specialized service agencies*. https://mentalhealth.vermont.gov/individuals-and-families/designated-and-specialized-service-agencies

[84] Vermont Agency of Human Services, Department of Mental Health. *Mental health provider manual, part 1: Community-based mental health services for children and adults*. https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/MH_Provider_Manual_1-14-21.pdf

which is intended to prevent or reduce severe crisis episodes. Every DA also operates at least one facility-based CSU that provides services similar to CSUs in the other states in this report.

Requirements for Vermont's CSUs are somewhat standard in that they must offer services such as care coordination, support, and referral. However, they are not subject to the statewide restrictions that exist in some other states, such as 23-hour observation stays and mandatory staffing levels, because the contracts between DAs and the state are intended to be flexible.[84] Vermont has many sparsely populated areas, so it would be difficult, for example, to require a specific number or ratio of how many highly trained and costly providers must be present in every facility. Therefore, DAs may determine what staffing configuration is the most appropriate for them, given network adequacy and financial viability.

Experiences with Crisis Stabilization Services

Some public funds are allocated specifically for crisis services, and state reimbursement for almost all DA services is calculated as a case rate, or per member per month, so providers with low patient volumes can afford to stay open.[84] The state is also in the midst of a multi-year effort to switch to a value-based model in which reimbursement is tied to outcomes, but it will be some time before this model is implemented statewide. One notable barrier that DMH staff stated severely limits the size and function of CSUs is that any facility with more than six beds must be separately licensed as a therapeutic living community. As a result, only the largest DAs operate CSUs with six beds, and most of the rest have approximately two beds. Furthermore, CSUs are required to admit people with SUDs who meet general admission criteria, but withdrawal management and most other SUD services fall under the purview of a separate state agency and not DMH.

The flexibility afforded by Vermont's decentralized crisis-system structure has allowed some DAs to experiment with innovative ideas. Roughly two or three years ago, two DAs began embedding crisis workers with law enforcement officers to assist them on calls involving people potentially experiencing a mental health crisis. DMH staff reported that feedback from law enforcement personnel about this program has been overwhelmingly positive. Both DAs have been collecting data to quantify the initiative's effect, but anecdotal evidence suggests that it has resulted in fewer ED visits and arrests for mental health-related calls. These programs were established through agreements between DAs and counties or cities in their catchment areas and required no changes to local or state laws. According to DMH staff, they are close to finalizing a similar agreement with Vermont State Police, although liability concerns remain a complication, and the state is still working to standardize data collection; the two DAs that piloted the program did not gather the same data. There is also interest in expanding crisis-identification and referral training to other first responders statewide, but this has not yet occurred. At this time referrals still come through local channels, such as EDs, community agencies, and the hotline that each DA maintains.

Conclusion and Next Steps

The expansion of a select number of OMHCs into CCSCs could significantly improve Maryland's behavioral health crisis network and allow individuals who experience a behavioral health crisis to receive treatment outside an ED. This initiative would represent a more unified vision of both behavioral health – as well as crisis care – than what currently exists in the state. OMHCs currently provide individual, group, and family therapy, as well as medication management. Many are capable of expanding to include the short-term observation and crisis stabilization services characteristic of CCSCs.

There are numerous examples of efforts by community organizations and various levels of government to increase access to behavioral health crisis stabilization services in communities within Maryland. The Tuerk House in Baltimore City opened in 2018 and closely resembles the proposed CCSC pilot sites in terms of target populations and service offerings. There are several other facilities across the state that serve as important access points to behavioral health crisis services. These facilities and the demand for similar facilities elsewhere are evidence that crisis stabilization services are not only a viable alternative to the use of traditional and costly emergency services for Marylanders in crisis, but also are greatly needed.

As described throughout this report, there are multiple potentially significant barriers to enhancing crisis service availability. These barriers can largely be categorized as either financial or regulatory.

The primary financial barriers to expanding the service offerings of OMHCs to include crisis stabilization services include: securing funding for the initial expansion, as well as ensuring that future funding streams will be consistent and sufficient to facilitate smooth functioning and allow facilities to adapt to changing community needs. At the core of this issue is that the state will need to ensure coverage of crisis services by Maryland payers. The Tuerk House and other crisis centers across the state have primarily relied on a combination of grant and local funding, which can be inconsistent and limit service offerings to certain modalities or populations, depending on the source. The Klein Family Harford Crisis Center in Bel Air bills insurance for professional fees and is reimbursed on a per diem basis by the state Behavioral Health Administration for room and board and case management. However, this arrangement does not cover all operating costs, and most private insurers will not reimburse any services. This facility and some others also receive philanthropic support.

Overcoming Financial Barriers

This report describes how other states have addressed financing issues when expanding their crisis services systems, and Maryland may be in a position to leverage the work performed by other states as they work to build out CCSC infrastructure and coverage. Of the states reviewed in this report, each one allows crisis providers to bill at least some services to the state or Medicaid. A sample of these services and their accompanying HCPCS codes are shown in Table 6. This table is far from a comprehensive crisis services billing manual, and just because a state is

not indicated as billing a particular code does not mean they do not in fact bill it. Rather, the purpose of this table is to illustrate the substantial variety and overlap in how states bill for crisis services, and that there is no single correct approach. Additionally, none of the codes in Table 6 were created or invented for these states; these codes already and were in use, they were merely adapted to fit the needs of each states' expanding crisis system.

Table 6. Selection of HCPCS Codes Used to Bill for Crisis Services in Arizona, Colorado, Georgia, and Vermont

HCPCS Code	Code Description & Duration	State(s)
90839	60-minute crisis psychotherapy session	VT
H0018	Behavioral health; short-term residential (non-hospital), without room and board, per diem	CO, GA
H0030	Behavioral health hotline service (per 15 minutes)	AZ
H0045	Respite care services, not in the home, per diem	CO, GA
H0046	Mental health services, not otherwise specified	VT
H2011	Crisis intervention service, per 15 minutes	AZ, VT
S5151	Unskilled respite care, not hospice, per diem	CO
S9484	Crisis intervention mental health services, per hour	AZ
S9485	Crisis intervention mental health services, per diem	AZ, VT
S9976	Room and board, per diem	CO

Based on this review of the literature, it is also common for state funds to be specifically allocated for crisis services every time a new state budget is passed. In some states, these funds are used to cover a facility's capital costs and can go a long way toward compensating for reimbursement shortfalls. Physically expanding or renovating an existing OMHC to include stabilization units with beds or chairs will be cost-prohibitive for the vast majority of Maryland providers. In order to overcome this challenge Maryland will need to determine the roles that the state, providers, and other stakeholders will play with regard to creating a pool of start-up expansion capital to assist OMHCs to secure suitable space, onboard staff, and enhance other infrastructure including security, capacity to provide low-level medical care, etc. In addition, the current regulations in Maryland surrounding billing for services will need to be addressed and expanded to include crisis services. It is possible that an hourly rate that takes the key service requirements into account might be the best solution to address these issues.

Overcoming Regulatory Barriers

There are several key regulatory barriers that will need to be addressed if Maryland pursues allowing OMHCs to expand to provide crisis services. One of the most challenging will be creating the licensing and accreditation processes for OMHCs wishing to expand to provide crisis services. The state will need to decide whether to create a new class of providers, or create an expanded level of OMHC licensing and accreditation that would include the provision of crisis services. There is overlap between the services offered by both types of facilities, but where they differ,

they differ significantly. People receiving services at a CCSC should have access to individual and/or group therapy, as they would in an OMHC. However, a typical OMHC is unlikely to have any beds for crisis observation or stabilization. If 23-hour observation and stabilization is offered at a facility, but inpatient or residential crisis services are not, then chairs might be suitable rather than beds (as in the Mental Health Association of Frederick County model). If so, the acceptable number of chairs per facility, the specific differences between a chair and a bed for billing purposes and other details remains to be determined.

With regard to a regulatory framework for CCSCs, the state must determine if expanding capacity for OMHCs to provide the full compendium of CCSC services will be treated like licensing and accrediting a new facility, or if the process will be comparable to an existing provider adding a new service line. Given the service overlap, both approaches could be justified. The Klein Family Harford Crisis Center takes pride in its open living room-style stabilization unit. This style of crisis services delivery has become popular in recent years because it naturally encourages positive peer interaction and has a less institutional feel. Regulatory bodies should consider whether a model such as this should be the standard that all OMHCs that expand to provide CCSC services must meet for licensure and accreditation, or if the minimum standard should be set lower, giving providers room for flexibility.

The second major regulatory barrier for OMHCs to expand to provide CCSC services expansion involves staff, specifically the minimum staffing requirements and training. Maryland's OMHCs are mandated to employ a team of multidisciplinary behavioral health specialists that can include, but is not limited to, psychiatrists, therapists, nurses, social workers, and case managers. This broad requirement may be well-suited to a CCSC, and indeed it has appeared to work well for the crisis centers currently operating in Maryland. However, because CCSCs provide care 24/7/365, staffing requirements are great, and it is important to determine which positions are necessary at all hours. Staff from multiple crisis centers in Maryland reported that salaries were the highest operating costs for their programs. CCSC staffing requirements must find a balance between what is appropriate for high-quality care around the clock and what the average facility can afford while still taking into account impacts of non-24/hour staffing on other aspects of crisis infrastructure including MCR teams, EMS, and law enforcement.

The state also must decide whether additional training and/or qualifications are necessary for CCSC service providers, as their responsibilities will be similar, but not the same as personnel in traditional outpatient clinics. Shortages of qualified staff have long been a concern in Colorado and elsewhere, in part due to licensing and credentialing rules that were developed for previous iterations of the crisis system, as well as overlapping responsibilities in the governmental agencies that oversee these processes. Attempts to streamline this bureaucratic complexity are underway, but it has taken and may still take years to fully address the issue in that state. Carefully identifying and resolving contradictions in staffing and other policies can help Maryland avoid similar complications. In addition, as access to telehealth expands, the role that this may play in increasing access to qualified personnel who may not be physically located in rural areas or are very expensive to retain on a full-time basis.

Appendix. Methodology for Environmental Scan

Assigning Team Leads and Determining Capacity

The project manager, David Idala, who has extensive experience leading program evaluations and addressing policy issues for the Maryland Department of Health (the Department), convened the Hilltop Health Reform Studies team and the Hilltop Medicaid Policy Studies team to develop the proposal and scope of work for the Department funding. Based on their content expertise and experience, three project leads (Brenna Tan, Tim Williams, and Morgane Mouslim) were chosen to develop and carry out the environmental scan process. Brenna Tan, who has complementary expertise in legal research and healthcare reform, was chosen to lead the environmental scan on legislative and regulatory barriers to the transformation of OMHCs to CCSCs. The two other leads (Morgane Mouslim and Tim Williams) were tasked with project coordination, the environmental scan of the OMHC transformation experience in Maryland and other states, and data analytics.

Outlining the Scope of Work

The purpose of this environmental scan was to 1) identify regulatory and licensing barriers to the expansion of OMHCs into CCSCs in Maryland, and 2) describe the development and implementation experiences of crisis providers in Maryland and of wider crisis services systems in other states.

Creating a Timeline and Setting Goals

The timeline for this project was set a priori in collaboration with the Department and OMHC-CCSC Transformation Workgroup. This environmental scan is one part of the multipronged project that is the Department's Opioid Operational Command Center (OOCC) Grant. The figure below depicts the OOCC Grant timeline; highlighted in yellow are the tasks completed by Hilltop as part of the funded scope of work. There were monthly internal meetings between Hilltop and the Department, during which any timeline revisions were addressed and progress reports were delivered.

Figure 1. Grant Timeline

	OOCC Competitive Grant Timeline	2020				2021					
		Q1	Q2			Q3			Q4		
Roles		Sept.	Oct.	Nov.	Dec	Jan.	Feb.	Mar.	Apr.	May	Jun.
MDH	Convene Stakeholders										
MDH	Monthly Stakeholder Meetings										
MDH	Pursue Sustainable Funding Mechanisms										
MDH	Hire Program Coodinator										
MDH	Onboard Contractors										
MDH	Formalize Data Sharing Partnerships										
UMBC	Perform Data Analysis										
UMBC	Perform Envionrmental Scan										
MDH	Onboard OMHC Buissness Coach										
MDH	Perform Buisness Needs Assessment										
MDH	Development of Pilot RFP										

**UMBC: University of Maryland Baltimore County*
*** MDH: Maryland Department of Health*

Outlining Information to be Collected

Two of the project leads (Tim Williams and Morgane Mouslim) reviewed the funded grant and approved scope of work for this project to create a proposed outline of the environmental scan. They assigned team members to work on different sections of the outline and the project based on personal expertise and prior experience. Team members were tasked with further editing their outline section based on their content knowledge. The final outline was reviewed and approved by the Department. The final outline included three broad sections:

1. A review of the legislative and regulatory requirements regarding OMHCs and CCSCs and an analysis of the potential legislative and regulatory barriers to OMHC transformation
2. A literature review and a series of semi-structured qualitative interviews with key informants at crisis services providers and regulatory agencies within and outside of Maryland to learn more about their experiences implementing and operating CCSCs and comprehensive crisis networks
3. A quantitative analysis of behavioral health ED utilization in Maryland, with the goal of identifying ED diversion needs by geographical area to guide pilot site selection

Identifying and Engaging Stakeholders

An initial list of important stakeholders was identified in two ways:

1. Hilltop closely collaborated with the Department and the OMHC-CCSC Transformation Workgroup to identify initial stakeholders to engage.

2. Hilltop did a preliminary scan of the OMHC-CCSC landscape, both nationally and in Maryland, to compile a list of potential stakeholders to engage.

To identify and convene additional stakeholders, Hilltop employed a "snowball" scheme, asking stakeholders to identify and refer other important stakeholders.

Analyzing and Synthesizing Results in a Report

Halfway through the funding period, team members began compiling and interpreting the results of the legislative and regulatory review, collecting and identifying common themes from the semi-structured interviews with key informants; and analyzing results from the ED-utilization analysis. The analysis and synthesis were carried out with the goal of identifying and reporting salient information that could best guide the Department in its assistance of OMHCs expanding to CCSCs and selection of pilot sites in Maryland.

Disseminating Results to Stakeholders

The Department did not specify a reporting format or reporting template. Hilltop elected to provide the final report of this project in paper format for the Department and any approved and interested stakeholders. Additionally, the environmental scan team may present this report at national, state, and local conferences, pending Department approval.

The Hilltop Institute

UMBC

Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854
www.hilltopinstitute.org