

Why Some Individuals Seeking Psychiatric Services are Waiting Extensive Lengths of Time for Beds in EDs and What Can be Done

There are a number of reasons that individuals wind up waiting, in some cases extensive lengths of time in EDs for inpatient psychiatric bed admission. The reasons relate to a combination of factors including the following key reasons:

- certain profiles of the individuals presenting, (those with medical co-morbidities, and/or aggressive behavior, and/or profound intellectual disabilities and/or substance abuse and/or no insurance tend to be those more frequently waiting longer);
- the time of week, data (from MBHP and DPH) indicate that weekends are by far the times when inpatient units are least likely to discharge patients and thus less able to admit patients (this is due in part to the fact that the inpatient and community-based psychiatric service system tends to be less well staffed and have fewer operating hours on the weekend so hospitals are reluctant and less prepared in their processes and staffing to discharge and admit, and the community system has fewer resources in place to support weekend discharges);
- the lack of standing crisis plans that the ESPs, EDs and inpatient units have access to for individuals whom are often known to the system, who typically have had several hospitalizations and are known to have had troubled inpatient stays;
- the dearth of inpatient units with true vacancies in the system (hospitals typically can only manage a certain number at a time individuals who are requiring single rooms and extra levels of staffing because of aggression and will have to decline other such individuals due to the high “acuity” level of the unit to protect the safety of the other patients and the staff),
- the fact that many private insurers and Medicare don’t cover critical community-based diversionary and step-down services, that are critical for diverting individuals from inpatient admission and are available for individuals to utilize as an intermediate step back into community living from inpatient hospital settings. For example, most respite and crisis stabilization services are not covered by private/commercial insurance, and many insurers do not provide coverage for case management,
- a shortage of acute inpatient psychiatric beds and for children/adolescents, a shortage of CBAT/ICBAT¹ beds during the school year, and a need to incent general hospitals to support psych units and promote opening of new psychiatric beds/units/hospitals, and
- a potentially protracted process in the ED when a prior authorization from an MCE to approve an admission and other accompanying resources such as “specials” are necessary to obtain before the search for a bed can begin and there is a delay in this process.

The following narrative provides more details about the process in EDs of individuals seeking and obtaining psychiatric inpatient services, the barriers to obtaining a bed, data on who is waiting. This is followed by priority issue and solution idea lists that were compiled from several workgroups that focused on different aspects of the noted problems, i.e., individuals presenting with aggressive behavior or substance use in the ED, medical co-morbidities, the particular issues when presenting individuals are children/adolescents and the particular issues that pertain to MassHealth participating insurers. The workgroups met in April and May to focus on their priority issues and develop potential strategies that they believed were the most feasible and would have the greatest impact in terms of addressing the issues.

¹ Community Based Acute Treatment settings.

The narrative is organized into the following sections:

1. The ED, bed locator and psychiatric inpatient hospital processes and some of the barriers to psychiatric inpatient admission in more detail;
2. Some highlights of the data on the profile of those most likely waiting longest;
3. A brief description of what agencies or entities have control over the operations and movement among the different locations (EDs, psych hospitals and community based providers), and
4. A description of what kinds of insurance coverage issues exist and for whom, and
5. A list of proposed priority solution ideas focusing on different “stuck” populations.

I. The ED, Bed Locator and Psych Hospital Intake Process

ED PROCESS

The following are the steps that occur in the ED when an ESP clinician and PA are involved. At the end are the steps that occur in the ED when an individual is privately insured or has no managed care insurance i.e., has Medicare or no insurance at all. Note: *ESPs see approximately 70% of all visitors to the ED for behavioral health issues. The commercially insured represent about 30% of those seeking psychiatric services who are seen in the EDs*

1. If private insurance is NOT the primary payer, the ED physician calls the ESP team to request a clinical evaluation. It varies from ED to ED when the call to the ESP team is made, and in some cases, the ESP team is integrated into the work of the ED and are already present.
2. ESP teams are under contract with each of the MassHealth-participating MCEs to arrive at the ED within 45 minutes of a call to conduct an evaluation (note: the statewide average time is running less than).
3. The clinical evaluation includes a mental status exam, psycho-social history, an assessment of acuity and of the risk of the individual attempting to harm him/herself or others, review of available clinical records, and an initial determination of the level of care needed. When the ESP clinician has made an initial determination of the level of care needed, he/she will to present the determination recommendation to another ESP clinician or supervisor, in more complex cases, an ESP psychiatrist, for approval.
4. The ESP clinician makes the ESP-approved recommendation to the ED clinician and if the ED clinician agrees (which is the majority of the time), the ED clinician signs the appropriate psychiatric admission papers (i.e. Section 12, 10, etc).
5. At this point the ESP clinician calls the MCE for an authorization to begin the bed search (if the recommendation is to hospitalize) or for admission to an alternative level of MCE-funded care such as Enhanced Acute Treatment Services (EATS) (which are substance abuse services), crisis stabilization services, or intensive outpatient care coordination if that is the recommendation.
6. The pre-authorization is a verbal approval to locate a bed for an acute admission. This is typically documented in the ESP record by noting the pre-authorization and the individual the ESP clinician spoke to. The pre-authorization in the case of hospital level of care is typically a 3-5 day pre-authorization. If the individual is waiting for admission in the ED, the ESP clinicians must update/notify the MCEs daily regarding whether there has been a level of care need change, and begin the bed finding process fresh each day. After a bed is located, the ESP then contacts the MCE again to finalize the authorization.

7. When the ESP has identified that a psychiatric inpatient facility has an available bed the ESP then waits for a call back from the prospective admitting facility at which point there is a phone intake and then documents are faxed from the ESP to the admitting facility for review of the case. Documents include the evaluation documentation and current labs that were done at the ED. Many hospitals and hospital units require a comprehensive set of labwork as standard practice. Often there is a call back from the admitting facility at which point clarifications are requested and additional information, such as further lab work or history may be requested as well. This is where discussion of the need for 1:1 or other special needs are discussed.
8. ESP clinicians provide services to individuals in the ED in addition to conducting the evaluations. They are trained in talking with individuals in behavioral health crisis and can assist in de-escalation. ESP clinicians are often in the ED during much of the time at the initial intervention while the individual is waiting for discharge to a hospital or alternative. If a bed is not located, the individual will board at the ED and the ESP clinician will then re-evaluate the individual every 24 hours. Note: Someone is considered by the ESP teams to be “boarding” in the ED after the ESP assessment has been completed and an acute inpatient bed has not been secured as a result of the ESP’s first calls to the psychiatric units in the state.
9. Once an admitting facility accepts the admission, the ESP clinician then contacts the MCE to get an authorization number. This step includes time needed for a call-back from the MCE and in some cases additional negotiations may occur at this stage regarding unique circumstances of the case. The MCE prior-authorization process steps can together typically add over an hour to the timeframe.
10. The ESP clinician then contacts the admitting facility with the authorization number and the admitting facility provides the date and time of admission as well as the admission contact.
11. The ESP clinician provides the admission information to the ED and the ED arranges for transport to the admitting facility.
12. The process that the EDs conduct when an individual has private insurance varies from ED to ED. In some cases, the EDs contract with ESPs separately. In other cases the EDs contract with another psychiatric evaluation services, as is the case with Morton, Sturdy, and Good Samaritan, Hospitals, which contract with a McLean Hospital psychiatric team, and in other cases the EDs rely on the psychiatric service staff of their own hospital or the ED clinicians themselves simply conduct the evaluation and seek the MCE authorization and find the beds themselves.

BED LOCATER PROCESS

The “bed locator,” MABHAccess.com, system was developed in 2009 for the purpose of giving entities that arrange admissions – ESPs, EDs, and MassHealth contracted MCEs- access to bed availability to assist with placing anyone in need of inpatient psychiatric admissions, i.e.,: people covered by any payer and those who are uninsured. The bed availability system includes all psychiatric hospitals in Massachusetts that wish to participate as well as some in close proximity in contiguous states; it also includes availability at other levels of care such as substance use programs, crisis stabilization units, etc.

Psychiatric hospitals and units report and update information about the availability of beds once every 8-hour shift. Some also provide additional information regarding the status of the vacant beds, for example if the vacant beds are blocked temporarily because of reasons such as: “X # beds closed due to construction, gender of beds available, X# people waiting in their own ED, no single rooms, can take low

acuity due to # on 1:1s,” etc. They are then asked to update the locator when these issues abate. MBHP calls any facility, 7 days/week, if it has not updated for 10 hours.

CASES OF UNINSURED OR MEDICARE/MEDICAID-COVERED INDIVIDUALS

The following describes the scenario regarding individuals who are uninsured and how/whether the hospital EDs are reimbursed. It should be noted that all general hospitals have financial staff who can assist with identifying an individuals insured status but hospitals do NOT typically have such staff available working on weekends, which may contribute to a delay in the bed location and approval process for an individual.

ED REIMBURSEMENT OPTIONS FOR NO INSURANCE² AND FFS INSURED

Person has No Insurance, And No CommCare eligibility info in system	Person has No Insurance, And system says: Eligible for CommCare-Unenrolled, Health SafetyNet is available	Person has No Insurance, And system says: Eligible for CommCare-Unenrolled, HSN is Exhausted	Person is Dually eligible or Medicare-only, but Lifetime coverage for psych inpatient days exhausted
<ul style="list-style-type: none"> • Help individual apply for emergency MassHealth • When eligibility is determined: <ul style="list-style-type: none"> ○ If MassHealth eligible, MassHealth FFS will pay with an effective date that depends on the coverage type and other factors. There is no specific provision for “emergency” coverage. ○ If CommCare-only eligible, will trigger Health SafetyNet (HSN) eligibility. HSN will pay from date of eligibility determination until CommCare plan effective date, and if no enrollment in Commcare plan, then will pay for up to maximum of 90 days. ED costs will not be covered 	<ul style="list-style-type: none"> • Help individual to enroll in CommCare • HSN will cover costs of general hospital ED services at Medicare outpatient rate until plan enrollment effective date or 90 days elapses (and HSN is exhausted), whichever is sooner. 	<ul style="list-style-type: none"> • Help individual to enroll in CommCare • HSN 90-day clock should start up immediately and will cover costs of general hospital ED services at Medicare outpatient rate until plan enrollment or 90 days elapses a(nd HSN is exhausted again) whichever is sooner. 	ED visit covered at a PAPE rate that includes Pharmacy as part of the technical component of the rate but not the physician professional fee. Payable Lab codes are paid according to independent lab fee schedule set by DHCFP. Also, MassHealth pays the lower of: (1) member’s liability and (2) MassHealth rate less Medicare payment.

II. Highlights of ED LOS Data (from MBHP data on ESP/MCI encounters across all contracted payers)

- Volume data for 2010 and 2011 based on volume of ESP/MCI encounters for adults, across all contracted payers, show that overall, volume of individuals seeking psychiatric services has continued to increase in both hospital EDs and community- based locations. For all ages, those who receive ESP/MCI interventions in community- based locations has increased at a higher percentage than those in EDs.
 - In January 2012, 28% of ESP/MCI encounters were in the community vs. 72% in the ED.

² According to recent DHCFP data, there is a high rate of individuals in EDs with no insurance (around 10%) presenting for psych services in EDs and it is speculated that a key reason for this is that individuals have allowed public insurance to lapse due to paperwork issues and/or have taken too long to make a choice of health care plan via the connector.

- For youth, the percentage of encounters in the community continues to significantly trend upward while the percentage of those in hospital EDs is significantly trending downward.
- In January 2012, 55% of youth MCI encounters were provided in the community vs. 45% in the ED.
- The average inpatient bed search time is approximately 4 ½ hours.
- The top barriers to admission between 9/11-2/12 for adult MBHP members were in the category “other” (31%), which includes member acuity, unit acuity, mobility/wheelchair, no single rooms, sexualized behavior, language, pregnancy, legal issues, member/family choice of facilities, etc., followed by medical co-morbidity (23%). For children/adolescent MBHP members in this same time period, Autism Spectrum Disorders (33%) was the most common barrier followed by “assault risk” (29%).
- Self/family referrals are the highest volume referral source.
- A greater proportion of the individuals in EDs awaiting psychiatric inpatient services are adults vs. children/adolescents.
- There has been a dramatic decrease in referrals to the ED from state-contracted community living/residential programs between 2010 and 2011.
- Of MBHP members, who typically comprise over a third of individuals seeking psychiatric services in EDs, for the period 9/11-2/12:
 - 59% were male while 41% were female,
 - 80% of the MBHP Members who waited for inpatient admissions were adults (19+), 16% adolescents (13-18), and 4% children (4%), and approximately half the children and adolescents and 86% of the adults had no state agency involvement identified at the time of the ESP/MCI encounter. Approximately half of the children and adolescents had DCF involvement. It is important to keep in mind that this data is for MBHP Members only; most DCF and DYS youth are MBHP Members, while most DMH and DDS adults are not MBHP Members, ie: they are covered by Medicare or Medicare/Medicaid.
- Psych hospital/unit beds: It should be noted that the rate of individuals seeking acute inpatient psychiatric hospital admission is increasing faster than the rate of new psychiatric beds coming on line and there is a threat of more hospital bed closures this summer.

2006	2007	2008	2009	2010	2011
Adult = 1730	Adult= 1730	Adult = 1751	Adult = 1774	Adult = 1773	Adult = 1746
Geri = 253	Geri = 253	Geri = 272	Geri = 321	Geri = 347	Geri = 347
Adol = 178	Adol = 178	Adol = 169	Adol = 146	Adol = 146	Adol = 146
Child – 61	Child = 61	Child = 61	Child = 49	Child = 49	Child = 49
Child/Adol = 80	Child/Adol = 104	Child/Adol = 80	Child/Adol = 80	Child/Adol = 92	Child/Adol = 92
2302 beds	2302 beds	2333 beds	2370 beds	2407 beds	2380 beds
	No change	Up 31 beds	Up 37 beds	Up 37 beds	Down 27 beds

Note: These beds are located in 60 hospitals statewide. Fourteen are freestanding private psych facilities and 46 are units in general hospitals.

III. The Parameters of Licensure vs. Contract Monitoring Activity and Psychiatric Inpatient Units/Hospitals

Licensure and Contracting of Acute Psychiatric hospital Services

- DPH licenses general acute hospitals and oversees compliance with licensure requirements including hospital performance relative to quality and access to care

- DMH licenses psychiatric hospitals and psych units in general hospitals and conducts bi-annual licensure audits – more if there are compliance issues found and corrective action plans in place. Note about psych unit staffing: DMH regulations indicate that facilities must maintain nursing force levels deemed adequate by the Department, but the formula for determining adequacy is informal and not in regulation. Furthermore, there is no provision or requirement that there be a higher level of nursing under different circumstances such as when there may be a few patients on a unit at a time requiring significantly more hours of nursing care than on average. Last, there is similarly not currently a licensure requirement for psychiatric units that the hospitals must employ nursing staff that maintain and update their medical care nursing skills as the units are not considered medical/psychiatric units.

The facility shall maintain such nursing force at levels deemed adequate by the Department.

- Licensure includes assessing whether planned staffing and actual physical plant meet a set of requirements for safe and high quality operations and that any serious incidents or complaints are investigated and ensuring that corrective actions occur, as required. Licenses are typically reviewed and renewed on an every year or longer basis. Licensing staff follow-up on incidents and complaints and as necessary may implement corrective actions with an entity, however, unless the licensing organization also contracts with a provider, the licensure process does not entail monitoring operations on a daily basis.
- All psychiatric hospitals and units are required to maintain a “no reject” policy that pertains to decisions not to admit a patient that are discriminatory. Licensing staff do not monitor adherence to this operating policy, though may be informed of non-compliance via a complaint or incident and/or upon review of documentation as part of a licensing review.

Contracting and Operations Oversight

- All acute inpatient hospital reimbursement for public and private psychiatric services is funded by public and/or private insurance.
- Processes by which insurers choose to reimburse for specialing and private rooms vary across insurers
- Each managed care organization contracts separately with a network of acute psychiatric inpatient hospitals and units within general hospitals. The majority of psychiatric beds are in general hospitals.
- Each managed care organization employs its own network management and quality management processes for ensuring that network providers comply with contractual requirements, which in the case of MassHealth-participating MCEs, include MassHealth requirements. The MassHealth Office of Behavioral Health oversees the implementation and quality management of the MBHP contract and the ESP contracts, and they and MassHealth quality managers oversee the performance of the other MassHealth managed care organizations in delivering MassHealth-covered behavioral health services to the managed care members.
- Insurers vary in the extent to which they will authorize specialing (1:1 staffing) in addition to the daily per diem (which for many insurers includes specialing) or will consider reimbursing a hospital adequate compensation for providing inpatient services to an individual who needs a single room when the hospital has only double rooms available.
- Insurers also vary in the extent to which they are responsive to calls from EDs and ESPs regarding authorization for inpatient psychiatric admissions particularly on weekends and after hours. Many, particularly non-MassHealth-participating private insurers are not accessible on weekends. This may mean for some individuals, that if they have been screened and determined to need a psychiatric admission and the individual’s emergency condition has stabilized but the insurer has not authorized a psychiatric inpatient admission, the individual may spend the weekend waiting in the ED.

IV. PRIORITY ISSUES/SOLUTIONS BY WORKGROUP

A. Recommendations from the Clinical-focused group for Addressing Priority Issues When Individuals with Medical Co-morbidities in EDs Seeking Psychiatric Inpatient Services

1. Recommendations about what kinds of medical conditions psychiatric hospitals/units should be able to address and the process by which medical condition information is communicated to the psych hospitals/units

Process Recommendations

- o ESPs should be obligated to convey in the information being provided to a psych hospital/unit if there is a history of a medical condition, and the current status related to that medical conditional, and if it has been managed and appears to be controlled, the last time it was not controlled.
- o There should be new licensing requirements such that psych hospitals/units should in most cases not be declining an admission when there is simply a history of a medical condition and if it has been managed at home by individual/family and the individual is not presenting with this condition in an “uncontrolled medical condition state.” Furthermore, in such cases when the reason given for a hospital opting to decline an admission is a medical condition, the hospital should not be allowed to decline the admission with out a conversation between a hospital psychiatrist and ED physician. Hospitals should be able to document this.
- o ESPs should be advised when it is implemented, of the existence of the requirement that the psych hospital/unit cannot decline an admission without there being a conversation between the ED physician and the inpatient facility psychiatrist. ESPs should be obliged to help facilitate that the conversation occurs in these circumstances and should have a role in the documentation.

Determination of Medical Conditions Psych Hospitals/units should be able to Manage and What, if Anything, is Necessary for the Psych Hospitals/Units to do so in the Future, and What Hospital Licensing Changes might Be Necessary to help Effect

After briefly discussing the list of medical conditions on the lists MBHP provided broken out by youth and adults that represent from their data collection the medical conditions noted to have created barriers for admission, it was clarified that in most cases, psych hospital/unit nursing staff are not required to have any medical training other than what they received in their nursing education process. Thus, we agreed to recommend:

1. DMH/OBH should convene a workgroup with MABHS, representative nursing staff from the free standing psych hospitals and general hospital psych units to review the list of medical conditions provided by MBHP and determine:
 - Whether and how to proceed to administer some version of the draft survey (that was developed following the discussion last week and which is attached to these recommendations) about capacity for handling medical conditions to all of the psych hospitals/units’ clinical staff, and to compile the information collected to discuss with the group;
 - As informed by the survey findings, which conditions the psych hospitals/units should be prepared to take and under what conditions, contemplating for example

how many individuals with medical conditions, such as those with G tubes, at a time is it reasonable to manage on a 16 bed unit;

- What training and potential changes in the number of nurses per shift would be necessary to manage additional nursing needs, keeping current with medical standards of care;
- What kinds of measures a hospital/unit can take in the short term, such as medical nursing consultation or rounding on the units, to effect changes now to enable facilities to feel prepared to more frequently and rapidly admit greater numbers of individuals with the medical conditions noted, including what funding this might require or hospital decisions.

2. Recommendations regarding changes to the Bed Locator System and Process to better support ED clinicians when individuals are seeking psych admissions.

Every ED, ESP and MCE should be familiar with how to use the current bed locator system and process; some EDs currently report they are not. The “bed locator,” MABHAccess.com, system was developed in 2009 for the purpose of giving entities that arrange admissions – ESPs, EDs, and MassHealth contracted MCEs- access to bed availability to assist with placing anyone in need of inpatient psychiatric admissions, i.e.,: people covered by any payer and those who are uninsured. The bed availability system includes all psychiatric hospitals in Massachusetts that wish to participate as well as some in close proximity in contiguous states; it also includes availability at other levels of care such as substance use programs, crisis stabilization units, etc.

The group has suggested that the bed locator should be more widely utilized and that there may be some improvements that could be made to increase its usefulness and its use such that all ED clinicians and ESP teams and all MCEs (and not just the MassHealth-participating) have access to and use it. The group has suggested that the information in the bed locator could be more useful if the information were updated even more frequently than currently and that all hospitals be obliged to describe when seemingly vacant beds are not available because of other reasons, and to describe the other reasons and then indicate when these other issues abate. (There are processes to hold hospitals accountable to report regularly and to allow them to provide barrier information to MBHP now and most do report two or three times per day. MBHP calls facilities, 7 days/week, if one has not updated for 10 hours. MBHP staff also receive monthly data about each hospital’s reporting compliance which they use in their network management meetings with providers. Furthermore, reporting compliance is also a pay-for-performance measure in MBHP’s rate structure with each hospital).

The group noted that to increase the access to all and oblige all hospitals to report all information and with greater frequency might necessitate transforming the locator system into an entirely public system. The group agreed that there would need to be a determination of whether this would indeed be necessary and if so, how this could be accomplished (i.e., what entity would house, and monitor and update the information) and funded.

In the immediate term, MBHP, which operates the locator noted that it would be happy to work with the MCEs, MABHS and the hospitals to set a more frequent and more comprehensive reporting expectation, that would include formalizing the practice of working with each hospital to note the current barriers and then to update the information when it changes. MBHP has also committed to resending the bed locator information to all EDs, providing demonstrations of its use, and ensuring they are fully aware of its capabilities.

3. Recommendation for supporting ED clinicians when individuals are waiting psych admissions.

In the cases of general hospitals that do not currently have a psych unit within the hospital that provides consultation support to the ED nor arrangements with behavioral health clinicians to support the efforts, particularly with medication prescribing by the ED clinicians in the EDs or available to EDs should be urged to at a minimum, establish a arrangement for providing at least telephonic psychiatrist consultation support to the ED clinicians. Such arrangements for consideration include the hospital contracting privately with an ESP team (which has psychiatric consultation around medications built into the service) and/or a psychiatric consultation service such as is the case with Sturdy, Morton and Good Samaritan Hospitals.

The following is a first draft of potential survey questions for psych hospitals/units. At the end of this document are the two lists of medical conditions noted by MBHP to have created barriers to admissions.

Draft Potential Survey Questions for Psych Hospitals/Units

Please answer the following questions regarding your current practice.

1. Upon referral, what is the process for determining that an individual's medical needs can or cannot be met on your unit?
2. Are acute and chronic medical conditions viewed differently with regard to admissions decisions?
3. What is your process for accepting an individual with a complex medical condition?
4. What are your protocols regarding medical clearance?
5. Are there any types of conditions or corresponding treatment requirements that you feel you can't handle in your hospital and would lead you to decline an admission?
6. Are there any medical conditions that you think you are able to accommodate well?
7. Which of the conditions below do you believe would require the addition of a nurse on a unit?
8. In what circumstances do you think a condition mainly requires more nursing time but not necessarily more medical training?
9. Please indicate whether you routinely accept individuals with the following conditions (below) or needs? In each case, if you do not typically accept individuals with these conditions, please explain why, including describing both the nursing and physical structure issues.
 - o MRSA
 - o Diabetes, Diabetes Type I with sliding scale insulin
 - o Need for oxygen
 - o CPAP
 - o Tracheotomy
 - o IV
 - o Wound care
 - o Anticoagulant therapy
 - o Seizure disorders
 - o Eating disorders, i.e. feeding tubes
 - o Catheter
 - o Colostomy
 - o Ambulation problems (cane? Wheelchair?)
 - o Fall risks
 - o Incontinence issues
 - o Psychosis secondary to medical condition
 - o Dementia

- r/o delirium or delirium v psychosis
 - Need for support with ADLs
 - Need for medical consult
 - Need for neuro consult
 - Need for STAT labs
 - Pregnancy- How advanced? How high risk? How is high risk determined? Substance abuse? Diabetes?
8. Please describe what you believe your facility/unit would have to implement or change in order to be able to more routinely accept individuals with those conditions that you currently are less typically able to admit. In what circumstances do you believe you would need to add nurses with more current medical training to each shift?
9. In what ways do you think you could ensure that there was nursing consultation readily available to a unit to enable your hospital to admit individuals with medical co-morbidities on this list more readily and in greater numbers in the short term?

B. Priority Solution Ideas from MassHealth-Participating Insurers

The following four solution proposals were developed in the 5/17/12 MCE behavioral health director meeting with the MassHealth office of behavioral health insurers agreed warranted focus, at least for more discussion as follows:

1. Insurers can contribute to efforts of ESPs to develop crisis plans for individuals who have tended to have frequent readmissions and/or whose inpatient stays have been extenuated and/or the inpatient facilities report difficult stays on the unit. The purpose of the crisis plans primarily would be do divert crises before they escalate and emergency services are necessary. However there was agreement that there should be inclusion of the kinds of activities and resources best enable an individual who is hospitalized to be effectively served on the inpatient settings such that trauma and disruptive behaviors are minimized, and that resources and activities that are known to work to help expedite discharges back to the community are documented. Insurers agreed it would be helpful if they collaborated on working on guidance and training for ESPs for crisis plan development such that the ESPs develop plans that are reasonable and draw on all available resources in the community and in the case of adults, utilize the principles of .Wellness Recovery Action Plans (WRAP) plan development.
2. Insurers agreed that it would be helpful to begin a discussion for how best to increase psych inpatient bed capacity and capacity for CBAT and DDAR beds in the system across the state and what the insurer role is in incenting network expansion and quality improvement in this regard (i.e., decreasing members' lengths of waits in EDs). All agreed with Chris Counihan's suggestion that a first step should be to convene the insurers to discuss the lessons learned and strengths identified in the recently completed process to support the opening of the Quincy Center – Arbour Hospital's new unit for persons with significant behavioral dysfunction.
3. Insurers should collaborate to standardize processes and criteria for coverage of "specialing." It was further recommended that the criteria for when reimbursement for specialing coverage above and beyond what is already included in psych inpatient reimbursement would be warranted be developed in a workgroup that includes the insurers, and inpatient unit/hospital representatives. All agreed it would be important before getting too far into criteria development to also discuss when it might be acceptable to hospitals to utilize staff for specialing that are not hospital staff.
4. Insurers acknowledged that there may be more opportunities to make inpatient units and ESP teams more aware of CSPs and In-Home Therapy to expedite discharges, particularly on

weekends, and that they can and should be working with ESP teams, the inpatient units and the trade associations to increase/standardize/improve the development of crisis plans for individuals admitted to avoid future inpatient admissions and make those next admissions that do occur shorter and calmer.

C. C/A-focused ED/Psych Services Access Workgroup in Rank Order of Priority

Top Three Proposed Sets of Priority Solutions in Order of Priority
<p>Issue I. To address the priority issues that: 1) There are not sufficient ICBAT/CBAT beds during the school year and providers struggle to afford empty ICBAT/CBAT beds in the summer; and 2) There are not sufficient adolescent inpatient beds during the school year and particularly on weekends. Furthermore, CBHI has successfully kept children out of inpatient facilities and the acuity of those admitted is higher. It was noted that there are 12-20 c/a waiting per week in one hospital’s system for CBAT beds. We recommend the following:</p>
<p>Solution Ideas:</p> <ul style="list-style-type: none"> ○ Look at data to determine the “right” number of c/a beds for the acute inpatient system, and/or ways to allow the system to flex down in the summer and add beds back into the system for the other 9 months. Consider ways to ensure sufficient OT and psychiatrist time all year <ul style="list-style-type: none"> ▪ To look at the data insurers can take a snapshot of past time period and 1) note how many individuals were admitted to inpatient settings that could have used CBAT instead but for capacity issues and 2) how many youth were awaiting CBAT placement in inpatient settings and 3) CBAT rates of utilization. ▪ Examine with providers whether/if inpatient units and CBAT providers are interested in opening more adolescent Beds. ○ Convene a group that includes Community-Based Acute Treatment for Children and Adolescents (CBAT) and Intensive CBAT (ICBAT) providers, insurers and hospitals (such as the Arbour System and Bournemouth) that have effective flex strategies to discuss different models for addressing the seasonal demand fluctuation issues. Determine models for replication. James Major of MAAPS (the trade organization that includes CBAT providers) has volunteered to convene one such meeting to brainstorm. ○ Insurers might consider ways to support the CBAT/ICBAT provider network with creative models of temporarily adding in staffing supports that might potentially be shared across providers during “high utilization “ time periods. ○ Consider changing licensing rules to enable temporary creation of single rooms from doubles by turning doubles into triples. ○ Work with insurers and psych and general inpatient hospitals/units to develop practices that will help increase the ability for psych inpatient discharges and admissions to occur on weekends and for general hospitals to better support ED clinicians both clinically and in terms of providing insurance information on weekends.
<p>Issue II. To address the issue that: There are not sufficient inpatient, ICBAT and CBAT beds in particular, for those with DD/intellectual disabilities and behavior problems, particularly during school year, and Relatedly, there are insufficient community-based specialized services for c/a with intellectual disabilities and behavior problems and their families, particularly for those from out-of-state. We recommend the following:</p>
<p>Solution Ideas:</p> <ul style="list-style-type: none"> ○ Consider creating specialized inpt units and ICBAT/CBAT units for c/a with intellectual disabilities. ○ Work with DDS to develop consulting support via DDS services, case management, respite for families. ○ Have ESPs develop PDD/ED consulting support.

Issue III. To address the issue that: Need to improve ability and timeframes within which c/a are admitted to and discharged from inpatient/CBAT beds. We recommend the following:

Solution Ideas:

- OBH/MCEs should work out strategies with each state agency and with agency regional staff for ED issues when c/a are clients of those agencies. OBH/state agencies can collaborate to facilitate processes to expedite IEP approvals.
- Utilize the EOHHS Children Awaiting Resolution and Disposition (CARD) meetings to collaborate on creating strategies.
- Crisis Plan Development: Require inpatient psych units reach out to ESP/MCI teams to schedule discussions regarding crisis planning to articulate and plan to prevent the issues of difficult stays from recurring. Require this for any instance when there have been several admissions in rapid succession. Strategies designed should focus on both diverting ED use and inpatient admissions, and should ensure that information is conveyed to inpatient units sooner and more comprehensively. Crisis plans should document what strategies work with a child/family and insurers should have the information and be prepared to support the resources/strategies documented in the future. Knowing the key services will be in place or put into place help inpatient facilities be more comfortable accepting a child in the future. Hospitals should be able to decline admissions when presented with a youth who has been readmitted to the facility and has had difficult stays, and for whom no crisis plan has been completed. MCEs should ensure that all Members receiving IHT and ICC have crisis plans in place.

D. Solution Ideas focused on the Issue of Individuals Presenting in EDs who are Aggressive or Actively Abusing Substances

Issue 1: Acute psych hospital may be familiar with an individual and familiar with a past behavior on the unit that was aggressive/assaultive and property was damaged and/or individuals injured and/or such individuals might be in and out of the hospital frequently and may often have uncertain discharge plans, and hospital is reluctant to admit for fear of a recurrence of these things, and may also be reserving beds for their own EDs.

Solution Ideas: (Note this solution proposal has been raised as a priority in three workgroups)

1. The state should facilitate the creation of regular processes for ESPs, EDs, psych hospitals and communities to work together to develop “crisis plans” so that there are better ways to address such individuals and share knowledge about what works to stabilize them, identify what hospitals need to be comfortable taking such individuals and to help them remain stable and be discharged quickly if admitted, and in such a way as to minimize the revolving door effect.
 - a. ESP teams should be encouraged to take a look at their lists of those with behavior issues and frequent hospitalizations and initiate such meetings.
 - b. ESPs should be guided to be clear in the write-ups for presentation to the inpatient facilities just what the nature of past aggression is, causes, etc. and in creating effective crisis plans that will be shared with the inpatient facilities.
 - c. The state should assist communities to establish interdisciplinary teams that are “qualified service organizations” with qualified service organization agreements among the participating agencies (pursuant to DPH regs). This allows consultation and treatment planning/information sharing around the care of individuals who may show up in an ED, etc. that doesn’t require individuals’ consent.
 - The “High Utilizers of Emergency Services” (HUES) model that the Boston Police participate in (led by the Boston Public Health Commission) and meets every other month, was described as an exemplary model of community service organization collaboration. It was suggested that this model be replicated everywhere. (Contacts at BPHC include David Thomas (dthomas@BPHC.org) and Beth Lheureux (BLheureux@BPHC.org))
 - d. The state should determine whom/how crisis planning can be conducted for individuals who are dual eligible or uninsured with no state agency involvement.

Issue 2: There is concern that inpatient psych hospitals/units decline admissions of individuals when they

don't want to take them because they are aggressive/assaultive and this is a breach of the "no reject" policies they have all signed. However, since the licensing process does not entail operations oversight, there is currently no robust inpatient psych hospital/unit admission operations oversight. There is currently an apparent need for more beds in the system.

Solution Ideas:

1. Implement a way for the state to monitor and collect data from psych hospitals/units regarding when and under what circumstances admissions of individuals both those who are MassHealth managed care members and those who are not, are being declined or passed over for those felt to be less aggressive, and to impose sanctions when it appears there is a pattern by a hospital for not adhering to their "no reject" policy.
2. It appears that hospitals declining admissions would not be as significant an issue if there were more beds in the system and other hospitals/units to turn to, thus there should be an assessment with insurers of the adequacy of the psychiatric inpatient bed supply.
3. Need to evaluate whether creating units such as the new Arbor unit "Quincy Center" (that receives a higher rate for higher staff ratios, and has predominantly single rooms and was created to serve patients with behavior dysfunction) can mitigate the problem as well as determine whether and how best to replicate it if so.

Issue 3: It is perceived that insurers are frequently unaware even when their member may have been waiting for an inpatient bed for hours, sometimes days and if they were aware much sooner, could intervene utilizing insurer behavioral health medical directors and other executives, as appropriate, to facilitate the bed finding process with the inpatient hospitals.

Solution Ideas:

1. Ensure the implementation of effective escalation processes within all insurers including the private-only. As a first step, the MassHealth OBH is piloting now through the end of July a process that requires the MassHealth-participating MCEs to inform OBH when a member has been waiting for placement for 72 hours and provide all of the information surrounding the case including the hospitals to which there has been outreach and reasons for admission declines. After the pilot concludes OBH will analyze the information collected and look for any patterns that may have emerged as well as assess the process in general and feedback received about it to consider whether to implement it or some version of it, perhaps with different time frames, permanently.
2. Insurers should develop a consistent mechanism for authorizing additional reimbursement for specializing and enable the authorizations to occur expeditiously in agreed on circumstances. (Note: this is also a solution proposed by the insurer workgroup)
3. Do away with PA in EDs but continue to require ESP evaluation and service provision in ED

Issue 4: There are 17 DMH-funded jail diversion programs in place that are thought to be effective in building trusting and collaborative relationships between state agencies and the police and diverting arrests and ED use, but there is no insurer funding for these programs and no mechanism or funding to implement them statewide.

Solution Ideas:

1. It was agreed that steps should be taken to expand the positive impact that the 17 programs are having to all communities statewide. The proposed first step in establishing a mechanism to replicate the jail diversion program activities in all communities is to analyze the Jail Diversion program data that is being collected and reported to Karen Orr in DMH currently, to identify the measures of effectiveness and with the input of Jenna Savage and others, to develop cost avoidance data such as the cost of arrests and court-fees averted, and ambulance and costs for days spent in EDs avoided. The quantitative evidence of effectiveness and relative resource and other costs and requirements for effective replication should then be used in discussions with MassHealth and DPH and at the EOHHS secretariat level and potentially across secretariats to determine whether/how to promote statewide implementation.
2. Insurers should consider in the short term how they can support ESP efforts to focus on relationship-building between EDs, courts and ESPs

Issue 5: ED clinicians, particularly those without a psychiatric inpatient service in their hospitals, could use help managing aggressive individuals in the EDs

Solution Ideas:

- ESPs can work more effectively with EDs and collect as much information about individuals coming to ED from collateral providers, try to get these other providers involved asap, such as VNAs, PCPs, and DMH's CBFS and PACT contractors, and get them to visit their clients while they are waiting and help develop written ED management plans for the EDs that might include psychiatric services, medications, other mechanisms for helping individuals stabilize.
- Hospitals should be encouraged to contract with ESPs or other psychiatric supports to assist EDs.
- Need more conversation and training for EDs regarding when is it appropriate to criminalize a behavior, and training on this should re-occur periodically.