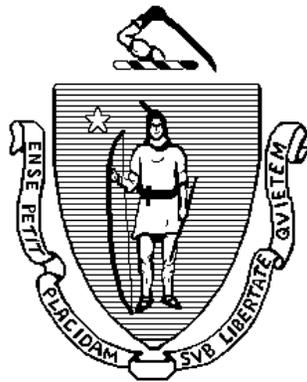


June | 2015

Task Force on Behavioral Health Data Policies and Long Term Stays

Final Report to the Health Policy Commission, the Joint Committee on Mental Health and Substance Abuse, and the Joint Committee on Health Care Financing, as Required in Section 230 of Chapter 165 of the Acts of 2014



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Letter from the Chair

Seeking treatment for mental health and substance use conditions is notoriously complex and frustrating. In an effort to support and accelerate data-driven policymaking on issues of behavioral health care, the Legislature created the Task Force on Behavioral Health Data Policies and Long Term Stays.

The Task Force was charged with improving care by focusing on two broad issues: promoting the effective use of data, and addressing the problem of inappropriately long lengths of stay in various behavioral health care institutions.

At the first Task Force meeting, I offered three principles to guide our approach. First, the work of the Task Force should be patient-focused; that is, our recommendations should be designed to improve the experience and outcomes of patients, not to serve narrow interests of other stakeholders. Second, we should seek to build upon past efforts rather than to recreate them. To this end, we collected a list of 68 relevant recommendations from previous panels, and used those ideas to inform our own work. Finally, we should develop recommendations that are specific and effective, not broad statements of values or aspirations.

Final recommendations are based on the discussion of the Task Force as well as consultation with key state agencies including, MassHealth, the Division of Insurance, the Health Policy Commission, the Department of Public Health, the Department of Mental Health, the Attorney General's Office, the Department of Corrections and other stakeholders, including health plans, providers and quality improvement organizations, and input provided from the public during each meeting. The input of these stakeholders provided important context and new ideas, and helped us craft recommendations that fulfilled our three guiding principles.

While developing these recommendations, the Task Force regularly remarked on the complexity of the behavioral health care system. We offer these recommendations while recognizing that there are no perfect solutions to the thorny challenges facing patients with behavioral health diagnoses.

In particular, the Task Force recognizes that implementing organizations – including the agencies of the Executive Office of Health and Human Services – may choose to adapt recommendations put forth.

While this is not a CHIA report, I'm proud of the role that we played in taking an organized, objective approach to the issues we faced, and for facilitating a vibrant and diverse discussion.

Thank you for the opportunity to be part of this important effort.

Respectfully submitted,

Áron Boros

Executive Director, Center for Health Information and Analysis

Executive Summary

Section 230 of Chapter 165 of the Acts of 2014 established a task force with broad charges related to the existing structural or policy-based barriers to delivering comprehensive and cost-effective behavioral and mental health treatment. The membership of the Task Force was set by the Legislature. Notably missing from the Task Force included persons identified as having lived experience and an advocate for the perspective of children, youth, and their families.

At the outset, the Task Force focused its efforts on two specific areas mentioned in Section 230 considering the availability of data to help inform policy decisions related to behavioral health care and longer than necessary stays in emergency departments (EDs), inpatient hospitals and Department of Mental Health's (DMH) continuing care facilities (CCFs) because individuals are unable to access the next level of behavioral health treatment. Over the course of seven months, the Task Force explored these issues.

Data Collection, Information Sharing and Reporting: While a broad continuum of services are offered, and plans and providers collect and analyze behavioral health data, it is difficult to quantitatively measure access to available providers and services, quality outcomes, and efficiency of care on a system basis. This is because the data collected and how it is analyzed differs across individual organizations, precluding the ability to compare similar populations across plans or providers. These difficulties often lead to anecdotal information and misinformation about the challenges that providers and individuals face when offering and accessing behavioral health care. In addition, inconsistent interpretation and application of state and federal privacy laws create other barriers to effective use of data to improve patient care.

Long Term Stays: The Task Force examined the complex and interdependent flow of patients through the behavioral health care system in Massachusetts. Long term stays in EDs are endemic to individuals who live with mental health problems in Massachusetts and across the nation. In addition, many individuals also have longer than necessary stays in inpatient hospitals or continuing care facilities based on difficulties in discharging to appropriate levels of care. Lack of capacity and operational challenges preventing timely admission within any care setting can lead to bottlenecks that stress another level of care that seeks to transfer a patient to a new and appropriate setting. Bottlenecks often occur on nights and weekends, and particularly are true for individuals with no or public insurance, or who may be difficult to manage without specialized or one-on-one care.

Task Force Recommendations

The recommendations of the Task Force are designed to improve data collection and reporting on outcome measures, as well as to reduce inappropriately long stays in emergency departments, inpatient facilities, and continuing care facilities by developing solutions to care

for difficult to manage patients, to improve patient flow in part through improved access to and utilization of community-based care. Our recommendations also consider ways to improve the treatment environment present in most EDs, and opportunities to include behavioral health within alternative payment methodologies. Once data on the performance of the behavioral health system are publicly available, it will be the responsibility of all stakeholders to hold the system accountable for providing high quality care to all residents of the state. We hope that the Legislature and the Administration will carefully consider and act on these recommendations to address the important issues tackled by the Task Force as part of its charge.

Recommendations to Improve the Collection, Sharing and Reporting of Behavioral Health Data

1. CHIA should, as part of its continuing study of Behavioral Health (ch 12C sec. 21A) periodically publish statistics measuring the performance of the behavioral health care system. By November 1, 2015, CHIA should publish a reporting plan that proposes reporting the measures described in the final report of this Task Force. The reporting plan should identify the feasibility, timing, and resources needed to collect and publicly report these measures, including new data collection if necessary. CHIA should provide a 30 day public comment period prior to finalizing the plan. A regular (annual) process should be included to review the reliability, validity, and utility of measures and to make recommendations to modify the list accordingly.

CHIA should collaborate with the Department of Public Health (DPH), DMH, MassHealth, the Division of Insurance (DOI), and any other agency as appropriate while developing and implementing this plan. CHIA also should monitor the ongoing development of pediatric behavioral health measures and should incorporate those measures as appropriate.

The Task Force developed a dashboard of suggested measures that would inform policymakers and stakeholders on the performance of the behavioral health system.

2. DMH should continue to track and then publicly report the number of clients in continuing care facilities who are being tracked for possible discharge by target discharge timeline and the common barriers for discharging those clients timely. DMH should work with CHIA to report aggregate information about these patients on a regular basis.

3. The Governor should establish an ongoing state-based data work group charged with resolving the barriers to sharing behavioral health data across agencies, including:

- (a) Linking data and systems so that individuals can be followed through the different agencies for better program coordination and outcome tracking;
- (b) Setting standard definitions for common data metrics; and
- (c) Resolving state-level privacy data issues, including review of existing state laws.

This work group should also work to streamline data reporting requests across agencies to reduce duplicative reporting, as well as data reporting requests from external parties. The work group should include, but not be limited to, any agency that collects, reports, or analyzes data related to the overall health of Commonwealth residents, including the health and human service agencies, the department of housing and community development, department of education, and department of correction. A report on its progress should be delivered to the Legislature by July 1,

| |
|--|
| 2016. |
| 4. The Task Force endorses the privacy recommendations put forth by the Behavioral Health Integration Task Force, July 2013. |
| Recommendations to Reduce Inappropriate Long Term Stays |
| 5. The Legislature should implement the recommendations put forth by the Special Commission to Investigate the Expansion and Enhancement of the Massachusetts Behavioral Health Access Website. |
| 6. Executive Office of Health and Human Services (EOHHS) should convene a multi-stakeholder needs assessment work group to determine the number of additional inpatient psychiatric and continuing care facility beds that should be made available in newly formed units for adult men and adult women who exhibit violent and / or aggressive behaviors, and for adolescents aged 15 – 17, who exhibit violent and / or aggressive behaviors and for whom placement in an adult unit or pediatric unit is not possible. The needs assessment should be completed by October 1, 2015. Based on the needs assessment, EOHHS, in coordination with DMH, DPH, and MassHealth to streamline licensure and coverage rules, should be responsible for ensuring the recommended number of beds are operational by July 1, 2016 first by issuing request for proposals (RFPs) to create the services privately or, if there are not adequate responses by private providers, by opening state controlled and operated beds. Should the state resume its planning process regarding the creation of a forensic hospital to be operated by the DMH, consideration should be given to the appropriateness of including specialty units for both adolescents and adults who exhibit intractable violent or aggressive behavior in such a facility. |
| 7. EOHHS should develop a strategy, in consultation and collaboration with stakeholders, to reduce weekend boarding of individuals with psychiatric disorders in EDs. EOHHS should identify and address operational and structural barriers to discharging patients from EDs on the weekend, including examination of how weekend admission and discharge practices at inpatient psychiatric hospitals and continuing care facilities, and access to community services on the weekend, affect the ability to admit patients from the ED in a timely manner. EOHHS should work with providers and public and commercial insurers to collect necessary data and facilitate the removal of identified barriers. |
| 8. The Task Force supports the expanded use of telehealth services by behavioral health providers, when clinically appropriate. The Board of Registration in Medicine (BORIM), the Division of Professional Licensure, and the Division of Health Professions Licensure should remove licensure, credentialing, and privileging barriers to allow behavioral telehealth in the health care system, including in hospital emergency departments, when clinically appropriate. Health plans, MassHealth, and providers should work together to promote the expanded use and coverage of telehealth by behavioral health providers in any care setting. |
| 9. DPH and DMH should jointly develop a working group of providers, Emergency Services Program (ESP) teams, persons with lived experience and family members to examine and where necessary revise regulations and guidelines in order to allow emergency medical services teams to bring individuals with a behavioral health condition to an appropriate placement, thereby |

diverting patients from using the emergency department if they can be safely managed in another setting (including, but not limited to, an inpatient psychiatric facility, substance use treatment facility or community crisis stabilization unit).

10. EOHHS should lead a campaign to increase awareness among patients, families, and providers of the available services that keep people healthier, preventing the need for more acute levels of care and that help people transition back to the community after discharge. EOHHS should coordinate with other state agencies, National Alliance on Mentally Illness (NAMI), consumer groups, health plans, provider, and provider associations.

11. DMH should evaluate the effectiveness of its readmission protocol that was designed for the FY 15 Community Expansion Initiative. DMH should reports on its effectiveness, and if effective adopt for all patients. DMH should report its proposed approach by January 1, 2016.

12. EOHHS, through the Health Planning Council, should conduct an analysis on outpatient capacity and demand, in order to assess the robustness of the community systems, including its weekend capacity, in part to identify whether additional investment is necessary. The outpatient system should include all outpatient services offered by state agencies, plus privately provided outpatient services conducted by providers under state licensure – including those provider that do not accept insurance. Following the initial analysis, outpatient capacity should be monitored by EOHHS and the Health Planning Council on a regular basis.

13. MassHealth should repeal regulation 130 CMR 411.406 and any other similar regulations that prohibit MassHealth from covering outpatient mental health services by any independently licensed behavioral health provider.

14. MassHealth, its behavioral health vendor, and all commercial health plans should be encouraged to develop policies that support the expansion and reimbursement of evidence-based group psychotherapy treatment for behavioral health.

15. CHIA should work with other state agencies, including the Attorney General’s Office (AGO), to report on the impact of public and private behavioral health payment rates on access and capacity.

16. The Task Force Members encourage the Legislature to increase funding for behavioral health services to eliminate barriers to access to care.

17. As EOHHS develops alternative payment models to meet its requirement under Chapter 224 of the Acts of 2012, it should develop, in consultation with providers, global payment models that include behavioral health services for a broad range of patients, including adults with serious and persistent mental illness and children and youth with serious emotional disturbance. Such alternative payment models should align with services provided by or on behalf of MassHealth, DMH, or Bureau of Substance Abuse Services (BSAS).

I. Introduction

Section 230 of Chapter 165 of the Acts of 2014 established a special task force “to identify existing structural or policy-based impediments to delivering comprehensive and cost-effective behavioral and mental health treatment within the Commonwealth’s health care system.”¹ The statute specifies the membership of the task force, herein titled “Task Force on Behavioral Health Data Policies and Long Term Stays²” (Task Force) and names the Executive Director of the Center for Health Information and Analysis (CHIA) as the its chair. Notably missing from membership of the Task Force were individuals as being identified for having lived experience and advocates for children, youth and their families. The text of Section 230 and a full listing of Task Force members is included in **Appendix A** to this report.

Section 230 outlines two topics for the Task Force’s consideration.

First, the Task Force was charged with reviewing state and health care provider and industry policies for collecting, evaluating, aggregating, and disseminating data relevant to behavioral health care, in order to make recommendations on:

- ways to encourage increased coordination and improved access to relevant health data among providers, hospitals and state agencies, and
- necessary industry, regulatory or legislative changes in order to improve collection and access to behavioral health data among providers, regulators, hospitals and other stakeholders.

Second, Section 230 required the Task Force to develop recommendations to reduce the number of long-term patients in Department of Mental Health (DMH) continuing care facilities, acute psychiatric units and emergency departments, including, but not limited to, considering the need for increasing the capacity of specialized crisis stabilization units and requiring the DMH to implement policies that prioritize the readmission of patients who are discharged from continuing care facilities and subsequently require hospitalization within 30 days of their discharge.

To address these two topics, the Task Force met nine times between November 2014 and June 2015. See **Appendix B** for meeting dates, topics, and presentations.

This report offers a series of recommendations that if implemented, may advise the Legislature and behavioral health care system stakeholders to assess the performance of the system, and reduce the number of long term stay patients in emergency departments, acute psychiatric

¹ Section 230 of Chapter 165 of the Acts of 2014, enacted July 11, 2014.

² The title: “The Task Force on Behavioral Health Data Policies and Long Term Stays” was determined by the chair upon commencement of the Task Force. The title was meant to reflect the two chief charges by the Legislature, however, one Task Force member believed the title and the focus, was narrowly interpreted.

units, and continuing care facilities.³ These recommendations detail actions that the Legislature and/or state agencies could consider, identified by the two major charges of the statute: behavioral health data and inappropriate lengths of stay. Some topics and recommendations cut across both issues and this report will specifically identify those areas.

II. Recommendations to Improve the Collection, Sharing, and Reporting of Behavioral Health Data

While a broad continuum of services are offered in Massachusetts, it is difficult to quantitatively measure access to available providers and services, quality outcomes, and efficiency of care. These difficulties often lead to a reliance on anecdotal information that perpetuates misinformation about the challenges facing providers and individuals when offering and accessing behavioral health care.

Many previous attempts to address these challenges are known. Several state agencies have made significant strides in collecting meaningful data and monitoring system capacity. For example, the Executive Office of Health and Human Services (EOHHS) collects data and reports on the number of adults who are awaiting placement to a DMH continuing care facility or outpatient service (the DART report) and children who are awaiting discharge from an inpatient psychiatric hospital (the CARD list). The Health Planning Council (a standing committee chaired by the Secretary of Health and Human Services) also recently released a comprehensive report evaluating inpatient behavioral health capacity in Massachusetts⁴.

In contrast to these efforts to measure inpatient capacity, there continue to be challenges in collecting data relating to outpatient behavioral health care. The Health Planning Council deferred efforts to develop quantitative measures of outpatient behavioral health capacity, because existing data sources didn't support convenient, meaningful, validated metrics absent significant additional investments and data validation.

Similarly, the Department of Public Health collects monthly emergency department boarding data from all Massachusetts hospitals.⁵ However, these data are not consistently reported from all hospitals, nor are they effectively standardized, leaving stakeholders with an unclear understanding of the issues affecting access and flow through emergency departments.

Moreover, data on behavioral health care quality are collected by health plans in order to meet state and/or National Committee for Quality Assurance (NCQA) requirements but, there is no comprehensive set of behavioral health measures that is reported across all providers, health

³ For a listing of recommendations and the voting record, please see **Appendix C**.

⁴ State Health Plan: Behavioral Health. Massachusetts Department of Public Health. December 2014. Available at: <http://www.mass.gov/eohhs/docs/dph/health-planning/hpc/deliverable/behavioral-health-state-health-plan.pdf>

⁵ Specifically, the data collected includes emergency department boarding of patients with a behavioral health diagnosis over 12 hours.

plans or by type of insurance coverage. Finally, information on behavioral health spending and its impact on the overall cost of health care is not routinely reported.

To better understand how and what data are collected by health plans and providers, and to develop solutions that could be implemented by state agencies, payers or providers, Section 230 required the Task Force to analyze existing policies for evaluating aggregate behavioral health data, and the challenges that exist in sharing and accessing relevant data. Using the survey tool included as **Appendix D**, the Task Force sought feedback from health plans and provider organizations. Ten health plans and one provider organization responded to the survey.

Survey responses indicated that payers and providers are collecting and analyzing behavioral health data, but what data are collected, and how and when the data are analyzed varies from organization to organization, precluding the ability to compare similar populations across plans or providers. For example, most plans reported collecting data on patient outcomes for mental health and substance use treatments. However, some payers were measuring outcomes through member satisfaction, others were monitoring antidepressant adherence, and still others were measuring readmission rates and average length of stay in inpatient psychiatric units. Many plans and the one provider respondent indicated ad-hoc data collection and analyses are commonplace with regard to behavioral health outcome measurement.

Inconsistent interpretation and application of state and federal privacy laws create other barriers to effective use of data to improve patient care. Survey respondents voiced strong opinions about the lack of consistency in applying state and federal privacy requirements, including the lack of shared and accurate understanding by payers and providers of the privacy regulations contained within the Health Insurance Portability and Accountability Act (HIPAA). These issues make it difficult for providers to share information with each other and also make it difficult for state agencies to share information across common clients.

To address these concerns related to the collecting, sharing, and reporting of aggregate behavioral health data, the Task Force makes the following recommendations with a focus on providing the Legislature and stakeholders with data to inform the many behavioral health policy concerns facing the Commonwealth.

 **CHIA should, as part of its continuing study of Mental Health and Substance Use Disorders (ch 12C sec. 21A) periodically publish statistics measuring the performance of the behavioral health care system. By November 1, 2015, CHIA should publish a reporting plan that proposes reporting the measures described in the final report of this Task Force. The reporting plan should identify the feasibility, timing, and resources needed to collect and publicly report these measures, including new data collection if necessary. CHIA should provide a 30 day public comment period prior to finalizing the plan. A regular (annual) process should be included to review the reliability, validity, and utility of measures and to make recommendations to modify the list accordingly.**

CHIA should collaborate with the Department of Public Health, Department of Mental Health, MassHealth, the Division of Insurance, and any other agency as appropriate while developing and implementing this plan. CHIA also should monitor the ongoing development of pediatric behavioral health measures and should incorporate those measures as appropriate.

To address the structural barriers that exist in lacking consistent and centralized access to information and data on the process and outcomes of the behavioral health system, the Task Force believes that a public dashboard should be published on an annual basis to help assess the performance of the behavioral health care system, inform the Legislature as it makes policy decisions, and to inform the broader health care stakeholder community, including patients, individuals with lived experience and their families.

Further, the Task Force offers suggested measures that would inform policymakers and stakeholders on the performance of the behavioral health system. In order to identify these measures, the Task Force participated in a brainstorming process over the course of two meetings to create a statement, included as **Appendix E**, which describes the characteristics of a high performing behavioral health system. With that statement as its guide, the Task Force suggested measures for a dashboard, attached as **Appendix F**, designed to measure the performance of the behavioral health system across several domains: person-centered care, workforce, access, outcomes related to care delivery, the health and wellbeing of individuals, costs, and level of behavioral health integration in the primary care setting.

As presented, the dashboard lacks sufficient measures to fully measure the experience of children and their families who require behavioral health care. The Task Force recognizes this gap, and suggests that CHIA monitor the ongoing development of child-focused measures and incorporate pediatric behavioral health measures as appropriate.

To implement the dashboard, the Task Force recognizes that CHIA will need to develop a reporting plan, including assessing the reliability, validity, utility and ease of collecting the data and developing the model measures. Additionally, other state agencies have behavioral health expertise, experience, and program knowledge that CHIA should seek in order to identify and implement appropriate measures.

In particular, the Task Force recommends that DMH should continue to track and begin to publicly report the number of clients in continuing care facilities who are being tracked for possible discharge by target discharge timeline and the common barriers for discharging those clients timely.⁶ DMH is solely responsible for the operation of the state's six continuing care facilities (CCFs). Individuals who receive care in CCFs typically require long lengths of stay

⁶ This is a formal recommendation of the Task Force that passed with unanimous support. The Task Force's use of the word "timely" is not meant to suggest a clinically standard length of stay and that length of stay appropriately varies by the severity of a persons' mental illness and their progress in recovery.

and need significant discharge planning in order to appropriately transition to community-based care settings, such as group homes. While DMH facilities Area and site offices track individuals today, there has traditionally not been a regular public-facing report that tracks the number of individuals being served within a CCF that have been identified for discharge. Making such data available will provide important information to the Legislature and policymakers regarding where additional services or resources can be directed to ensure that all patients are supported in the least restrictive setting appropriate for their needs. The Task Force recommends that CHIA seek to collaborate with DMH to report aggregate information about these patients on a regular basis.

Likewise, the Task Force encourages CHIA to work with DPH to evaluate, improve, and potentially expand current hospital reporting of patients with a behavioral health diagnosis who board in the emergency department.

Task Force members also acknowledged the need to strike a balance between developing a complete picture of behavioral health care, and minimizing the burden of reporting on payers and providers. CHIA should coordinate with data collection or reporting efforts made by other state agencies, stakeholders, Task Forces, and Commissions, in order to minimize the reporting burden on payers and providers.⁷



The Governor should establish an ongoing state-based data work group charged with resolving the barriers to sharing behavioral health data across agencies, including:

- (a) Linking data and systems so that individuals can be followed through the different agencies for better program coordination and outcome tracking;**
- (b) Setting standard definitions for common data metrics;**
- (c) Resolving state-level privacy data issues, including review of existing state laws.**

This work group should also work to streamline data reporting requests across agencies to reduce duplicative reporting, as well as data reporting requests from external parties. The work group should include, but not be limited to any agency that collects, reports, or analyzes data related to the overall health of Commonwealth residents, including the health and human service agencies, the department of housing and community development, department of education and department of correction. A report on its progress should be delivered to the Legislature by July 1, 2016.

In December 2014, the Health Planning Council recommended the creation of “a Behavioral Health Data Planning group with staff from key agencies, including DPH, DMH, MassHealth,

⁷ CHIA should also consider feedback received from stakeholders during the Task Force’s deliberations, including but not limited to specific feedback from the Massachusetts Association of Advanced Practice Psychiatric Nurses, the National Association of Social Workers, Massachusetts Chapter and the Mental Health Legal Advisors Committee.

CHIA, and the Health Policy Commission (HPC).” Task Force staff facilitated a meeting of state agency program and data experts in January 2015 to better understand and build upon this recommendation.⁸ Agencies reported devoting significant resources today to collecting, reporting and analyzing data, including behavioral health data. State agency staff expressed the need for greater consistency and coordination across all agencies of state government to resolve some long standing and difficult issues, including the inability to follow an individual across state agencies, the use of different terms for similar services by different agencies, and privacy constraints. This recommendation is consistent with the Health Planning Council recommendation, identifies three specific areas that require inter-agency coordination, and specifically suggests that convening the working group within the Governor’s office would offer the ability to consider cross-secretariat issues.



The Task Force endorses the privacy recommendations put forth by the Behavioral Health Integration Task Force, July 2013.

Both the survey findings and the state agency meeting highlighted the lack of consistency in applying state and federal privacy requirements. The Task Force reviewed and endorsed the privacy recommendations of the 2013 Behavioral Health Integration Task Force which are included in **Appendix G**.

III. Recommendations to Reduce Long Term Stays

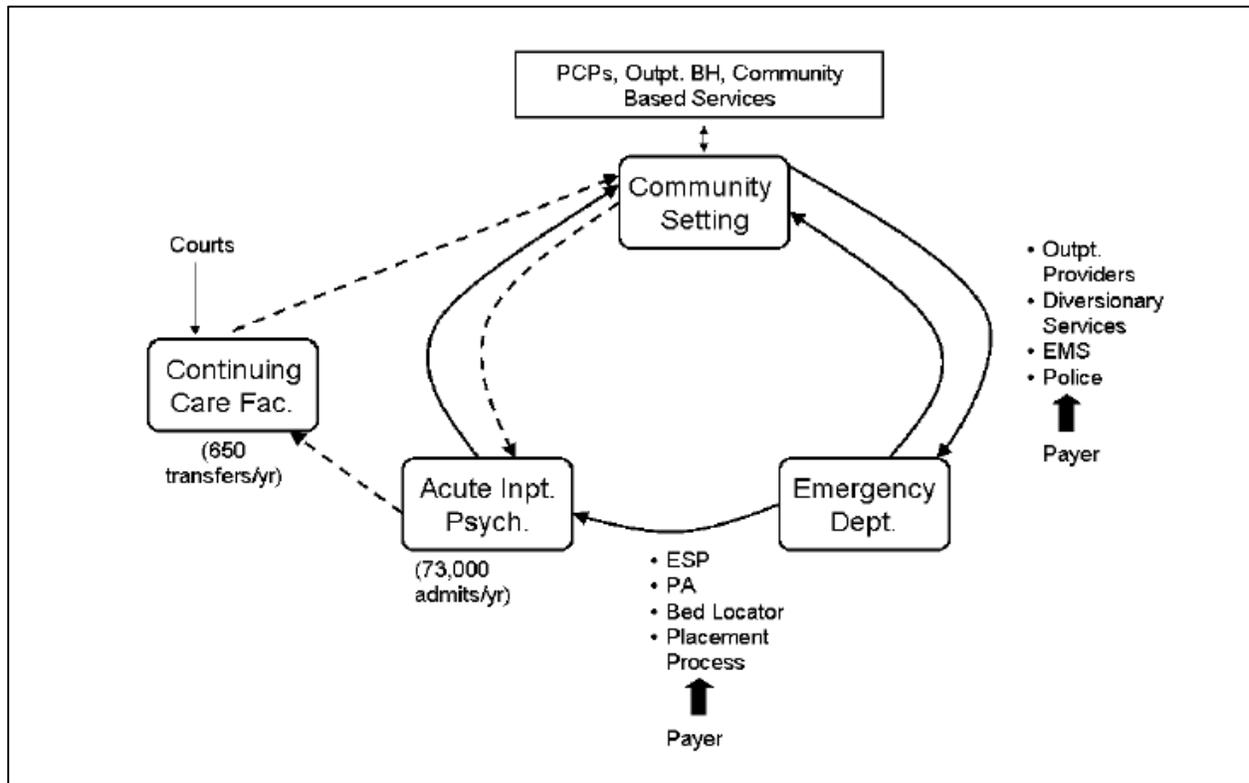
The second charge of the Task Force was to identify solutions to reduce the number of long-term patients in emergency departments (ED), acute psychiatric hospitals or units, and Department of Mental Health (DMH) continuing care facilities. To focus its discussion, the Task Force considered the issues that cause individuals to have stays in any care setting that are longer than medically necessary, loosely defined as time spent awaiting the next level of care, which is sometimes referred to as “boarding” or being “stuck.”

During the meetings, the Task Force examined how the flow of patients through the behavioral health care system in Massachusetts is complex and interdependent. Figure 1 depicts the interconnectedness of the different levels of care and the multiple pathways in which individuals access each level of care. However, the flow of individuals seeking care is relatively fluid with no prescribed pathway. Lack of capacity and operational challenges preventing timely admission within any care setting can lead to bottlenecks that stress another level of care that seeks an appropriate setting to transfer a patient. The Task Force understood that identifying solutions to alleviate inappropriate long term stays is complex and requires

⁸ Staff attended from the Attorney General’s Office, the Center for Health Information and Analysis, the Department of Insurance, the Department of Mental Health, the Department of Public Health, the Health Policy Commission, and MassHealth.

systematic changes by both providers within each care setting and payers, as well as to the regulations governing both payers and providers.

Figure 1. Behavioral Health Care System⁹



While a very complex topic, the Task Force attempted to focus its discussions on each care setting within the behavioral health care system to identify and understand the barriers that exist in admitting and then discharging from each of those settings, and then to develop solutions. The following subsections of this report articulate the solutions developed by the Task Force, by care setting. As mentioned, however, many of the issues and solutions are interrelated and cut across the different care settings.

A. Emergency Department

Long term stays in EDs are endemic to individuals who live with mental health problems in Massachusetts and across the nation. “Boarding” in Massachusetts is defined as a patient who remains in the emergency department 2 hours after the decision has been made to admit the patient to a more intensive level of care. The DPH has requested hospitals to provide data on the number of patients whose boarding time is greater than 12 hours. Boarding in the emergency department is more likely to happen to individuals who live with mental health

⁹ ED Length of Stay Issues for Behavioral Health Patients: Update. June 6, 2013. EOHHS

conditions,¹⁰ which can delay care for all patients or take away critical resources for those with life threatening emergencies, potentially resulting in poor quality care for all patients.

The issues that may contribute to the boarding of individuals are multifactorial and include, but are not limited:

- the lack of inpatient beds available for unique and difficult to manage populations;
- the lack of patient flow throughout the behavioral health care system on the weekend;
- the insurance status of the patient;
- the high occupancy rates of inpatient psychiatric units and continuing care facility beds; and,
- difficulty in accessing outpatient and community-based services that may prevent crisis situations or divert from the emergency department.

The Task Force recognized that much work on this topic has been done in the past. The Task Force leveraged this previous work and reviewed the 68 different recommendations that had been made by many previous state-based Task Forces, Commissions, and agency working groups, and considered the relevance and importance of those recommendations to the specific charge, and considering recent developments and research.

The Task Force considered the recommendations made by the:

- DPH Boarding and Patient Flow Task Force;
- DMH ED Length of Stay and Psych Bed Access Initiative;
- EOHHS ED Length of Stay Issues for Behavioral Health Patients;
- Division of Insurance (DOI) study of differences in plan records between behavioral health and non-behavioral health patients in the ED;
- Mental Health Advisory Committee, and
- Special Commission to Investigate the Expansion and Enhancement of the MABHA Website.¹¹

Based on this review, the Task Force's understanding of the problem, and the Task Force's own discussion of new ideas, the Task Force made recommendations to address the following five discrete problems that directly impact the long lengths of stay within the emergency department.

1. Identifying solutions to care for the "difficult to manage population."

The Task Force reviewed a 2 week observational study across 10 EDs throughout the state conducted by the Massachusetts College of Emergency Physicians (MACEP) on the

¹⁰ Abid Z, Meltzer A, Lazar D, et al. "Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions." *Urgent Matters* Vol 1, Issue 2; June 2014.

¹¹ The Task Force endorses the recommendations put forth by the Special Commission to Investigate the Expansion and Enhancement of the MABHA website.

characteristics of patients boarding in the ED and the possible causes. Individuals with prolonged boarding time were more likely to have public insurance or no insurance, a history of incarceration or sexual offense, active substance use issues, exhibit behaviors that are “difficult to manage” (e.g., aggression, violence), among other characteristics.¹² Certain of those characteristics were particularly indicative of longer lengths of the stay in the emergency department. For example, persons with history of aggression stayed an average of 4 hours longer and having been incarcerated lengthened time in the ED by 7.5 hours.¹³ In addition, having public insurance was the greatest predictor of the longest length of stay.¹⁴

As mentioned, the Task Force considered a number of previously made recommendations to address the volume of “difficult to manage” patients who board in the emergency department. Those recommendations included establishing a single authority to make determinations for placement for patients who have extended boarding, been refused admission or whose course of treatment is in dispute;¹⁵ piloting the use of single rooms / appropriate staffing ratios and other techniques to help patients with aggressive behavior;¹⁶ reinforcing no reject provisions in provider contracts;¹⁷ increasing reimbursement for psychiatric inpatient admissions to allow for staffing and coordination of individuals with complex needs;¹⁸ licensing specialized beds,¹⁹ and other ideas.

The Task Force believes that the “difficult to manage” patients are boarding in the ED because there are only a few health care providers that have the resources and training to care for the unique needs of these individual patients. For example, health plans have reported a particular concern over the lack of appropriate settings to care for adolescent males who exhibit violent or aggressive behaviors, who cannot be cared for safely on a pediatric unit, and who are not age-appropriate for an adult unit.

The Task Force learned about the experiences of a program between The Quincy Center operated by the Arbour Health System and the Massachusetts Behavioral Health Partnership (MBHP). Under the program, enhanced rates are offered to the provider to manage a unit for patients who meet certain criteria that indicate that a more specialized level of care is appropriate. The Task Force found that more units like the one operated at the Quincy Center

¹² Chang, Grace, et al. “Characteristics of adult psychiatric patients with stays of 24 hours or more in the emergency department.” *Psychiatric Services* 63.3 (2012): 283-286 and Pearlmutter, Mark. “Mental Health ED Boarding.”

Presentation made to the Task Force on Behavioral Health Data Policies and Long Term Stays, February 26, 2015.

¹³Pearlmutter, Mark. “Mental Health ED Boarding.” Presentation made to the Task Force on Behavioral Health Data Policies and Long Term Stays, February 26, 2015.

¹⁴ Ibid.

¹⁵ Report of the Mental Health Advisory Council in accordance with Section 186 of Chapter 139 of the Acts of 2012 and Chapter 38 of the Acts of 2013. June 2014

¹⁶ DMH ED LOS and Psych Bed Access Initiative, Unpublished Meeting Materials. May 2012

¹⁷ Report of the Mental Health Advisory Council – Appendix C – Consultant Report Abt, June 2014.

¹⁸ Ibid

¹⁹ Report of the Mental Health Advisory Council in accordance with Section 186 of Chapter 139 of the Acts of 2012 and Chapter 38 of the Acts of 2013. June 2014

might help care for these patients, but the Task Force did not have the expertise or resources to identify the number of beds that were needed for the different segments of the population. The Task Force also did not review any data as to the results of the program. In addition, the Task Force was informed that an additional 300 new acute psychiatric beds are scheduled to be operational within the next twelve months, but the capability these beds will offer is still unclear.

Therefore, with unanimous agreement, the Task Force makes the following recommendation.



EOHHS should convene a multi-stakeholder needs assessment work group to determine the number of additional inpatient psychiatric and continuing care facility beds that should be made available in newly formed units for adult men and adult women who exhibit violent and / or aggressive behaviors, and for adolescents aged 15 – 17, who exhibit violent and / or aggressive behaviors and for whom placement in an adult unit or pediatric unit is not possible. The needs assessment should be completed by October 1, 2015.

Based on the needs assessment, EOHHS, in coordination with DMH, DPH, and MassHealth to streamline licensure and coverage rules, should be responsible for ensuring the recommended number of beds are operational by July 1, 2016 first by issuing RFPs to create the services privately or, if there are not adequate responses by private providers, by opening state controlled and operated beds. Should the state resume its planning process regarding the creation of a forensic hospital to be operated by the DMH, consideration should be given to the appropriateness of including specialty units for both adolescents and adults who exhibit intractable violent or aggressive behavior in such a facility.

If the needs assessment concludes there is a need for more beds for this specific population, it is important to note that the Task Force is not recommending that the state solely pay for these beds, but that the state be responsible for ensuring that they are available. Some Task Force members expressed concerns that EOHHS has previously taken action to close specialized units for this population and may not be open to considering the potential need for these beds. To address that concern and provide for an open process, the assessment should be conducted with a multi-stakeholder team of providers, payers and persons with lived experience. In addition, one Task Force member has concerns that if additional beds for this population are privately operated, but if there are no privately operated continuing care beds, then the state facilities would continue to receive these patients without the specialized units necessary to appropriately care for these patients.

Some Task Force members suggest that this assessment also consider inpatient access needs of children and youth with autism spectrum disorder (ASD) and other developmental delays. The Task Force reviewed data on the number of youth and children awaiting inpatient psychiatric admission and is aware of the seasonal variation in needs and bed availability. The Task Force is also aware of a lack of inpatient services for children west of Worcester. While, the Task Force was focused on adult populations – mainly because of the membership of the Task Force and the data available – it does recognize the needs to pay particular attention to

youth and adolescents and their unique challenges with respect to delays in admission to appropriate inpatient units and urges EOHHS to do the same.

Lastly, this working group should also examine the causes for acts of serious violence or aggression and whether alternatives to and within inpatient care may reduce the incidence of violence and aggression.

2. Improving patient flow in the behavioral health system on the weekend

ED boarding is particularly acute during the weekend. The length of stay during weekend days can be between 5-9 hours longer than during week days.²⁰ The cause of the issue is multifactorial, and certainly cross cutting. Anecdotal information by health plans and Task Force members suggests that flow through the entire behavioral health system on the weekend is a known problem, which is partly caused by operational-level issues of each stakeholder in the system. Access to psychiatrists and other behavioral health providers on the weekend, as well as reimbursement policies²¹ that might not encourage efficient flow, may also contribute to the lack of flow through the system on the weekend.

The Task Force believes that the issues surrounding weekend patient flow are amenable to coordinated, targeted intervention. Therefore, the Task Force members made the following recommendation.



The Executive Office of Health and Human Services should develop a strategy, in consultation and collaboration with stakeholders, to reduce weekend boarding of individuals with psychiatric disorders in Emergency Departments. EOHHS should identify and address operational and structural barriers to discharging patients from Emergency Departments on the weekend, including examination of how weekend admission and discharge practices at inpatient psychiatric hospitals and continuing care facilities, and access to community services on the weekend, affect the ability to admit patients from the Emergency Department in a timely manner. EOHHS should work with providers and public and commercial insurers to collect necessary data and facilitate the removal of identified barriers.

While Task Force members believe that availability of care on the weekends has a significant impact on ED boarding, comprehensive data on the issue was not available. In addition, this Task Force did not have sufficient time to fully engage in the development of a comprehensive recommendation to address this issue. There have been a number of other efforts to address this issue in particular, and Task Force members believe it is important for a solution to this

²⁰ Pearlmutter, Mark. "Mental Health ED Boarding." Presentation made to the Task Force on Behavioral Health Data Policies and Long Term Stays, February 26, 2015.

²¹ Payers pay consistent rates regardless of the day or time care is provided.

complex issue be led by EOHHS as it has the unique ability to implement solutions with a combination of leadership, incentives, and regulation.

The Task Force identified a number of areas that deserve consideration in this effort, including:

- Whether payment policies restrict or promote weekend availability of community-based mental health services (e.g. outpatient providers accepting appointments on the weekend, expanding capability for admitting to group homes, and nursing/ rehab and assisting living facilities, developing partial hospitalization programs with weekend appointments). Such policies could include incentives (e.g. additional payments for weekend services provided post-discharge) or modification of existing practices.
- State program capacity to expedite the placement of children and adults within DCF and DMH coverage services during a weekend discharge.
- Necessary operational and staffing changes at the discharging institutions (e.g. additional staff for weekend discharge planning; better Thursday/Friday discharge planning and coordination).
- Strategies and an assessment as to how pilot programs using ACO or medical home-based care can help improve coordination between and among inpatient, outpatient, and post-acute services available to patients.

3. Addressing the treatment environment present in most emergency departments

The Task Force recognized that Emergency Departments are often not able to provide an appropriate environment to care for individuals with acute behavioral health needs and that the extended lengths of stay for those individuals can escalate or exacerbate behavioral health conditions, putting both emergency department staff and the patients in unsafe conditions. Furthermore, most EDs in Massachusetts do not have access to behavioral health providers that can provide initial treatment to individuals with mental health needs, including prescribing the appropriate medication, while awaiting placement in an alternative care setting.²² To address this issue, the Task Force considered recommendations made by prior groups including supporting tele-psychiatry,²³ and the establishment of care settings specifically for individuals with acute mental health needs.²⁴

The Task Force learned of a pilot program at Morton Hospital that offers behavioral health assessments via telehealth during the hours of 8pm-8am. This program allows access to a case worker to evaluate the patient for appropriate placement within the behavioral health care setting and reduces the “decision to admit” time. However, this program was limited in the

²² Pearlmuter, Mark. “Mental Health ED Boarding.” Presentation made to the Task Force on Behavioral Health Data Policies and Long Term Stays, February 26, 2015.

²³ DMH ED LOS and Psych Bed Access Initiative, Unpublished Meeting Materials. May 2012

²⁴ Report of the Mental Health Advisory Council in accordance with Section 186 of Chapter 139 of the Acts of 2012 and Chapter 38 of the Acts of 2013. June 2014 and Report of the Mental Health Advisory Council – Appendix C – Consultant Report Abt. June 2014.

services provided and to which patients, due to regulatory barriers. Consequently, the Task Force made the following recommendation.



The Task Force supports the expanded use of telehealth services by behavioral health providers, when clinically appropriate. The Board of Registration in Medicine (BORM), the Division of Professional Licensure, and the Division of Health Professions Licensure should remove licensure, credentialing and privileging barriers to allow behavioral telehealth in the health care system, including in hospital emergency departments, when clinically appropriate. Health plans, MassHealth, and providers should work together to promote the expanded use and coverage of telehealth by behavioral health providers in any care setting.

The Task Force recommends support from the Legislature to ease the use of telemedicine by behavioral health providers in all care settings, but especially in the ED to ensure individuals boarding receive the most appropriate possible care while they are awaiting an inpatient admission or other level of care. Chapter 224 supports the general use of telehealth, but several Task Force members believe the support should be specifically extended to cover the services provided by behavioral health providers, including psychologists, licensed social workers, and other behavioral health providers. Increasing use of telehealth in other care settings where timely access to behavioral health providers is otherwise limited, may improve the flow of the system by providing earlier access to care, thereby avoiding crisis situations that may result in emergency department visits.²⁵

While the Task Force supports expanded use of telemedicine, some Task Force members expressed concern that telehealth not replace adequate networks of in-person care where available and that provider and payer systems should be responsible for providing adequate access to in-person behavioral health providers in all care settings. The availability of telehealth services may not be used to refute the need for out-of-network single case agreements for in-person care. Other Task Force members support consistency with CMS requirements for privileging and credentialing of telehealth programs for providers operating in the Medicare program, while others believe some CMS telehealth payment and coverage policies would be a barrier to telehealth.

4. Improving the utilization of care settings other than the emergency department

In order to reduce the number of individuals experiencing a mental health crisis that is exacerbated by long stays in the ED, Task Force members brought attention to approaches that could help prevent individuals from requiring care in the ED. This is consistent with the State Health Plan.²⁶ Some Task Force members believe that requiring medical clearance through the

²⁵ BORIM and the Division of Insurance (DOI) were directed through Section 249 of Chapter 224 to conduct a “report on the potential for out-of-state physicians to practice telemedicine in the commonwealth.” This report has not yet been completed. However, Task Force members believe that there would still be utility in completing the study.

²⁶State Health Plan: Behavioral Health. Massachusetts Department of Public Health. December 2014.

ED prevents individuals who are experiencing mental health crises from being transported to alternative settings by emergency medical services. Likewise, current practices among intensive care settings prevent medically stable individuals from being directly admitted to inpatient psychiatric facilities, substance use treatment facilities, or community crisis stabilization units. It is in this context, that the Task Force made the following two recommendations.

 **DPH and DMH should jointly develop a working group of providers, ESP teams, persons with lived experience and family members to examine and where necessary revise regulations and guidelines in order to allow emergency medical services teams to bring individuals with a behavioral health condition to an appropriate placement, thereby diverting patients from using the emergency department if they can be safely managed in another setting (including, but not limited to, an inpatient psychiatric facility, substance use treatment facility or community crisis stabilization unit).**

The Task Force recommends the creation of a multi-stakeholder working group, consisting of providers, emergency service personnel, ESP teams, persons with lived experience, family members, plans, local law enforcement, city and town representatives, and other stakeholders, to develop solutions to assist in patients directly accessing services in the most appropriate venue. Task Force members recommend that this working group consider the results of programs intended to reduce ED and inpatient psychiatric utilization for individuals experiencing mental health crises, both in Massachusetts and across the United States, such as the Massachusetts-based Emergency Service Program (ESP) for adults, the Mobile Crisis Intervention program for youth, and the Massachusetts Mental Health Diversion and Integration Program.²⁷

Some Task Force members expressed concern that while diverting medically stable individuals away from the ED is the goal, there is evidence that psychiatric symptoms could be indicative of a medical problem, thereby causing a risk that some individuals who truly need emergency medical evaluation and treatment might be inappropriately deterred for receiving such care. Therefore, these Task Force members wish to ensure that the working group, in order to avoid unintended consequences resulting from a misperception of medical stability, include equal and fair representation of all stakeholders, including emergency department providers experienced in handling care for individuals who present with behavioral health symptoms that are manifestations of other medical problems, as well as providers experienced with treating behavioral health conditions. These Task Force members also wish to ensure that the working group carefully considers the implications of ED diversion practices to not put undue risk on individuals. Lastly, some Task Force members wish to ensure that emergency department

²⁷ The Massachusetts Mental Health Diversion and Integration program is not a program to reduce ED or inpatient psychiatric admissions, per se, however it is a program to reduce the incarceration of individuals with mental illness by providing police with the tools needed to de-escalate individuals in crisis and communicate the availability of community resources available as alternatives to arrest.

diversion not be practiced for individuals who make a 911 phone call to access emergency services.



EOHHS should lead a campaign to increase awareness among patients, families, and providers of the available services that keep people healthier, preventing the need for more acute levels of care and that help people transition back to the community after discharge. EOHHS should coordinate with other state agencies, NAMI, consumer groups, health plans, provider, and provider associations.

In addition to industry practices that might not support clinically appropriate diversion, certain Task Force members felt that individuals needing care, their families, and providers do not have a full understanding of the panoply of behavioral health offerings within the system and, even when they do, are not always sure how to access these services and anecdotal information about how to access certain behavioral health services permeates throughout. A campaign to inform the larger public of all available behavioral health offerings might help in keeping people healthier and help those experiencing illness know the most appropriate setting in which to receive care.

5. Notifying payers of individuals boarding in the ED

According to some Task Force members, there is some misunderstanding of health plan requirements related to if and when prior authorization or notification is required for inpatient service. To resolve this issue, the Task Force asked the Massachusetts Association of Health Plans (MAHP) and the Massachusetts Hospital Association (MHA) to bring together appropriate stakeholders to create a document, that lists health plan requirements for prior authorization and notification, and key contact information for providers to use when assistance is needed in finding an appropriate placement for a member who has an extended emergency department length of stay. The resulting document is attached as **Appendix H**, and will be distributed to all EDs in Massachusetts and posted online where users can access the most up-to-date version.²⁸

B. Inpatient Psychiatric Units

To understand what contributes to long lengths of stay in inpatient psychiatric units, the Task Force looked at data on the characteristics of patients with longer lengths of stay, and at the occupancy rates of the units themselves.

With respect to the average length of stay, data collected from a small sample of private inpatient acute hospitals²⁹ suggests that the length of stay for individuals who are involved with

²⁸ In addition to MAHP and MHA, the Massachusetts Board of Emergency Physicians, the Massachusetts Psychiatric Association, MassHealth and MBHP participated in the development of this document which provides a quick guide to health plan policies regarding prior authorization. This document applies only to health plans' fully insured business; rules for self-insured employers may differ based on employer choice.

²⁹ This sample includes the average length of stay from two large private, inpatient acute hospitals in 2014. The source is the Massachusetts Association of Behavioral Health Systems.

state-agency services (e.g., adults involved with DMH or youth involved with DCF/DYS) can be upwards of 80 days longer than individuals not involved with a state-agency. Some of this difference can be expected because individuals receiving state-agency services tend to have higher acuity needs, however, it is unclear whether individual patient acuity is the sole contributor to the variation in length of stay.

In terms of occupancy rates, the publicly available data on occupancy rates in Massachusetts' psychiatric hospitals with a large number of annual discharges shows many of these hospitals were above 85 percent in FY 13.³⁰ Research suggests that high occupancy rates can cause bottlenecks when units have to turn away potential admissions,³¹ which may contribute to the problem of long lengths of stay in the emergency department. In the course of its deliberations, the Task Force learned that several hundred new privately operated inpatient psychiatric beds are projected to become available over the next 12-18 months in the Commonwealth. The effect of these additional beds on the flow, throughput and discharge capabilities of the system are unclear and will need to be considered when adopting any related recommendations within this report.

Because new beds are expected to be available in the short-term, yet the capability of the beds is still unknown, Task Force members believed it was prudent to allow those beds to come on-line and evaluate their impact before making any specific recommendations focused on inpatient stays specifically. In addition, Task Force members believe that the interrelatedness of the system is such that many of the recommendations made by the Task Force do impact the inpatient psychiatric system in terms facilitating timely admissions and clinically appropriate discharges.

C. DMH Continuing Care Facilities

Finally, the Task Force considered the flow, throughput, and discharge planning issues related to DMH's continuing care facilities and the unique opportunity DMH was given in FY 15 to identify community-based care settings for discharge ready patients.

Following an inpatient stay, certain individuals that meet DMH requirements, may benefit from a transition to a DMH continuing care facility (CCF). Before an individual is admitted to a CCF, the individual must meet DMH eligibility requirements. After a complete application has been received by DMH, the agency has five days to make an eligibility determination for children, adolescents, or MassHealth adults. Otherwise, DMH has 20 days to determine eligibility. After eligibility has been determined, a placement within a continuing care facility bed can be made. To help facilitate the admission process, including the eligibility application and potentially locating alternatives to continuing care facilities, DMH has employed agency liaisons to provide

³⁰ Massachusetts Center for Health Information and Policy. "Massachusetts Hospital Profiles: Data Through Fiscal Year 2013. Published databook online January, 2015 available <http://chiamass.gov/massachusetts-non-acute-hospital-profiles/>

³¹ Jones, R. "Optimum Bed Occupancy in Psychiatric Hospitals." *Psychiatry On-Line*. July 2013

services to each inpatient psychiatric hospital or inpatient unit. **Appendix I** provides a full description of the DMH Liaison Function. Despite efforts to ease the discharge from inpatient facilities to CCFs, data shared with the Task Force suggested that individuals awaiting a CCF placement stay an average of 70 days longer in inpatient facilities than those who are discharged back to the community.

Section 230 specifically required the Task Force to consider recommendations that would require the DMH to implement policies that prioritize the readmission of patients who are discharged from continuing care facilities and subsequently require hospitalization within 30 days of their discharge.

In FY 2015, DMH was appropriated \$10 million to facilitate the placement of at least 100 discharge-ready individuals from continuing care facilities into community-based settings. By the time that this Task Force began meeting to deliberate, DMH had already developed a protocol for readmitting any patient that was part of its FY 15 Community Expansion Initiative.³² The protocol, included as **Appendix J**, is a clinically driven protocol that was meant to facilitate any necessary readmissions to the most appropriate level of care, and when the most appropriate level of care was a continuing care facility, to the one the individual had been previously discharged. In addition, within 24 hours of readmission, a case conference will be held to determine the causes of unsuccessful transition to the community and a new disposition plan will be developed.

As such, the Task Force made the following recommendation.



DMH should evaluate the effectiveness of its readmission protocol that was designed for the FY 15 Community Expansion Initiative. DMH should report on its effectiveness, and if effective, adopt for all patients. DMH should report its proposed approach by January 1, 2016.

The Task Force appreciated that DMH was piloting this readmission protocol and therefore unanimously recommended that the pilot be evaluated with the ultimate goal of spreading this or a similar protocol to all individuals discharged from continuing care facilities.

D. Outpatient Behavioral Health System

The utility and capacity of the outpatient behavioral health system has a direct impact on the lengths of stay for individuals in the emergency department, inpatient psychiatric units, and DMH's continuing care facilities. The outpatient behavioral health system plays an important role in both preventing individuals from needing intensive levels of care, but also to help those who are discharged from intensive levels of care adjust to and stay in the community setting.

³² In the FY 15 state budget, the Legislature appropriated the Department of Mental Health \$10 million to expand community-based placements by no fewer than 100 placements for discharge ready individuals who were in DMH continuing care facilities. This effort was known as the FY 15 Community Expansion Initiative.

The State Health Plan recommends patients be provided with strong post-discharge supports, to enable timely discharges and the outpatient system is poised to provide those supports.³³

Despite the importance of outpatient behavioral health services, the Task Force found limited objective information about capacity, access and the resulting impact on the flow, throughput and discharge issues associated with emergency departments, inpatient psychiatric units, and continuing care facilities. The State Health Plan did not meaningfully address the capacity of outpatient and community care providers, which leaves a large gap in knowledge of the behavioral health care system. Therefore, the Task Force makes the following recommendation.

 **EOHHS, through the Health Planning Council, should conduct an analysis on outpatient capacity and demand, in order to assess the robustness of the community systems, including its weekend capacity, in part to identify whether additional investment is necessary. The outpatient system should include all outpatient services offered by state agencies, plus privately provided outpatient services conducted by providers under state licensure – including those providers that do not accept insurance. Following the initial analysis, outpatient capacity should be monitored by EOHHS and the Health Planning Council on a regular basis.**

The Task Force understands that the Health Planning Council did not have the time and resources necessary to conduct a capacity analysis on the outpatient and community behavioral health systems. The task of doing so is quite complex because the behavioral health system it is disparate in number and type of providers that offer services, the variation with which insurance is accepted among providers, and the significant number of individuals with mental illnesses that do not receive treatment and do not report an unmet need.³⁴

However, in order to fully understand whether the outpatient system that exists in Massachusetts is adequate, the Task Force believes a comprehensive analysis should be conducted using the best possible information that can be obtained from currently available data as well as newly collected data (e.g., through surveys). The Task Force also believes that the resulting analysis should be made publicly available.

 **MassHealth should repeal regulation 130 CMR 411.406 and any other similar regulations that prohibit MassHealth from covering outpatient mental health services by any independently licensed behavioral health provider.**

³³ State Health Plan: Behavioral Health. Massachusetts Department of Public Health. December 2014.

³⁴ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011 and 2012 http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm - Tables 1.1A , 1.24A , 1.39A Source on Massachusetts: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Massachusetts, 2013. HHS Publication No. SMA-13- 4796MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857, p.9

Task Force members articulated known regulatory and industry barriers that limit access to important services. For example, while clinical psychologists and other independently licensed behavioral health providers are an important part of the outpatient behavioral health system, MassHealth regulations currently limit members' ability to access certain therapeutic services offered by psychologists and independently licensed behavioral health providers.³⁵ Specifically, 130 CMR 411.406 states that MassHealth "does not pay a psychologist for diagnostic (other than by testing) or treatment services, including services the psychologist performs when working under the supervision of a psychiatrist or when responding to a referral from a psychiatrist." Regulations like this unnecessarily limit access to services within a provider's scope of practice. Given the difficulty in accessing outpatient services, the Task Force recommends MassHealth review and repeal this and other similar regulations.



MassHealth, its behavioral health vendor and all commercial health plans should be encouraged to develop policies that support the expansion and reimbursement of evidence-based group psychotherapy treatment for behavioral health.

As mentioned, there are some perceived and known industry policies that represent barriers to accessing the outpatient behavioral health system. For example, some individuals living with a behavioral health condition can benefit from effective, evidence-based group psychotherapy as one treatment option.³⁶ While one Task Force member reports that health plans currently pay for group psychotherapy, another Task Force member believed that access to outpatient group therapy in Massachusetts is limited by reimbursement levels for group psychotherapy that may act as a disincentive for providers to offer group therapy and therefore, new policies could encourage payers to support the expansion and reimbursement of evidence-based group psychotherapy.

E. Financing the Behavioral Health System

The Task Force spent considerable time discussing the appropriateness of the financing of the behavioral health system, in terms of the reasonableness of rates paid for behavioral health services, differences in payment between behavioral health and physical health providers, the number of behavioral health services that are traditionally unreimbursed, and perverse incentives due to siloed fee-for-service payment methodologies. The following recommendations address the financing of the behavioral health system.



CHIA should work with other state agencies, including the AGO, to report on the impact of public and private behavioral health payment rates on access and capacity.

³⁵ This recommendation should be implemented to the extent possible while remaining in compliance with Medicare policies and regulations.

³⁶ "Evidence on the Effectiveness of Group Therapy." AGPA Evidence Based Group Practice. Web. 21 May 2015. <<http://www.agpa.org/home/practice-resources/evidence-based-group-practice>>.

Some Task Force members expressed the belief that payments impacted access to behavioral health services, thereby delaying individuals from seeking care and having their illness escalate to the point where they require an emergency department visit and/or an inpatient hospitalization, and contributing to the overall problem of long lengths of stay. However, to date, a comprehensive comparative analysis of behavioral health payment rates has not yet been conducted. During its deliberations, the Task Force became aware that the Attorney General's office is poised to release an examination of health care cost trends and cost drivers related to behavioral health. This report is scheduled to be released shortly after this Task Force completes its work. The Task Force is hopeful that this report will shed some light on payment levels and provide the Health Policy Commission with the ability to consider the Attorney General's Office report as part of its annual Health Care Cost Trends Hearings.³⁷

The Task Force therefore recommends that CHIA work in coordination with the AGO and other state agencies to leverage existing information about behavioral health payment rates and highlight new information regarding the impact current behavioral health payment rates have on individuals accessing services and the capacity for providers to care for behavioral health patients. Some Task Force members asserted that until a comprehensive comparative analysis determines that current reimbursement practices by payers are in indeed affecting access and capacity, recommendations relating to payers increasing funding for behavioral health services should be reserved. However, a majority of Task Force members make the following recommendation.



The Task Force Members encourage the Legislature to increase funding for behavioral health services to eliminate barriers to access to care.

Over the seven meetings of the Task Force, many members often voiced opinions that low reimbursement rates for behavioral health services, especially when compared to certain medical services (e.g., reimbursement differences between physician office visits for psychiatrists vs. medical physicians), impedes access to services because providers are not willing or able to delivery services at the set rates. Some Task Force members noted the Commonwealth's mandate to balance the annual budget and Chapter 224's requirement limiting health care expenditures growth to an annual cap. However, a majority of the Task Force further noted that this cap does not apply to behavioral health spending as a subset of overall spending, and suggested that it may be possible to increase spending for behavioral health services while still meeting the overall annual cap.

³⁷ The Task Force was asked to consider voting on this as a recommendation but as a group felt that they could not support a recommendation where they did not have sufficient detail on the Attorney General's Office confidential examination.



As EOHHS develops alternative payment models to meet its requirement under Chapter 224 of the Acts of 2012, it should develop, in consultation with providers, global payment models that include behavioral health services for a broad range of patients, including adults with serious and persistent mental illness and children and youth with serious emotional disturbance. Such alternative payment models should align with services provided by or on behalf of MassHealth, DMH, or BSAS.

EOHHS and MassHealth are currently doing significant work to meet the requirements of Chapter 224 to pay for care of 80% of the MassHealth population through alternative payment methodologies. Based on purchasing for value rather than volume, these payment arrangements focus on increased provider accountability for provision to the appropriate services at the right time and in the right setting, with a focus on both improved quality outcomes and cost containment. The theory is that if providers are accountable for the overall care of an individual, they will have more incentive to ensure that the health care system as a whole, responds appropriately to individual care needs.

As discussed above, individuals with behavioral health needs may have a difficult time flowing through the system due to bottlenecks in the emergency department, inpatient units, and continuing care facilities, as well as inability to access outpatient, community-based treatment. Where an alternative payment methodology may offer providers with incentives for improved quality and costs, or go further and hold them accountable for care provided, it is important for behavioral health to be included in alternative payment methodologies. Inclusion of behavioral health is essential to the further integration of behavioral and physical health care services, and to ensure that behavioral health providers are appropriately incentivized for the care they provide.

Where EOHHS is actively engaged in initiatives to develop alternative payment methodologies, the Task Force recommends that any alternative payment methodologies developed by EOHHS include behavioral health services within any global capitation model, and that individuals with serious mental illness be included in such payment models.³⁸ Further, the Task Force recommends that EOHHS consider the potential to align payments for services paid for through MassHealth, the Bureau of Substance Abuse Services (BSAS), and DMH as part of its payment models. If it is feasible to include payments across the continuum regardless of which state agency is paying for the service, it may allow for greater coordination of an individual's care and ultimately better care outcomes. In development of any alternative payment model involving behavioral health patients, persons with lived experience should be included in discussions.

³⁸ However, according to some public comments that the Task Force received, there may be some unintended consequences to alternative payment models with respect to those with behavioral health conditions. For more information, see: Fendell, S. "The Unintended Results of Payment Reform and Electronic Medical Records." *Journal of Health & Biomedical Law*. 2014.

IV. Conclusion

Over the course of seven months, the Task Force established in Section 230 of Chapter 165 of the Acts of 2014 deliberated complex issues surrounding the availability of adequate data to assess the performance of the behavioral health system and solutions to reduce clinically inappropriate long term lengths of stay for patients in the behavioral health setting. The recommendations of the Task Force are designed to improve data collection and reporting on outcome measures, as well as to reduce inappropriately long stays in emergency departments, inpatient facilities, and continuing care facilities. Once data on the performance of the behavioral health system are publicly available, it will be the responsibility of all stakeholders to hold the system accountable for providing high quality care to all residents of the state.

If you have questions pertaining to this report, please contact Joe Vizard at 617-701-8313 or at joseph.vizard@state.ma.us.

Appendix A. Legislative Charge and Task Force Members

SECTION 230. There shall be a special task force convened to identify existing structural or policy-based impediments to delivering comprehensive and cost-effective behavioral and mental health treatment within the commonwealth’s health care system.

The task force shall consist of 14 members:

| Organization Appointed in Legislation | Designee |
|--|--|
| Center for Health Information and Analysis (CHIA) | Áron Boros (Chair) |
| Department of Mental Health | Teresa Anderson, PhD & Clifford Robinson |
| Massachusetts Association of Health Plans | Matt Collins, MD & Sarah Chiaramida |
| Massachusetts Nurses Association | Karen Coughlin |
| Massachusetts College of Emergency Physicians | Mark Pearlmutter, MD |
| Association of Behavioral Healthcare | Vic DiGravio |
| Massachusetts League of Community Health Centers | Patricia Edraos |
| Massachusetts Hospital Association | Timothy F. Gens |
| Massachusetts Psychological Association | Michael Goldberg, PhD |
| Massachusetts Psychiatric Society | Gregory G. Harris, MD, MPH |
| SEIU Local 509 | Melody Hugo |
| American Nurses Association of MA | Anne Manton, RN, PhD |
| National Alliance on Mental Illness | Laurie Martinelli |
| Massachusetts Association of Behavioral Health Systems | David Matteodo |

In its examination, the task force shall review how health care providers deliver behavioral health services, including but not limited to:

- (i) an analysis of existing state and health care provider policies for collecting and evaluating aggregate data regarding the numbers of patients treated for behavioral or mental health diagnoses, provided treatments and patient outcomes;
- (ii) a review of existing state and industry policies for collecting and evaluating aggregate data regarding the annual number of people hospitalized due to a behavioral or mental health related diagnosis, including emergency room visits and the associated costs for treatment;
- (iii) a review and analysis of existing state and industry policies regarding access to behavioral health services data and information, including recommendations to encourage increased coordination and improved access to relevant data among providers, hospitals and state agencies; and

- (iv) recommendations for necessary industry, regulatory or legislative changes in order to improve collection and access to behavioral health data among providers, regulators, hospitals and other stakeholders.

The task force shall also develop recommendations to reduce the number of long-term patients in department of mental health continuing care facilities, acute psychiatric units, and emergency departments including, but not limited to, increasing the capacity of specialized crisis stabilization units and requiring the department of mental health to implement policies that prioritize the readmission of patients who are discharged from continuing care facilities and subsequently require hospitalization within 30 days of their discharge.

The task force shall submit its report, findings, recommendations and any proposed legislation and regulatory changes to the health policy commission, the joint committee on mental health and substance abuse and the joint committee on health care financing not later than July 1, 2015.

Appendix B. Meeting Dates and Topics

| Date | Meeting Topic |
|-------------------|--|
| November 20, 2014 | <ul style="list-style-type: none">• Welcome and introductions• Discussion of scope, identification of key issues (and definitions)• Presentation of project plan |
| December 18, 2014 | <ul style="list-style-type: none">• Characteristics of a high performing behavioral health system• Review of Potential Measures |
| February 26, 2015 | <ul style="list-style-type: none">• Reducing long term stays in the emergency department |
| March 10, 2015 | <ul style="list-style-type: none">• Potential dashboard measures |
| March 24, 2015 | <ul style="list-style-type: none">• Reducing long term stays in the inpatient psychiatric units and the DMH continuing care facilities |
| April 28, 2015 | <ul style="list-style-type: none">• Follow-up conversation on both topics |
| May 19, 2015 | <ul style="list-style-type: none">• Review and vote on recommendations |
| June 11, 2015 | <ul style="list-style-type: none">• Vote on tabled recommendations and review final report |

The agendas, materials, and summaries of each meeting are available here:

<http://chiamass.gov/task-force-on-behavioral-health-data-policies-and-long-term-stays/>

Appendix C. Summary of Task Force Vote

The following is the record of opposing and abstaining Task Force votes for each recommendation. Unless otherwise indicated as having opposed or abstaining from voting on the recommendation, the Task Force member’s vote was in the affirmative. The recommendations are in the order in which they appear in the report, including those that appear in footnotes.

| Recommendation | Opposed | Abstained |
|---|---------|-----------|
| <p>CHIA should, as part of its continuing study of Behavioral Health (ch 12C sec. 21A) periodically publish statistics measuring the performance of the behavioral health care system. By November 1, 2015, CHIA should publish a reporting plan that proposes reporting the measures described in the final report of this Task Force. The reporting plan should identify the feasibility, timing, and resources needed to collect and publicly report these measures, including new data collection if necessary. CHIA should provide a 30 day public comment period prior to finalizing the plan. A regular (annual) process should be included to review the reliability, validity and utility of measures and to make recommendations to modify the list accordingly.</p> <p>CHIA should collaborate with the Department of Public Health, Department of Mental Health, MassHealth, the Division of Insurance, and any other agency as appropriate while developing and implementing this plan. CHIA also should monitor the ongoing development of pediatric behavioral health measures and should incorporate those measures as appropriate.</p> | | DMH |
| <p>The dashboard of suggested measures that would inform policymakers and stakeholders on the performance of the behavioral health system.</p> | | |
| <p>DMH should continue to track and then publicly report the number of clients in continuing care facilities who are being tracked for possible discharge by target discharge timeline and the common barriers for discharging those clients timely. DMH should work with CHIA to report aggregate</p> | | |

| Recommendation | Opposed | Abstained |
|--|---------|-------------|
| information about these patients on a regular basis. | | |
| <p>The Governor should establish an ongoing state-based data work group charged with resolving the barriers to sharing behavioral health data across agencies, including:</p> <p>(a) Linking data and systems so that individuals can be followed through the different agencies for better program coordination and outcome tracking;</p> <p>(b) Setting standard definitions for common data metrics;</p> <p>(c) Resolving state-level privacy data issues, including review of existing state laws.</p> <p>This work group should also work to streamline data reporting requests across agencies to reduce duplicative reporting, as well as data reporting requests from external parties. The work group should include, but not be limited to any agency that collects, reports, or analyzes data related to the overall health of Commonwealth residents, including the health and human service agencies, the department of housing and community development, department of education and department of correction. A report on its progress should be delivered to the Legislature by July 1, 2016.</p> | | DMH |
| The Task Force endorses the privacy recommendations put forth by the Behavioral Health Integration Task Force July, 2013. | | CHIA MHA |
| The Legislature should implement the recommendations put forth by the Special Commission to Investigate the Expansion and Enhancement of the MABHA website. | | MACEP |
| EOHHS should convene a multi-stakeholder needs assessment work group to determine the number of additional inpatient psychiatric and continuing care facility beds that should be made available in newly formed units for adult men and adult women who exhibit violent and / or aggressive behaviors, and for adolescents aged 15 – 17, who exhibit violent and / or aggressive behaviors and for whom | DMH | |

| Recommendation | Opposed | Abstained |
|--|---------|-----------|
| <p>placement in an adult unit or pediatric unit is not possible. The needs assessment should be completed by October 1, 2015.</p> <p>Based on the needs assessment, EOHHS, in coordination with DMH, DPH and MassHealth to streamline licensure and coverage rules, should be responsible for ensuring the recommended number of beds are operational by July 1, 2016 first by issuing RFPs to create the services privately or, if there are not adequate responses by private providers, by opening state controlled and operated beds. Should the state resume its planning process regarding the creation of a forensic hospital to be operated by the DMH, consideration should be given to the appropriateness of including specialty units for both adolescents and adults who exhibit intractable violent or aggressive behavior in such a facility.</p> | | |
| <p>The Task Force supports the expanded use of telehealth services by behavioral health providers, when clinically appropriate. The Board of Registration in Medicine (BORM), the Division of Professional Licensure and the Division of Health Professions Licensure should remove licensure, credentialing and privileging barriers to allow behavioral telehealth in the health care system, including in hospital emergency departments, when clinically appropriate. Health plans, MassHealth and providers should work together to promote the expanded use and coverage of telehealth by behavioral health providers in any care setting.</p> | MNA | |
| <p>The Executive Office of Health and Human Services should develop a strategy, in consultation and collaboration with stakeholders, to reduce weekend boarding of individuals with psychiatric disorders in Emergency Departments. EOHHS should identify and address operational and structural barriers to discharging patients from Emergency Departments on the weekend, including examination of how weekend admission and discharge practices at inpatient psychiatric hospitals and continuing care facilities, and access to community services on the weekend, affect the ability to</p> | | |

| Recommendation | Opposed | Abstained |
|---|---------|------------------------------|
| <p>admit patients from the Emergency Department in a timely manner. EOHHS should work with providers and public and commercial insurers to collect necessary data and facilitate the removal of identified barriers.</p> | | |
| <p>DPH and DMH should jointly develop a working group of providers, ESP teams, persons with lived experience and family members to examine and where necessary revise regulations and guidelines in order to allow emergency medical services teams to bring individuals with a behavioral health condition to an appropriate placement, thereby diverting patients from using the emergency department if they can be safely managed in another setting (including, but not limited to, an inpatient psychiatric facility, substance use treatment facility or community crisis stabilization unit).</p> | | <p>DMH MARN</p> |
| <p>EOHHS should lead a campaign to increase awareness among patients, families, and providers of the available services that keep people healthier, preventing the need for more acute levels of care and that help people transition back to the community after discharge. EOHHS should coordinate with other state agencies, NAMI, consumer groups, health plans, provider and provider associations.</p> | | <p>CHIA DMH NAMI</p> |
| <p>DMH should evaluate the effectiveness of its readmission protocol that was designed for the FY 15 Community Expansion Initiative. DMH should reports on its effectiveness, and if effective adopt for all patients. DMH should report its proposed approach by January 1, 2016.</p> | | |
| <p>EOHHS, through the Health Planning Council, should conduct an analysis on outpatient capacity and demand, in order to assess the robustness of the community systems, including its weekend capacity, in part to identify whether additional investment is necessary. The outpatient system should include all outpatient services offered by state agencies, plus privately provided outpatient services conducted by providers under state licensure – including those provider that do not accept insurance. Following the initial analysis, outpatient capacity should be monitored by</p> | | <p>DMH</p> |

| Recommendation | Opposed | Abstained |
|--|-------------|-----------|
| EOHHS and the Health Planning Council on a regular basis. | | |
| MassHealth should repeal regulation 130 CMR 411.406 and any other similar regulations that prohibit MassHealth from covering outpatient mental health services by any independently licensed behavioral health provider. | | DMH |
| MassHealth, its behavioral health vendor and all commercial health plans should be encouraged to develop policies that support the expansion and reimbursement of evidence-based group psychotherapy treatment for behavioral health. | | |
| CHIA should work with other state agencies, including the AGO, to report on the impact of public and private behavioral health payment rates on access and capacity. | MHA | |
| The Task Force Members encourage the Legislature to increase funding for behavioral health services to eliminate barriers to access to care. | CHIA DMH | |
| As EOHHS develops alternative payment models to meet its requirement under Chapter 224 of the Acts of 2012, it should develop, in consultation with providers, global payment models that include behavioral health services for a broad range of patients, including adults with serious and persistent mental illness and children and you with serious emotional disturbance. Such alternative payment models should align with services provided by or on behalf of MassHealth, DMH or BSAS. | | DMH |

Appendix D. Payer and Provider Survey Tool

Questions Relating to Behavioral Health Data, Generally

1. What would help you to be able to improve data sharing and access to relevant data for behavioral health patients?

(please use as much space as you require)

2. What recommendations would you make to improve the collection and access to behavioral health data among all stakeholders (e.g., providers, regulators, hospitals, etc.)

(please use as much space as you require)

| | <p align="center">Data Element (as specified in Section 230 of Chapter 165 of the Acts of 2014)</p> | <p align="center">Do you currently <u>collect</u> this data element?</p> | <p align="center">Do you currently evaluate this data element on any periodic basis?</p> |
|---|---|---|---|
| | | <p>If yes, please describe what method you use.</p> <p>If no, <u>and the measure is relevant to you</u>, please describe the barriers to collecting the data element, including access to the data.</p> | <p>If yes, what measures do you use to assess performance and with what periodicity do you assess performance?</p> <p>If no, what are the gaps to evaluating this data?</p> |
| 1 | <p># of patients treated for mental health or substance use diagnoses</p> | | |
| 2 | <p># and type of mental health or substance use treatments</p> | | |
| 3 | <p>Patient outcomes for mental health and substance use treatments</p> | | |
| 4 | <p># of people hospitalized due to a mental health or substance use related diagnosis</p> | | |
| 5 | <p># of ED visits for a mental health or substance use related diagnosis</p> | | |
| 6 | <p>the costs of treating individuals hospitalized or who visit the ED with mental health or substance use issues</p> | | |

| Potential Measures for Inclusion on a Behavioral Health Dashboard (Please respond to each data element as defined. If you collect data using a similar definition, please indicate so.) | Do you collect the data? Y or N | Who is the steward of this measurement? <i>(e.g., HEDIS, CAHPS, NQF, etc.)</i> |
|---|--|--|
| <i>Patient Experience Measure:</i> How much improvement patients perceived in themselves as a result of care provided (e.g., CAHPS) | | |
| <i>Patient Experience Measure:</i> Percent of patients that agree they had a team of providers working to meet the patient's needs (e.g., CAHPS) | | |
| <i>Patient Experience Measure:</i> Ability to access comprehensive assessment and treatment when needed and desired, in the right setting and geographic area sought. (e.g., CAHPS) | | |
| <i>Patient Experience Measure:</i> Consumer and family participant in treatment planning, as desired, and agreement with plan of care and duration of treatment. (e.g., CAHPS) | | |
| <i>Access:</i> Number of patients in the emergency department that are ready to be discharged or admitted but unable to leave ED because they are waiting for available care in either the community or hospital. | | |
| <i>Access:</i> Number of patients in inpatient psychiatric care that are ready to be discharged to step-down care but unable to leave inpatient care because they are waiting for available step-down care. | | |
| <i>Access:</i> Average time to appointment for outpatient behavioral health care, by service type | | |
| <i>Care Outcomes:</i> Provider performance against evidence-based standards of care (e.g., PQRS) | | |
| <i>Care Outcomes:</i> Re-admissions to any care setting within 30 days of discharge from inpatient psychiatric care (e.g., HEDIS) | | |
| <i>Care Outcomes:</i> Follow-up after hospitalization for mental illness or substance use disorder within 7 days and within 30 days (e.g., HEDIS) | | |
| <i>Care Outcomes:</i> Reason for death if death occurred within 30 days | | |

| | | |
|---|--|--|
| of discharge from inpatient psychiatric care. (e.g., HEDIS) | | |
| <i>Care Outcomes:</i> The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. (e.g., HEDIS) | | |
| <i>Care Outcomes:</i> The percentage of members with an AOD diagnosis who initiated treatment and had two or more additional services within 30 days of the initiation visit. (e.g., HEDIS) | | |

Appendix E. Characteristics of a High Performing Behavioral Health System

A high-performing behavioral health system will be integrated with the medical health system to deliver appropriate access to the right care, at the right time and in the right place across the full continuum of care (starting with prevention). The system should be patient-centered, age appropriate and consist of culturally competent care. Behavioral health needs and treatments are diverse, so there should be 'no wrong door' to access appropriate care.

In general, access to diagnosis and treatment of behavioral health and physical health conditions should be similar; any differences should be evidence-based, and avoid implementing or reinforcing unnecessary distinctions. A well-trained workforce of both behavioral health specialists and other medical professionals should deliver evidence-based care, coordinated and supported by tools such as an interoperable electronic health record. Adult and pediatric patient's families should be involved in care decisions and information sharing where appropriate (e.g. with the adult patient's informed consent).

The system should be of sufficient capacity to ensure that there is adequate diversionary care and no emergency-room boarding, and that children and adults are able to flow through the system and access different levels of care as needed, without undue waits, and well-informed as to how, where and when to access care. Payment for these services should be fair and reasonable to allow for sustained capacity, and should include incentives for providers to work together to provide effective care towards maximizing patient outcomes and experience.

Appendix F. Measures Dashboard

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|------------------------|---|---|------------------|----------------|---|
| 1 | Person-centered | How much improvement they perceived in themselves as a result of care provided. | Each MCO or MBHO could administer the ECHO or similar survey. | Every other year | Age | <p>While this is a CAPHS measure, other measures may more concretely address “improvement,” including functional improvement, symptom improvement, physical improvement and reduction in risk behaviors.</p> <p>The ECHO survey can be found here: https://cahps.ahrq.gov/surveys-guidance/echo/index.html</p> |
| 2 | Person-centered | Percent of patients that agree they had a team of providers working to meet the patient’s needs | Each MCO or MBHO could administer the ECHO or similar survey. | Every other year | Age | <p>Additional information that may be helpful here is whether the patient was satisfied with the makeup and involvement of the team.</p> <p>The ECHO survey can be found here: https://cahps.ahrq.gov/surveys-guidance/echo/index.html</p> |

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|------------------------------|---|--|------------------|----------------|---|
| 3 | Person-centered | Ability to access comprehensive assessment and treatment when needed and desired, in the right setting and geographic area sought. | Each MCO or MBHO could administer a survey. A new and consistent individual / family survey may need to be developed to obtain specificity. | Every other year | Age | |
| 4 | Person-centered | Consumer and family participant in treatment planning, as desired, and agreement with plan of care and duration of treatment. | Each MCO or MBHO could administer the ECHO or similar survey. | Every other year | Age | The ECHO survey can be found here: https://cahps.ahrq.gov/surveys-guidance/echo/index.html |
| 5 | Workforce and Infrastructure | Number of providers in specialty, including: <ul style="list-style-type: none"> • Hours worked • Work setting • Types of insurance accepted, or not • Specialty training • Ethnicity • Languages spoken • Types of services provided • Practice affiliation, if any. • Rate of patient | A newly developed provider survey, coupled with licensure data from Board of Registration of Allied Health and Board of Registration in Medicine | Every other year | By profession | CHIA might consider working with SEIU Local 509, as they have recent experience in administering a survey to behavioral health providers in the state. CHIA might also consider working with state provider associations. |

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|--------|--|--|---|---|--|
| | | acceptance <ul style="list-style-type: none"> Type of financial arrangement Caseload | | | | |
| 6 | Access | Number of patients in the emergency department that are ready to be discharged or admitted but unable to leave ED because they are waiting for available care in either the community or hospital. | DPH data on ED Boarding | Collected daily, but reported annually and stratified by month. | Geography; Primary Diagnosis; Co-morbidity Age; Payer; Arrival Day/Time at ED; LOS in ED; Reason for Boarding | Consistency in which hospital submit data will need to be improved. |
| 7 | Access | Number of patients in inpatient psychiatric care that are ready to be discharged to step-down care but unable to leave inpatient care because they are waiting for available step-down care. | Already collected in part through DMH's DART and CARD lists. | Collected daily, but reported annually by month. | Age; Payer; Geography; and Reason why cannot be placed; | May also want to consider measurement of children that are waiting at home for higher levels of care. Additional work is required to capture all stratifying variables for DMH data. |

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|--------|---|---|--|---|-------|
| 8 | Access | Number of patients in DMH Continuing Care Facilities that are ready to be discharged to community but are unable to leave because they are waiting for community-based supports | The Task Force recommends that this data be collected by DMH, similar to the DART and CARD lists. | Collected daily, but reported annually by month. | Age; Payer; Geography; and Reason why cannot be placed; | |
| 9 | Access | Unduplicated count of individuals receiving behavioral health services in the state as compared to those expected to need behavioral health services (based on prevalence data) | The APCD might be a potential source for claims data on behavioral health services matched on an individual user basis. | Annually | Age, Payer, Geography, and Service type | |
| 10 | Access | Average time to appointment for outpatient behavioral health care, by service type | Newly developed provider survey | Quarterly | Age, Payer, and Geography, New vs. Current Patient | |

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|---|---|--|-----------|---|--|
| 11 | Care delivery; Health and Well-being Outcomes | Provider performance against evidence-based standards of care | Providers could report into the federal quality program, PQRS. It contains 22 measures related to effective clinical care ranging from ADHD, Major Depressive Disorder, Bipolar, dementia, SUD and Parkinson's (psych disorders assessment). | Annually | Specialty | Some Task Force members expressed concern about the PQRS. Ultimately, whatever vehicle for assessing evidence-based practices is compliant, agreement on which measure to use will be necessary. |
| 12 | Care delivery; Health and Well-being Outcomes | Re-admissions to any care setting within 30 days of discharge from inpatient psychiatric care | Already an existing HEDIS measure that could be pulled from health plans or the APCD | Annually | Age Geography Diagnosis Race and Ethnicity | |

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|---|--|--|-----------|---|---|
| 13 | Care delivery; Health and Well-being Outcomes | Follow-up after hospitalization for mental illness or substance use disorder within 7 days and within 30 days | Already an existing HEDIS measure that could be pulled from health plans or the APCD | Annually | Age Geography Diagnosis Race and Ethnicity | |
| 14 | Care delivery; Health and Well-being Outcomes | Reason for death if death occurred within 30 days of discharge from inpatient psychiatric care | This measure would require a data match between death records and inpatient psychiatric stays; would also need to link to data for reason for death. | Annually | Age Geography Diagnosis Race and Ethnicity | Additional work is needed to determine appropriate sources of data for this measure. |
| 15 | Care delivery; Health and Well-being Outcomes | Number of arrests for individuals who have received behavioral health care and for individuals who have received treatment within the past 30 days | Data from the Department of Corrections and the Criminal History Systems Board would need to be linked with health care claims. | Annually | Age Geography Diagnosis Race and Ethnicity | There is no central repository for arrest records, rather each municipality has its own arrest records. |

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|---|---|--|-----------|---|--|
| 16 | Care delivery; Health and Well-being Outcomes | The percentage of members who initiate treatment through an inpatient alcohol and other drug treatment admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis | Already an existing HEDIS measure that could be pulled from health plans or the APCD | Annually | Age Geography Diagnosis Race and Ethnicity | |
| 17 | Care delivery; Health and Well-being Outcomes | The percentage of members with an alcohol or other drug use diagnosis who initiated treatment and had two or more additional services within 30 days of the initiation visit. | Already an existing HEDIS measure that could be pulled from health plans or the APCD | Annually | Age Geography Diagnosis Race and Ethnicity | |
| 18 | Care delivery; Health and Well-being Outcomes | Percent of individuals with behavioral health needs who have stable housing | This could potentially be done as part of a patient experience or other survey. | Annually | Age Geography Diagnosis Race and Ethnicity | Additional work is needed to refine this measure and determine appropriate source of information |

| Measure # | Domain | Measure | Data Needs & Potential Data Sources | Frequency | Stratification | Notes |
|-----------|--|---|---|-----------|---|---|
| 19 | Fair and Reasonable Payment Rates and Financial Alignment | Total cost of care for individuals receiving behavioral health services | APCD | Annually | Age Geography Type of Service (e.g., IP, OP RX) Setting Race and Ethnicity Diagnosis | This measure should be considered relative to overall spending on health care |
| 20 | Measures of Behavioral Health Integration | Number of primary care practices that offer integrated behavioral health services | This measure might be collected in the future by the Health Policy Commission through its medical home certification process. | Annually | Geography | |

Appendix G. Excerpt of the Behavioral Health Integration Task Force’s Privacy Recommendations

What are the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable health records?

There are differences in privacy concerns across populations, but as noted in the background section above. There are particular concerns regarding the use of information from behavioral health treatment both within and outside of the health care system, particularly in schools and the legal system. There are numerous state and federal privacy laws that provide parameters to what can and cannot be shared. For example, the Health Insurance Portability and Accountability Act (HIPAA) together with numerous provisions of Massachusetts law provides broad protection of individually identifiable health information. In addition, the Federal Drug and Alcohol Confidentiality Law (42 CFR Part 2) provides additional protection relating to individuals with or who seek treatment for alcohol or other substance use problems. 42 CFR Part 2 applies broadly to any program that provides alcohol or drug abuse diagnosis, treatment, referral for treatment or prevention and is “federally-assisted” and requires specific written authorization by an individual to share information on substance use, diagnosis and treatment at the point of each potential disclosure.

The Task Force recognizes that stigma and discrimination are significant problems for individuals with behavioral health disorders. The recommendations below aim to balance stigma and consumer choice, current federal privacy laws, and the importance of providers understanding the totality of a patient’s needs in order to provide optimal care and obtain optimal health results.

15. There must be a respectful equilibrium, or balance, between what information providers need to deliver quality care and what the individual needs to seek and receive appropriate care.

Rationale: Electronic health records (EHRs) are a potentially useful tool in providing effective, efficient, integrated and safe health care. Electronic health records are broadly defined as longitudinal electronic records of patient health information generated by one or more encounters in any care delivery setting and can include information such as: patient demographics, diagnosis progress notes, problem lists, medications, vital signs, past medical history, diagnostic results and more.³⁹

³⁹ Healthcare Information Management Systems http://www.himss.org/ASP/topics_ehr.asp

Since the majority of mental health and substance use needs are addressed within the primary care practices, EHRs, and information sharing generally, are especially critical for a primary care physician to provide safe high quality care to patients, particularly in managing the care of these complex patients. EHRs can assist primary care teams in providing important components of primary care, including complex care management, medication management, reminders for timely care (like administration of screening tools), and warnings for adverse interactions, outcome reports and follow-up lists for a population of patients. For example, physicians in Massachusetts with access to electronic problem lists performed better on quality measures related to depression (as well as other measures) compared to physicians not using electronic health records.⁴⁰

However, barriers to including behavioral health information within the electronic health record exist – including lack of standardization for inclusion of behavioral health care processes within the electronic record, and important privacy and confidentiality concerns. As reported by both individuals and family members, as well as providers, confidentiality is a basic requirement of persons seeking behavioral health services and the lack of such confidentiality may result in individuals avoiding care or being less forthright while engaging in services. Individuals with behavioral health disorders and some providers are also concerned by the impact of real and perceived stigma on the quality of integrated health care. The Task Force heard from individuals with lived experience that were inappropriately treated for physical health conditions based on a provider’s knowledge of a behavioral health diagnosis. A new survey of providers found that providers, including mental health providers, view patients with serious mental illness more negatively than those without and that these attitudes impact treatment decisions, including referrals.⁴¹

The Task Force spent much time deliberating the issue of privacy and balancing the need to protect individual rights and consumer choice with the clinical need for information sharing to provide high quality integrated care. These privacy issues exist in the absence of electronic health records but become more pressing as more providers utilize electronic health records that include most information about a patient.

Studies have shown that individuals with mental health conditions die 25 years earlier due to largely preventable and treatable physical health conditions⁴² and that having appropriate access to all pieces of an individual’s health history could improve those outcomes. In addition, primary care physicians report that the lack of (and difficulty of obtaining) information from an individual’s behavioral health record can lead to adverse consequences on the health and

⁴⁰ EG Poon et al. “Relationship between use of electronic health record features and health care quality: results of a statewide survey.” *Medical Care* March 2010, Volume 48, Issue 3, pp 203-209.

⁴¹ Jeffrey, S. “Psychiatrists not immune to mental health bias.” *Medscape*, May 21, 2013.

⁴² Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, October 2006.

outcomes of an individual. As an example, not knowing which medications a patient may be taking or what conditions they live with, primary care physicians might risk prescribing medications that may negatively interact with existing medications or produce side effects that exacerbate a behavioral health issue.

Implementation Action Steps: There was general agreement that, except in emergency situations where the individual is unable to give consent, persons receiving care should have the authority to determine with whom that information is shared. There was also general agreement that information sharing should be categorized into tiers, and each tier should have a set of rules governing the disclosure of information within the tier, including provisions for patient choice of opt-in (individual affirmatively agrees to share information across providers) or opt-out (information is shared across providers unless the individual specifically requests for it not to be shared) of standard disclosure practices.

The Task Force agreed on three categories of bi-directional⁴³ information sharing:

- Tier 1: medication, lab results and mental health diagnoses
- Tier 2: all other behavioral health information not in Tiers 1 or 3, for example, treatment plans, functional and risk status (e.g., suicidal ideation), psychological and neuropsychological assessments, stress factors, community supports, and substance use diagnoses
- Tier 3: diagnostic evaluation and treatment notes

A majority of the Task Force agreed that Tier 1 information be shared with other treating providers within the confines of existing law without prior written consent, which is the case for other specialties.⁴⁴ The individual would have the ability to revoke the sharing of information at any time. A minority of Task Force members voiced strong opinions that, due to stigma, sharing of Tier 1 information presents a documented risk of denial of physical health care and may discourage individuals from seeking behavioral health care, and that informed consent should be sought prior to the sharing of this information. While all Task Force members agreed that stigma among medical and behavioral health professionals negatively affects care, the majority felt that the problem of stigma needs to be addressed separate and apart from the benefits of integrated information sharing and that greater information sharing may help to reduce the burden of stigma by not continuing to create two different systems of care.

The Task Force unanimously agreed that Tier 3 information does not need to be shared to appropriately treat an individual and should only be shared if the individual affirmatively

⁴³ One Task Force member noted that medical providers should not restrict access to any information related to the behavioral health needs of the patient to a behavioral health provider.

⁴⁴ As noted, special rules apply to substance use information under 42 CFR Part 2. In addition, some mental health information is further restricted pursuant to G.L. ch. 123 § 6.

agrees to its sharing through the execution of a signed standardized release of information form and an informed conversation with their provider prior to the release of information.

Task Force members engaged in meaningful discussion of the benefits and concerns of how information in Tier 2 should be shared, but remained split on whether the category of information should be opt-in or opt-out. Given that the Task Force was not able to reach consensus, we recommend continued discussion of the appropriate level of information sharing for Tier 2. Task Force members raised viable arguments for both opt-in and opt-out in Tier 2. To further this discussion, it will be helpful to collect data on individual patient choice in terms of information sharing under an opt-in model, and whether the individual would have objected to this information being shared under an opt-out provision. This could potentially be included as part of the standardized forms to be developed.

One particular discussion among Task Force members centered on whether psychological and neuropsychological assessments should be in Tier 2 or Tier 3. Some Task Force members noted that the results of these assessments were very important to medical providers and barriers to reviewing the information should be mitigated. However, other Task Force members felt that the privacy of the personal nature of what is contained within a psychological and neuropsychological assessment must be maintained at the strictest standards given in Tier 3. The Task Force recommends continued discussion of the particulars of Tier 2 information sharing in other forums, including the subcommittee of the Health Policy Commission recommended as part of Recommendation #27.

A standardized release of information form needs to be created to accommodate the different tiers of information sharing. For Tier 1, the form should clearly state the potential risks as well as the benefits of not sharing this information. For Tiers 2 and 3, a standardized release form with an opt-in provision should be created that clearly states the potential risks as well as benefits of sharing this information. The form must comply with the provisions of 42 CFR Part 2, as discussed above.

In addition to the form and perhaps more important, Task Force members felt it was important that providers have a detailed conversation with individuals about what information will be shared, with whom, and the implications for doing or not doing so. Person-driven healthcare should be supported by ensuring that individuals receiving care are active participants in all phases of their care and that the records document this participation: from a description in narrative as well as diagnostic terms, to the formulation of goals, to the recording of progress, to the evaluation of outcomes.

Task Force members agreed that in emergency situations, it was essential that full medical records be available to properly assess diagnoses, medical and behavioral disorders and risks to patients from any and all possible disorders in accordance with federal and state laws.

In order to do business with Massachusetts providers, the Legislature should require EHR vendors to include certain elements to support affordable and interoperable behavioral health records and the granularity to make certain information private, particularly treatment notes. The Task Force recognizes that many providers have implemented various EHRs. Vendors should advise where possible system modification could occur to allow for increased granularity to only show certain information based on an individual's decision to opt-in or out of information sharing.

Inpatient psychiatric providers should be required to communicate in a timely fashion with integrated risk bearing provider organizations information about the date of admission, the reason for admission, medical-behavioral conditions, and in a timely fashion prior to discharge, the discharge plan and hospital record, at a minimum.

As noted above, one of the unique factors with respect to children exists in the relationship between healthcare providers and school-based health services. Exchange of information between the two is both critical and challenging. Recent conversations among DMH, the Department of Children and Families (DCF), and parents indicate that parents might be comfortable sharing information about a child's behavioral health issues/care with a school as long as it is for a specific purpose; however, they don't want to share the entire family history. In addition, there are legal issues regarding consent to the sharing of information by parents and/or young people that must be resolved. Consent by the parent(s) may be sufficient in one context, but consent by the parent and consent/assent by the young person may be required in other circumstances. The MA Child Health Quality Coalition's Communication and Confidentiality Task Force are identifying issues impacting communications and confidentiality across the Coalition's stakeholder groups as well as resources that can help address those issues.

16. Certification requirements for integrated risk bearing provider organizations should include training of health care providers on privacy and confidentiality and such organizations should be required to have a privacy officer.

Rationale: Given the importance of privacy within integrated settings, the Task Force believes it is essential that integrated risk bearing provider organizations be required, as part of their certification, to conduct training on privacy and confidentiality. In addition, these organizations should be required to include a privacy officer to monitor its ability to meet privacy and confidentiality requirements, and obtain feedback from both individuals and providers of the impact of the privacy requirements.

Implementation Action Steps: The Legislature should direct the Division of Insurance (DOI) to develop and consider privacy requirements consistent with Task Force recommendations, as

well as policies, procedures and training requirements as part of its review and certification of an integrated risk bearing provider organization. The DOI should provide sample training materials upon request.

17. Massachusetts should establish criteria in statute or regulation that would limit the circumstances under which a behavioral health care provider can restrict an individual's access to his or her records to those situations that present a clear and articulated harm.

Rationale: Electronic health records are often hailed for their ability to rapidly transmit medical information to a vast array of providers with a click of the mouse. Unfortunately, this means that misinformation can be spread just as rapidly.⁴⁵ While Massachusetts law grants an individual broad access to his or her physical health records, it does permit withholding at least portions of behavioral health records, under certain circumstances, if the provider determines that release of such records could cause harm to the individual or others. However, existing statutes and regulations do not provide clear guidance on the standards under which this authority may be exercised, and to what extent such records may be withheld.

Implementation Action Steps: The state should adopt legislation reaffirming a broad right of access, establishing narrow criteria for withholding behavioral health records, and documentation of the rationale for the failure to provide an individual with access to his or her own records. Such criteria should be applicable to all covered entities under HIPAA. The legislation should make it clear that only those parts of the record that meet the criteria established may be withheld, and that, to the extent possible, a summary of the withheld information must be provided. Persons denied records should be given notice of why (the individualized documentation in the record) and their avenues of internal appeals and external complaints. In addition, a speedy means of appealing the denial of records should be mandated and, if possible, an external complaint procedure (other than the federal Office of Civil Rights (OCR)) should be established. Finally, a meaningful way of addressing errors in electronic health records must be developed (both corrections and, upon request of the patient, distribution of those corrections to parties to whom the erroneous records had been provided).

⁴⁵ There is reason to be concerned about errors in electronic health records. A pilot study found that inaccuracies in medication lists were reported in 51% of records reviewed with 32.1% of all medications being inaccurately recorded. Tse J, You W. "How accurate is the electronic health record? - a pilot study evaluating information accuracy in a primary care setting." *Stud Health Technol Inform.* 168:158-64. Royal Melbourne Hospital Clinical School, The University of Melbourne, Parkville, Victoria. 2011.

Appendix H. Plan Requirements for Prior Authorization / Notification [DRAFT TEMPLATE]

Health Plans requiring a Prior Authorization from the ED for BH services:

| Health Plan | Require a PA following ED visit for additional BH services? | Require notification following admission to inpatient BH facility? | Contract with ESPs? | Does your health plan provide 24/7 access to management services? | What is the Number for providers to call for assistance with locating a bed? | Contract with BH Partner? |
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❖ Notification requirements are the responsibility of the admitting facility and do not require a phone call or the communication from the ED.

Health Plans that DO NOT require a Prior Authorization from the ED for BH services

| Health Plan | Require a PA following ED visit for additional BH services? | Require notification following admission to inpatient BH facility? | Contract with ESPs? | Does your health plan provide 24/7 access to management services? | What is the Number for providers to call for assistance with locating a bed? | Contract with BH Vendor? |
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❖ Notification requirements are the responsibility of the admitting facility and do not require a phone call or the communication from the ED.

Appendix I. DMH Liaison Function in/on Acute Hospitals/Inpatient Units

Purpose: Assist in identifying any DMH or non DMH client admitted to an acute unit who may be referred to DMH for a continuing care inpatient bed; 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 community and acute facility agree that alternative dispositions are not appropriate or possible within an agreed upon time frame.

Process:

A DMH employee will be assigned to each acute psychiatric hospital or inpatient unit in the Commonwealth.

This DMH employee will be contacted whenever an acute facility has identified an individual who may need extended inpatient care in a DMH facility.

The DMH employee will determine if the identified person is an active DMH client receiving services from a provider or state operated service.

The DMH employee will notify the local DMH Site if the identified person is a DMH client. The DMH Site will notify the service provider of the identified person's presence in the acute setting and arrange for the provider to make an assessment of the hospitalized client within 24 hours.

The DMH employee, provider, and acute hospital will make a determination as to whether a return to an existing community based service will be attempted and identify a timeline during which such a disposition will occur. If consensus is reached that a diversion from a continuing care bed is not possible, the DMH employee and acute unit will submit a co-signed request for continuing care to the appropriate Site/Area. It is understood that the DMH employee will provide these services in the acute facility whenever possible.

If the individual identified as possibly needing DMH continuing care is not a DMH client, the DMH employee will assist the acute facility in forwarding an application for DMH service authorization to the appropriate Area and Site Offices. If the clinical and needs and means assessments indicate eligibility for DMH services, the DMH employee will provide provisional "bridging" services in the acute facility. More specifically, the DMH employee will assist the acute facility in identifying alternatives to continuing care beds. If the acute facility and the DMH employee agree that a community placement is not appropriate or possible within an agreed upon time frame, the DMH employee will facilitate the acute hospital's request for continuing care by co-signing the request.

Co-signed applications for continuing care beds will be given priority at the Area level.

Applications for DMH service authorization for non DMH clients will be given priority at the Site and Area levels.

Appendix J. DMH Internal Protocols Regarding Discharge of Clients Covered by the FY 15 Community Expansion Plan

The Massachusetts Department of Mental Health, in the interest of promoting and maintaining optimal clinical care and treatment for DMH clients, plans to implement the following practices and protocols concerning patients who are to be discharged from DMH continuing care hospitals under the FY 15 Community Expansion Plan.

- If any of the 100-160 patients discharged from DMH Continuing Care Facilities as part of the FY15 Community Expansion Initiative is determined to need inpatient level of care by an Emergency Services Program (ESP) in conjunction with her/his DMH or CBFS care team within 30 days of discharge, the appropriate Area Medical Director will be notified by that ESP or involved DMH or provider staff. The following steps will then be taken:
 1. The Area Medical Director, in collaboration with the State Medical Director, will authorize and facilitate admission to the continuing care facility from which the patient was discharged. It is understood that prior to authorizing such an admission, all involved parties will consider other dispositions (e.g. respite, community crisis beds, etc) as well as the appropriateness of a brief acute admission. Admission decisions must be clinically driven.
 2. Within 24 hours of the patient's readmission to the Continuing Care Facility, a case conference will be convened to review the circumstances of the "unsuccessful discharge" and a revised disposition plan will be developed.
- DMH is interested in ensuring that all DMH clients discharged from acute inpatient and continuing care facilities have a "Crisis Plan" in hand when they leave. This "Crisis Plan" will be developed in conjunction with Inpatient Staff, the DMH Site Office Staff, the CBFS or PACT worker or the DMH Case Manager and most significantly, the client.

The "Crisis Plan" may include the following:

1. Name, telephone number and email addresses of all outpatient and community based care givers. Such a list might also include family members, peer supporters, community and social supporters, et al. Staff and clients will work collaboratively to identify individuals who can be called upon to avert or ameliorate a crisis.
2. DMH will coordinate the action steps to be taken if disposition plans and recommendations are not followed. These action steps may include: identification of the emergency services program/staff to call when an emergency is imminent; the names and numbers of peer supports and navigators; the names and numbers of therapists and counselors; the names and numbers of respite and community crisis bed

providers. Ideally, the client will connect with all or any of the above responders if he or she is in crisis or at risk of such. If any individual identified in the “Crisis Plan” has a concern about the client, that individual may reach out to whomever he or she thinks might be helpful in managing a crisis that could lead to a hospital admission.

3. The “Crisis Plan” may also state a preference for a particular facility should acute hospitalization be required.
4. If the client is able to fully understand and accept the need for and benefit of treatment at the point of discharge from an acute hospital, a signed voluntary “treatment contract” that allows for the administration of medications and other appropriate interventions in a non hospital setting and in a non coercive manner might be completed. ESPs, urgent care/walk in centers, etc. should be identified so that a client experiencing a decline in functioning or a change in mental status can receive help in an environment that he or she plays a role in choosing.

At discharge, a designated DMH staff person (possibly the DMH Liaison) will forward these “Crisis Plans” to all DMH and provider staff and programs identified in the “Crisis Plan” and to the appropriate emergency services programs and all others named in the Plan. It is expected that these plans will become a part of the client’s community based medical or program record. “Crisis Plans” should be updated every time they are used.

- If a DMH client is acutely hospitalized more than three times in a calendar year, the appropriate DMH Site Office and possibly the DMH Liaison will convene a clinical case review during the third hospitalization that will examine the following:
 1. The reasons for and courses of the previous hospitalizations.
 2. Compliance with prior treatment recommendations
 3. The patient’s understanding of why multiple hospitalizations occurred; the patient’s thoughts about what he or she needs to do (e.g. identify service gaps or problems) to avoid repeated hospitalizations.
 4. Community programs’ input regarding the “unsuccessful discharges”.

It is expected that the clinical review generated after the third hospitalization in a calendar year will yield a new treatment/disposition plan that addresses whatever deficiencies, gaps in services, etc. are identified. These revised treatment/disposition plans should be appended to the above described ‘Crisis Plans” and disseminated to all involved DMH and provider staff and programs.

If appropriate, a referral to a continuing care facility will be generated after this clinical case review and given priority status for transfer.

- DMH liaisons should be contacted by acute hospital or ESP staff if there are questions as to whether or not a patient is covered by the FY 15 Community Expansion Initiative.

