Commonwealth of Massachusetts
Executive Office of Health and Human Services

ED Length of Stay Issues
for Behavioral Health Patients: Update

Overview

- EOHHS is committed to addressing the problem of behavioral health patients in emergency departments who face long delays waiting for disposition to appropriate settings for behavioral health care
- EOHHS has reviewed information on this topic, including information provided by stakeholders, data reported by hospitals to the Department of Public Health, and studies published in the academic literature
- EOHHS has identified strategies that could potentially improve the care system for behavioral health patients
- EOHHS obtained stakeholder feedback on a number of different strategies, and would like to provide an update on these initiatives at this time

Review

- Background
- Care system for Behavioral Health patients
- Policy statement
- Strategies for discussion

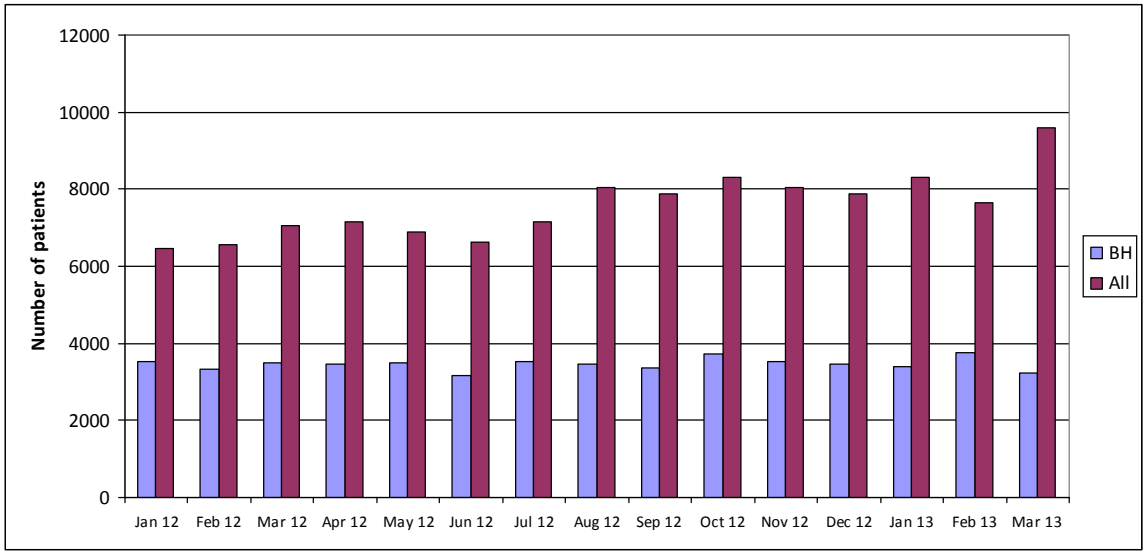
Background

- Delays for behavioral health patients awaiting disposition from EDs to appropriate settings is a national problem:
    - A 2008 survey by the American College of Emergency Physicians found that 80% of ED medical directors report “boarding” of psychiatric patients (defined by this survey as waiting 8 hours or more after a disposition decision)
    - From 2001-2006, the average duration of mental health ED visits exceeded the average duration of non-mental health ED visits by 42%
    - At the same time, psychiatric visits represent a growing percentage of ED visits nationally
- In Massachusetts, behavioral health patients can face long delays awaiting disposition from EDs to appropriate settings

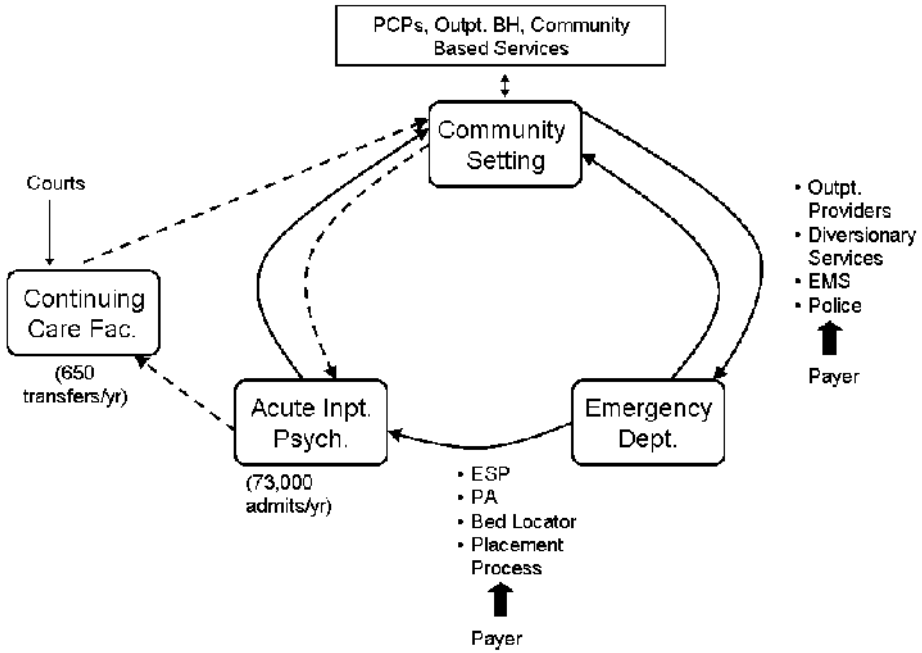
Data from Massachusetts

- Sources:
    - "Snapshots" provided by the Massachusetts Hospital Association
    - Data collected by the Department of Public Health
    - Data reported by the Massachusetts Behavioral Health Partnership
    - Published studies

ED patients waiting 12 or more hours after a disposition decision (January 2012-March 2013)



Care system for behavioral health patients



Proposed policy statement

- All patients, regardless of insurance status or diagnosis, deserve prompt and appropriate care in the Commonwealth's emergency departments. Patients with behavioral health diagnoses are disproportionately represented among all patients “boarding” in the emergency department.
- The "boarding" of behavioral health patients in the emergency department has negative consequences for patients, emergency departments, and the health care system as a whole.
- The delays in behavioral health patients receiving appropriate care following an emergency department visit is a multifactorial, system-wide problem that requires a coordinated approach and collaboration between patients, providers, payers, and government.
- EOHHS is committed to ensuring that all patients receive the benefits of statutory protections, including but not limited to mental health parity and EMTALA protections.
- EOHHS is committed to working in partnership with all stakeholders to find solutions that will result in better care and better outcomes.

On-going activities

EOHHS and its agencies have been committed to addressing the issue in a serious and multi-faceted way. Examples of on-going activities include:

- Ongoing collaboration to resolve high profile cases of excessive wait times
- Jail diversion programs
- Work with managed care entities on corrective actions: capacity analysis, internal review and resolution of cases of excessive wait times, quality improvement with inpatient providers around weekend discharges and admissions, and community-focused solutions
- Data collection
- Alignment of licensing requirements to support behavioral health and primary care integration
- Detox facilities added to bed finder tool

Principles and expectations for moving forward

- EOHHS has reviewed opportunities for additional strategies to address delays.
- The strategies should be part of a coordinated effort that addresses multiple parts of the system simultaneously. This coordination is important so that delays are not simply extruded from one step in the care cycle to the next.
- The strategies also need to acknowledge that different solutions will be needed for different patient subpopulations.
- Significant structural changes in the landscape of behavioral health care may be needed over a period of years to effectively address the true root causes of this problem; the state can directly influence some but not all of the factors necessary for this change.
- EOHHS is working in collaboration with DOI to understand and address issues related to commercial payers.
- To succeed, all parties need to come to the table and to be willing to collaborate and compromise.

Strategies presented for input and feedback

1. On-line reporting system
2. Eliminate prior authorization for acute inpatient psychiatric care (MassHealth MCEs)
3. Promote use of ESPs in the community
4. Strengthen care coordination for patients referred to continuing care
5. Restructure MBHP incentive payments
6. Encourage use of bed-finding tool
7. Review rates and consider introducing risk adjustment
8. Review regulations

1. Create a mechanism for capturing information about facilities that show a pattern of refusing admissions

- **Summary of Stakeholder Feedback**
  - — Support
    - — Please include additional clinical and operational factors as to why psychiatric facility might not be able to provide services
    - — Because of the varying interests involved, we recommend that EOHHS contract with an independent group to gather this data
    - — Creating a “report back” hotline or other mechanism for registering feedback will give emergency department staff a productive outlet for providing feedback to the administration
  - — Oppose
    - — The filing of an “access to care complaint” already triggers an investigation by the payer and corrective actions, if warranted

1. Create a mechanism for capturing information about facilities that show a pattern of refusing admissions

- **Update**
  - System will be voluntary
  - Initiating IT build, will request stakeholder input to test system
  - Aim to have demo available for input over the summer
  - Suggested questions on next page, for discussion/input

1. Create a mechanism for capturing information about facilities that show a pattern of refusing admissions

- Questions include:
  1. Name of the facility wishing to transfer the patient
  2. Date that refusal occurred
  3. Length of time patient has been in ED at time report is being filed
  4. Primary health insurance coverage of patient who was denied admission
  5. Whether patient is a child (18 or under), non-elderly adult (19-64), or senior (65 or over)
  6. Name(s) of the inpatient psychiatric facility/unit that declined the patient
  7. For each declining facility:
     - 7.1 Was the bed system checked? If yes, how many beds were listed as available?
     - 7.2 What factors were cited by the declining facility as cause for denial? (see next slide)

1. Create a mechanism for capturing information about facilities that show a pattern of refusing admissions

7.2 What factors were cited by the declining facility as cause for denial?
(can choose more than one)

- Acuity of patient
- Anticipated difficulty with discharging patient
- Inadequate staff
- Need for 1:1 care
- Need for a single room
- Bed available only for opposite sex patient
- Behavioral health issues too complex
- Medical issues too complex (if selected—provide field to describe)
- Patient has aggressions that cannot be managed at facility
- Patient has serious history of violence
- Patient has criminal charges making him/her inappropriate for facility
- Patient's self-injury cannot be managed at the facility
- Other (free text)

2. Eliminate prior authorization requirement in MCE contracts

- **Summary of Stakeholder Feedback:**
  - Support
    - Important “implications around parity for mental health and addiction treatment”
    - “Strongly support” but “any changes should not create additional barriers or increased administrative requirements on providers”
    - Prior authorization “significantly and unnecessarily delays access to treatment for behavioral health patients”
  - Oppose
    - Prior authorization is a primary tool to “ensure that utilization and cost are managed effectively”
    - Concerns about nonpayment to hospitals

2. Eliminate prior authorization requirement in MCE contracts Update:

- MassHealth is developing proposed policies and procedures to implement this requirement.
- The proposed policies will then be reviewed with other internal stakeholders.
- The updated changes will be then shared with contracted MCE's.

3. Strengthen community-based intervention

- **Summary of Stakeholder Feedback**
  - Support
    - We recommend that MassHealth focus ESP services on community diversion sites and community hospitals that lack 24/7 behavioral health services.
    - All ESPs should be closely monitored to ensure members continue to be diverted from more restrictive levels of care.
  - Other considerations
    - DMH and MassHealth should increase the number of individuals accepted for admission by free-standing psychiatric facilities directly from community based settings
    - Develop new point of entry protocols that would enable ambulances to transport some individuals with behavioral health needs to ESP/MCI's community-based locations rather than to EDs.
- **Additional data**: MBHP reported that for FY13 YTD, 26% of interventions for adults occurred in community based settings. 53% of interventions for youth occurred in community-based settings.

3. Strengthen community-based intervention

- **Update**

— Governor's FY2014 budget proposed additional resources for ESPs; if appropriated by the legislature, these funds will be used to enhance their ability to provide mobile crisis intervention. DMH is working with ESPs in order to maximize any additional resources.

4. Strengthen discharge planning for patients leaving acute inpatient psychiatric units

- **Summary of Stakeholder Feedback**
  - — Strong support for this proposal, with the following additional considerations identified:
    - — Please expand the proposal to include serious review of DMH case management system to identify ways to address the backlog
    - — There must be strict timelines for attending discharge meetings as well as state agency involvement/inclusion in treatment planning similar to what is done with CBHI
    - — Encourage free standing psychiatric facilities to increase their ability to receive and discharge patients on weekends.
- **Data:** The number of individuals on the Section 3 Referral list (or waitlist) has been near 20 (in early 2013), ranging from 10 to 25 on a weekly basis

4. Strengthen discharge planning for patients leaving acute inpatient psychiatric units

- **Update**
- DMH has worked with partners to establish a “care liaison” for each acute psychiatric hospital or inpatient unit as a voluntary program.
- The DMH Liaison will help identify patients earlier who might potentially be better served with appropriate community placements as well as to prevent delays in the transfer process for those patients who do require continuing care.
    - The care liaison can assist in identifying any DMH or non DMH client admitted to an acute unity who may be referred to DMH for a continuing care inpatient bed (Section 3 process);
    - work with acute hospital/inpatient unit and DMH community staff to identify possible alternatives to inpatient continuing care;
    - facilitate linkages between acute hospital/inpatient unit and existing community providers;
    - facilitate transfer to continuing care unit when appropriate.

This program was launched in April 2013.

5. Restructure MBHP rapid admission incentive

- **Summary of Stakeholder Feedback**

— Support

  — Interest in restructuring the incentive

— Oppose

  — Concerned about proposal where incentive model may be rewarding the wrong part of the process

- **Data/clarification**: Rapid admission incentive is funded by MBHP, not by MassHealth

5. Restructure MBHP rapid admission incentive

- Update: MBHP has met with providers to discuss restructuring this incentive. As this is an issue specific to MBHP, EOHHS proposes to remove this item from the list

6. Expand use of Mass. Behavioral Health Access website

- **Summary of Stakeholder Feedback**

— Support
  — Propose to add enhancements to site
  — We recommend looking at some of the demographic fields and search functions to target searches more effectively

— Oppose
  — Simple expansion of the existing bed-finding tool does not hold much promise

6. Expand use of Mass. Behavioral Health Access website

- **Update**

— Stakeholder comments provided to MBHP

— EHS and DMH Staff have also tested website; would like to provide demonstration of this tool and ask for collaboration with EDs and other stakeholders partnership in increasing awareness about its availability. Will monitor use and consider working to expand use gradually over time.

— MBHP is also implementing a mobile application for easier access to the website.

7. Evaluate payment structure for psychiatric care

- **Summary of Stakeholder Feedback**

— Support
  — Strong interest and support; some raised tie-in to on-going work of Mental Health Advisory Committee
  — Strategy has a “great deal of merit”; rates of payment for psychiatric care are inadequate

— Oppose
  — Please wait for new initiatives and development of the behavioral health care coordination project at MassHealth to be released before any discussion in this area
  — Need clarity on definition of “complexity”

7. Evaluate payment structure for psychiatric care

- **Update**
  - In FY13, MassHealth and MBHP were able to provide one-time increases for both outpatient and inpatient behavioral health providers.
  - MassHealth is evaluating options for FY14 and beyond.

8. Review licensing requirements for psychiatric units

- **Summary of Stakeholder Feedback**:

– Support
  – Interest in ensuring the “same intensity of care regardless of day of the week”
  – Support for “increased funding and staffing for DMH to strengthen its ability to address admission delays”
  – Consider adding “no reject” policy and/or requiring reporting on refused admissions
– Oppose
  – Concern about ability to meet additional administrative and oversight requirements; need for financial support
  – Caution that proposals cannot be “one-sided”

8. Review licensing requirements for psychiatric units

- **Update:** Continue to review relationship between staffing patterns, admission rates, payment methods, and licensing authority

Next steps

- Demonstration of Massachusetts Behavioral Health Access website
- Feedback