Commonwealth of Massachusetts
Executive Office of Health and Human Services

Expedited Psychiatric Inpatient Admission (EPIA) Initiative 2.0

November 14, 2019

Expedited Psychiatric Inpatient Admission Initiative

- Purpose:
  - Decrease ED boarding for Behavioral Health patients needing inpatient level of care
  - Decrease the length of stay for ED Boarding individuals
  - Ensure no one is boarding without an advocate
  - Establish baseline information for long stay ED boarders for monitoring and policy purposes

Background

- Process convened by Secretary Sudders in 2016 to mitigate long waits in EDs for inpatient psychiatric admission (days to weeks)
- Expedited Psychiatric Inpatient Admission (EPIA) Initiative
  - Started on February 1, 2018
  - Escalation process applies to those waiting more than 24 hours in EDs for a psychiatric inpatient bed
  - Process has expectations of Insurance Carriers, Provider Hospitals, EDs, ESPs and State Agencies (DOI, DPH, DCF, DMH, DDS)
- Stakeholders developed an Escalation process by consensus
- Ongoing meetings of the EPIA Implementation Workgroup to identify problems through data analysis and work on solutions
- EPIA 2.0 is the result of more than 1 year of experience, data, and best practices

Background

- This process was developed, implemented and redesigned based on data analysis and problems encountered over the last two years by the Stakeholder group convened by DMH and members include:

  - MassHealth
  - Massachusetts Department of Public Health
  - Massachusetts Division of Insurance (DOI)
  - Massachusetts Health and Hospital Association (MHA)
  - Massachusetts Association of Behavioral Health Systems (MABHS)
  - Massachusetts Association of Health Plans (MAHP)
  - Blue Cross Blue Shield of Massachusetts
  - Massachusetts Behavioral Health Partnership (MBHP) / Beacon Health Options
  - Children's Mental Health Campaign (CMHC)
  - Participants from individual providers

- The Department of Mental Health (DMH), the state licensor of the inpatient psychiatric hospitals/units, has made changes to its regulations as part of this process (No Reject and Needs of the Commonwealth)

What we have learned – first year

- Interventions Used:
  - Create shared responsibility among stakeholders
  - Escalation Protocol used by all stakeholders
  - Maximize partnership with DOI
  - Collect data to measure effectiveness
  - Enhance licensing authority through regulatory change & subregulatory bulletins:

    Clinical competencies

    Medical Director sign off of rejected admissions

    Unit acuity data

    Payer mix reporting

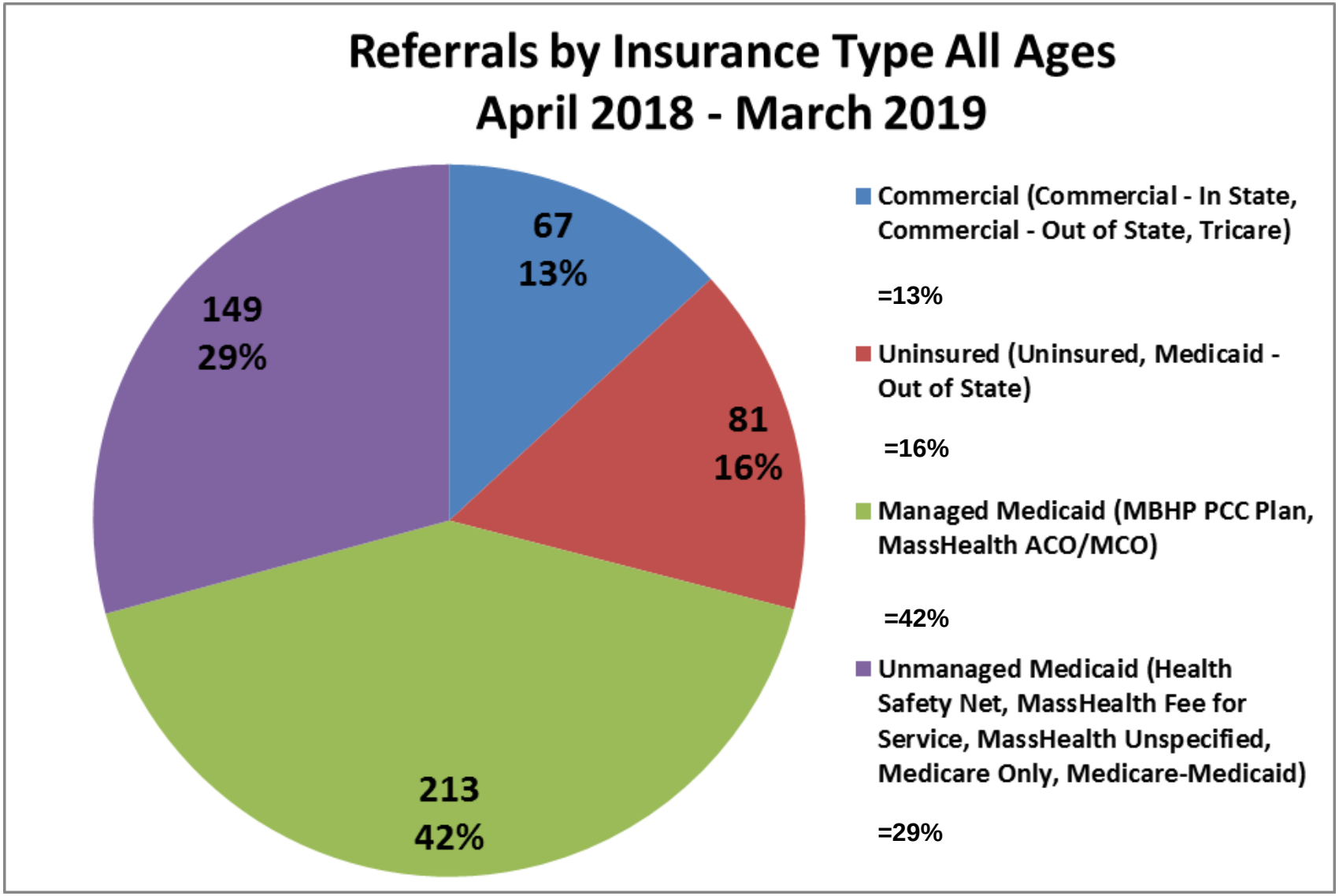
EPIA First Year Summary Statistics
Total Number of Referrals – 510

- Age
  - Under 18 yo — 258 (51%)
  - Adults between 18 & 64 yo — 212 (41%)
  - Adults over 65yo: — 40 (8%)
- Gender
  - Female — 169 (33%)
  - Male — 325 (64%)
  - Transgender — 12 (2.5%)

EPIA First Year Summary Statistics
Total Number of Referrals – 510

- 62 Different Boarding Emergency Rooms
- 23 ERs sent only 1 DMH request
- 14 ERs had 10 or more DMH requests
- Outcome after DMH Referral (N=510):
  - 45 were discharged home & 34 LOC changed (15%)
  - 431 DMH EPIA admissions accomplished (85%)
- 54 Admitting Inpatient Facilities (3 Out of State)

EPIA First Year Summary Statistics
Total Number of Referrals – 510



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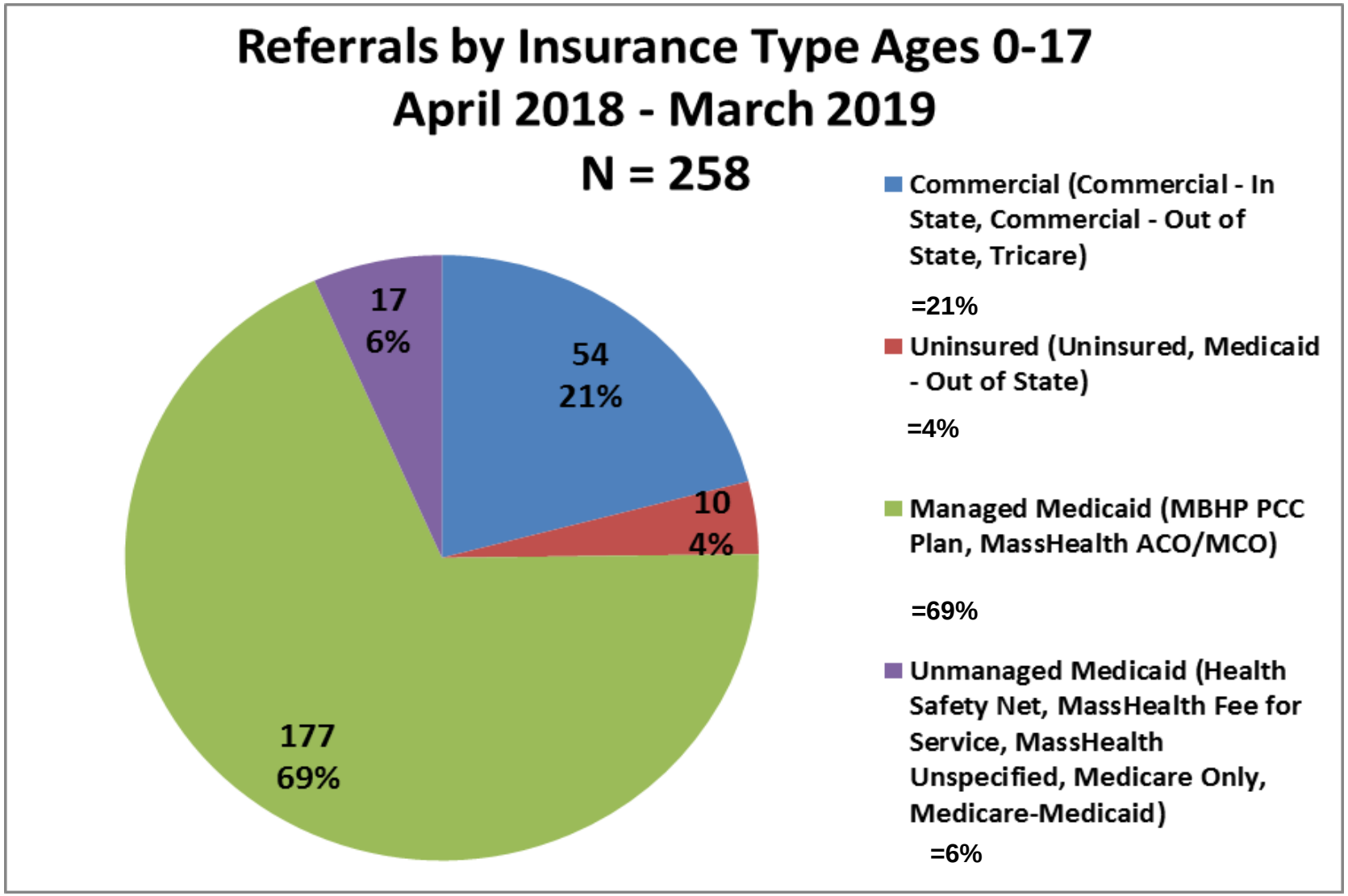

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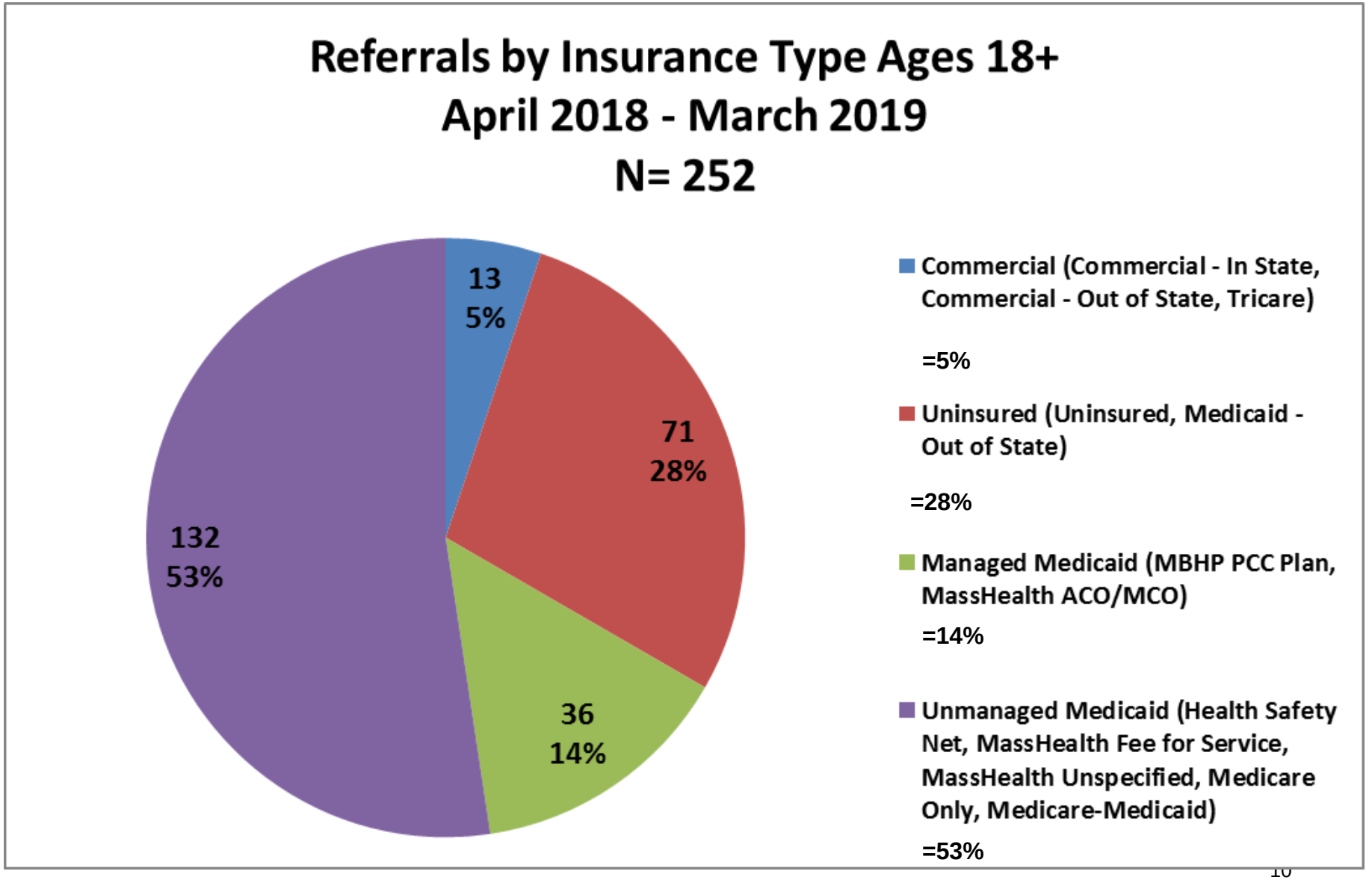


Diagnoses
(in descending order of prominence)

- **Top 5 Diagnoses for those under 18 yo (N=258)**
  - PTSD
  - Impulse Control/Conduct Disorder
  - Depression
  - Autism Spectrum Disorders
  - ADHD

- **Top 5 Diagnoses for those 18 yo & older (N=252)**
  - Depression
  - Schizophrenia
  - Bipolar
  - Schizoaffective
  - Dementia

State Agency Involvement
Total N = 188 out of 510 (37%)

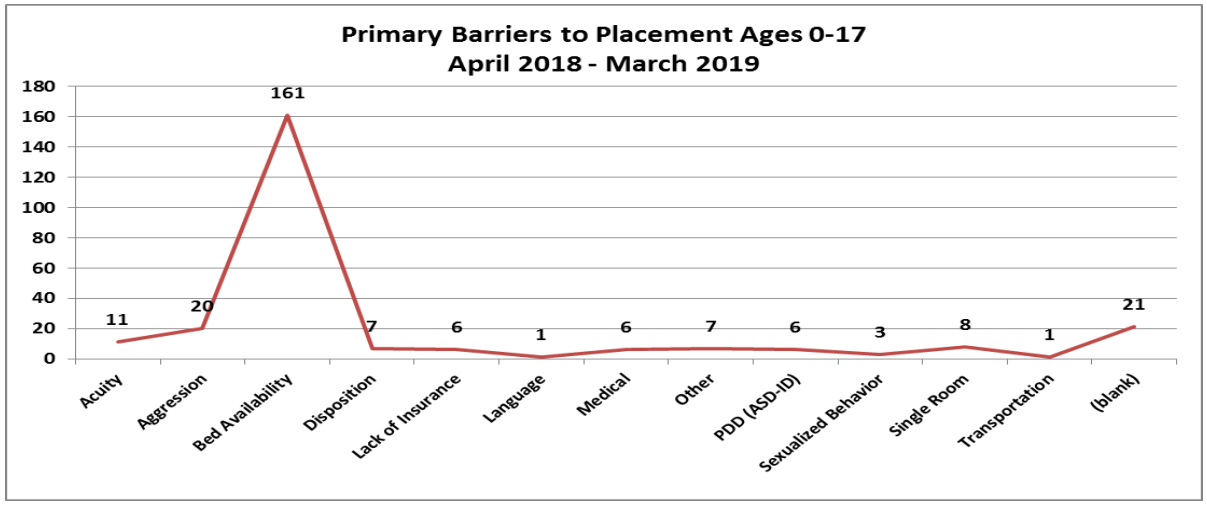
Of the total State Agencies Involved:

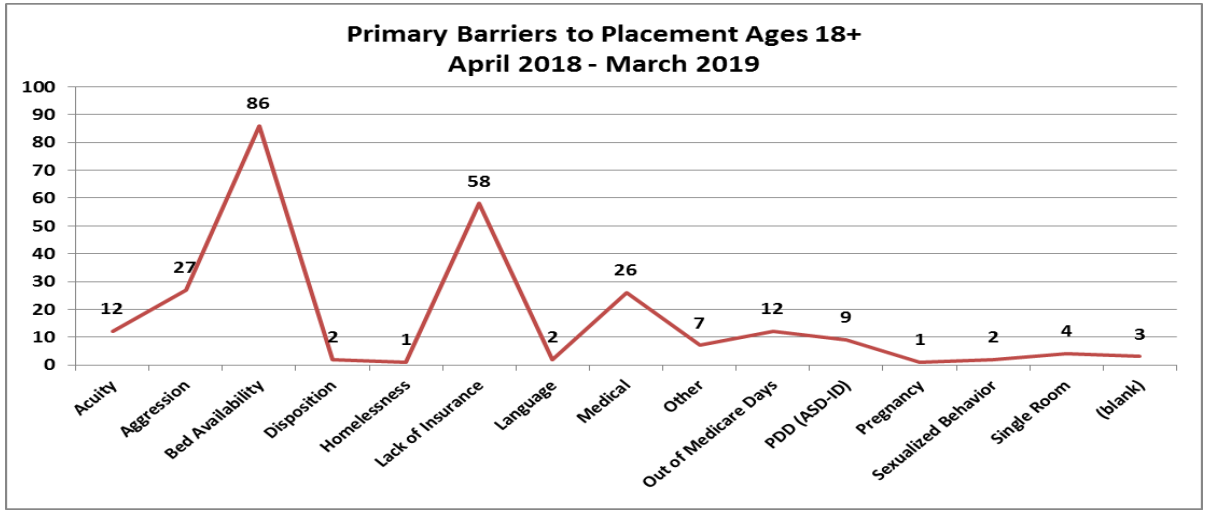
- DCF 97 or 51.6%
- DMH 53 or 28.2%
- DDS 30 or 16.0%
- DYS 2 or 1.1%
- IEP 6 or 3.2%

Barriers to Placement (N=510)

All ages

- Bed Availability (8%)
- Lack of Insurance (13%)
- Aggression (9.2%)
- Medical (6.3%)
- Acuity (unit) (4.5%)





Summary: What we learned

- Disproportionate Child/Adolescent issue
  - Under 13: bed availability critical
  - Over 13: disposition, aggressive or complicated presentations
- Adults have long boarding stays if
  - No insurance
  - Unmanaged insurance
  - Medical, developmental, and/or aggressive presentation
- State Agency involvement mostly about youth
  - Majority DCF
  - Youth and Adults equally represented in DDS and DMH involvement
- Need for more efficient Bed Search Processes
- Need Better Communication
- Need to prevent insurance lapses
- Help adults get insurance (preferably managed care)

Changes for EPIA 2.0 Protocol - Principles

- Escalation process MUST start by 24 hours
- Special Services Billing Codes for single room, 1:1 or extra staff etc required for admission by a facility adhered to by Carriers and authorization documented
- For timely clinical communication, a point person MUST be identified for each shift at the ED and ESP level
- Use of a standard bed search protocol by all
- When family preference limits bed search, DMH will still get involved at 96 hours
- DMH will consider pre-96 hour escalations on a case by case basis due to complexity, history of previous long ED stay etc

Changes for EPIA 2.0 Protocol--Carriers

- Documentation and authorization of level of care as well as specialing needs for the admitting facility
- Carriers and Providers must rehospitalize patients at the same facility to the maximum extent possible to ensure continuity of care for better patient outcomes
- Bed searches continue even if a preferred, in-network hospital promises a bed in the next 24-48 hours
- Ongoing communication with senior leaders of inpatient units to advocate for their members admission
- Ability to escalate to DMH prior to 96 hours if complexity is a major barrier to placement

Changes for EPIA 2.0 Protocol – ED/ESPs

- Internal Escalation Policy/Protocol established for all long stay boarders (>24 hours)
- Use of the Standard Bed Search Protocol for bed searches
- Use of Adobe when submitting referral to DMH
- ED and/or ESP clinical and administrative leaders will contact clinical and administrative leaders at the Provider Facilities
- Expectation that senior leaders work within their hospital network/system to place boarder
- Active efforts by the ED to assist in the application for MassHealth for those uninsured
- Escalation efforts by the ED and ESP will be documented and sent to DMH when escalating to DMH for help

How does it work – the first 24 hours

- When a person in need of inpatient psychiatric hospitalization goes to an ED, they are seen by the ED staff, and in some cases by an ESP provider
- The ED and/or ESP determines that a person needs to be hospitalized and works to find an appropriate placement
- If the person is not placed within 24 hours, the ED/ESP must let the person's Insurance Carrier know that they are looking for a placement which activates Carrier assistance:
  - The Carrier uses its internal processes for finding a placement and provides any useful information to the ED/ESP including recent hospitalizations
  - The Carrier is expected to decrease barriers to admission including but not limited to authorizing and paying for special services and going out of network
  - The Carrier works within, and if needed, outside of its contracted network, to secure an appropriate placement

How does it work – 24 to 96 hours

If the person is not placed by 24 hours:

- The ED/ESP makes a formal Request for Assistance to the insurance Carrier
  - This Request may be made before 24 hours but MUST by 24 hours
  - The Carrier responds within 2 hours during business hours and by the next day when contacted after hours or on weekends
  - The Request gives the carrier information about the person's condition, what has been done so far, and the barriers to finding a placement
- The Carrier works closely with the ED/ESP to determine the best placement options for the person
- The Carrier works with leadership at inpatient units and provides specialing and single room authorization, etc to ensure admission

How does it work – by 96 hours

If the person is not placed by 96 hours:

- The Carrier contacts DMH by submitting an online referral using the latest Adobe software through a secure web site
- The Carrier provides detailed information about what has happened so far and the person's current situation and barriers to placement
- Ongoing bed search work is coordinated and pursued by all parties
- DMH coordinates calls with senior clinical & administrative staff from the Carrier and hospital(s) to identify and resolve clinical barriers to placement
- Barriers related to payment, coverage or network access are referred to MassHealth or to DOI, as appropriate
- DMH initiates ongoing calls with involved parties, including other state agencies, as appropriate, until placement

Insurance Carriers

- Some insurance Carriers are regulated by the state and some are not
  - They are regulated by other states or the federal government
- The Carriers regulated by MA will be required to use these processes
- EDs/ESPs will use the same process with all Carriers whenever possible

Regulated by Massachusetts	Not Regulated by Massachusetts
• MassHealth (Medicaid)	• Other states' Medicaid plans • Medicare
• In-state commercial carriers Examples: • Blue Cross Blue Shield (BCBS)of MA • Tufts Health Plan • Harvard Pilgrim • National Insurance Carriers offering fully insured products in Massachusetts: e.g. some Cigna, Aetna, UnitedHealthcare offerings	• Self-Funded / ERISA plans* • Other states' commercial carriers Example: • Blue Cross Blue Shield of Minnesota • National Insurance Carriers Examples: • Cigna • Aetna

* Some of these plans are through in-state commercial carriers (e.g. BCBS of MA). Even when that is true, they are not regulated by the MA Division of Insurance (DOI)

If a Carrier isn't involved

If the process cannot be used with an insurance Carrier advocate, either because the ED/ESP cannot engage the Carrier or because the person does not have managed care insurance or is uninsured:

- The ED/ESP will continue to look for a bed while activating their leadership's help through an *Internal Escalation Protocol*
- At 96 hours, if there is not a secured bed, the ED/ESP contacts DMH by submitting an online referral using the latest version of Adobe software using a secure web site and provide the same information that a Carrier would receive and send in this process

Note: *ED/ESPs will verify MassHealth eligibility for anyone who is uninsured & assist in the application for MassHealth coverage*

Communication Expectations

Throughout a person's stay in the ED, the ED/ESP, Carrier, and state agencies are in regular, ongoing communication

- Current clinical information should always be brought forward & readily available to all engaged parties
- Use of Standardized Bed Search Protocol is expected by all ED/ESPs and inpatient psychiatric units
- A point person for EDs, ESPs, Carriers, Providers, & DMH is required for Weekdays (8a to 5p) and weekend days for ease of communication among the parties working for admission
- Status of placement should always be communicated back to the ED/ESP

Questions?

<u>Please send additional questions to:</u>

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