

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF MENTAL HEALTH

25 Staniford Street
Boston, MA 02114



FINAL REPORT

RFI No. BD-17-1022-DMH08-8210B-00000009836

Acute Psychiatric Inpatient Services for Special Populations

March 15, 2017

INDEX

TABLE OF CONTENTS	PAGE NO
Summary	3
Attachment 1 <i>(Request for Information (RFI) Acute Psychiatric Inpatient Services for Special Populations)</i>	8
Attachment 2 <i>(Responding Hospitals, Hospital Systems and Organizations by Category)</i>	20
Attachment 3 <i>(Meeting Attendees by Category)</i>	23
Attachment 4 <i>(Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Autism or Other Intellectual and Developmental Disabilities (ASD/IDD))</i>	25
Attachment 5 <i>(Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Severe Behavior/Assault Risk)</i>	28
Attachment 6 <i>(Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Substance Use Disorder)</i>	32
Attachment 7 <i>(Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Physical Illness/Condition Requiring Medical and Nursing Care)</i>	36

I. INTRODUCTION

The Department of Mental Health (DMH) released a Request for Information (RFI) (see [Attachment 1](#)) seeking information from individuals and/or organizations regarding the need for, design of, and use of psychiatric inpatient services (provided through psychiatric units within general hospitals or freestanding behavioral health hospitals). This request specifically sought feedback regarding services for individuals with particular clinical co-occurring disorders, who may remain waiting in the Emergency Department (ED) of acute care hospitals for acute psychiatric inpatient admission.

The RFI was to provide the DMH and other stakeholders with information about what services may be necessary to best meet the treatment needs of the populations identified below, including the development of specialty units, if applicable, and the associated operational logistics and costs involved, rather than fitting these services into pre-existing structures. The information DMH received will guide future policymaking discussions around access to quality inpatient treatment for specialty populations including children and/or adults with acute psychiatric illness and the following co-occurring presentations/conditions:

1. Autism or other Intellectual and Developmental Disabilities (ASD/IDD);
2. Severe behavior/assault risk;
3. Substance use disorder; and/or
4. Physical illness/condition requiring medical and nursing care.

Review Process: By November 4, 2016, DMH received responses from twenty-one (21) hospitals or hospital systems, and four (4) submissions representing seven (7) organizations. See [Attachment 2](#) for a listing of the individuals, hospitals and organizations that submitted responses to the RFI. Of the hospital submissions, there were thirteen (13) related to co-occurring substance use disorders, and ten (10) related to co-occurring serious physical illnesses. Eight (8) submissions were in response to co-existing assaultive behaviors, nine (9) related to co-occurring ASD/IDD, and six (6) regarding children in any category.

During the week of November 14, 2016, DMH held a series of 8 meetings for each of the four subpopulations with State Agency stakeholders and select experts to review and discuss the RFI responses. These meetings included a focus on both child/adolescent and adult age groups. Please see [Attachment 3](#) for a listing of the individuals engaged in the response review.

Many respondents provided detailed answers to the questions outlined in the RFI and proposed specific systemic/programmatic changes that would be necessary to meet the needs of the children and/or adults included in the specialty populations. Others provided a general overview of the issues currently confronting service providers. For detailed synopses of the issues, barriers, and proposed improvements to the service delivery systems identified by the RFI respondents, broken out for each of the four sub-populations, please see the last four Attachments.

After reading the RFI responses and analyzing the data included in the synopses, one can see that there are a myriad of reasons identified as impacting the quality of care provided to children and adults in the specialty groups. The purpose of this report is to summarize the key findings and recommendations from the RFI responses and Agency stakeholder meetings and to propose a series of possible next steps that will result in the design of appropriate service levels and rates for providing care for these specialty populations.

II. HIGH LEVEL SUMMARY OF KEY FINDINGS AND RESPONDENTS' RECOMMENDATIONS

Although the types and array of services that have been identified through the RFI process are unique to each specialty population, the key findings and recommendations revealed a number of common themes, which are identified in the broad categories below:

1. Coordination of Care

Better coordination of care across all levels of service was consistently identified as an area in need of improvement. One organization noted that “care coordination can reduce redundant care...and prevent unnecessary utilization of health services like hospital admissions and emergency department visits.” (Association of Behavioral Healthcare) The comments highlighted the need for the provision of timely, consistent outpatient services in order to prevent an exacerbation of behavioral health conditions, partial hospital programs or other intensive outpatient services as a way of preventing the need for a hospitalization and to use these services as a method to “step down” from inpatient care. Residential and group living environments of care also require extensive coordination and communication with outpatient services along with emergency, crisis and respite services, intermediate services, and hospital facilities.

2. Enhancement of Non-Hospital Services/Interventions

Many respondents said that there are a variety of non-hospital services that can be expanded/developed to treat individuals in the specialty groups in the community and thereby reduce the reliance on EDs or facilitate timely aftercare services post discharge. These include community crisis stabilization, urgent care centers, rapid response centers, outpatient services, respite and visiting nurse services that emphasize psychiatric, substance use, and medical interventions. Community Based Acute Treatment (CBAT) programs for adolescents are needed in some geographic areas of the state, as these programs frequently serve to reduce ED waiting times for youth.

3. Review and Revise Regulatory/Contract/Program Requirements

There were a number of regulations, procedures, or practices that were identified by respondents as impediments to timely/appropriate services for the specialty populations. Some that were mentioned include:

- conflicting definitions of medical clearance;
- requiring nursing homes to decrease antipsychotic medications after 90 days after inpatient discharge even when there were clear inpatient discharge recommendations that changes not be made to the medication regime;
- requiring that access to certain levels of care can only occur after admission to an inpatient unit;
- difficulty operating/accessing an E-ATS (Inpatient/Enhanced Acute Treatment Services) program within a hospital setting due to DMH regulations regarding psychiatry and nursing staffing, or having these programs exist only as a contractual relationship between the hospital and a given insurance payer; and
- requiring a person being considered for a psychiatric admission to be transported to the closest ED for a psychiatric evaluation rather than a regionally developed Emergency Services Program (ESP) site or designated behaviorally staffed ED.

4. Inpatient Unit Structure/Staffing Redesign for Specialty Services

Unit design and staffing was noted as a key factor in addressing the needs of the specialty populations when an inpatient admission is necessary. It was clearly recommended that a specialty unit(s) is/are necessary to meet the needs of children/adolescents/youth with Autism or other Intellectual and Developmental Disabilities. There seemed to be consensus among respondents that individuals in the other identified sub-populations can be effectively treated within the current inpatient system with some unit modifications and/or enhanced staffing/ specialized staff. The behavioral health workforce shortage is a significant issue in developing separate and embedded programs.

5. Availability of Appropriately Trained Staff/ Workforce Development

There is a serious workforce shortage of skilled behavioral health staff of all types. Issues in this area centered on the recruitment, retention and on-going development of both para-professional and professional staff, including psychiatric, addictions, rehabilitative, and medical personnel across all levels of care. In terms of providing care to children and adolescents, the need to understand, educate, and respond to the concerns of parents and guardians was specifically acknowledged.

6. Financing/Payer Issues

Financing/third party payer issues were consistently reported across all respondents. Most noted that a standard per diem rate was insufficient to meet the resource needs of an individual in one of the specialty categories. Many others noted that insurers would not pay for two types of service on the same day. This was especially relevant for an individual experiencing an acute psychiatric illness with a co-occurring physical illness/condition requiring medical and nursing intervention. Onerous authorization procedures with different utilization review criteria for a medical vs. a psychiatric admission were also reported as a barrier to timely treatment. Lastly, many if not most of the innovative non-hospital services/interventions identified in number 2 above have not traditionally been purchased by Medicare or other insurers. Parity concerns should be addressed.

Please refer to the last four Attachments that provide more details specific to each of the subpopulations reviewed. Each Attachment is organized in the above 6 categories for continuity of findings.

III. RECOMMENDED NEXT STEPS

The responses to the RFI reflect a consensus concerning the need for specialized units to manage populations defined in this RFI. With the exception of those with intellectual and developmental disabilities and autism spectrum disorders, much of the care needed for these populations can and should be delivered on the general acute units with some accommodations on an individual basis (e.g., special 1:1 staffing, single rooms, de-stimulating and/ or geographically distinct, smaller environments). Additionally, there was a consistent and recurrent perspective that more access to and availability of community based care and a robust continuum of care with care coordination should be available for mental health and substance use treatment to avoid the need for emergency room evaluation whenever possible. Issues concerning payment, work force development, and simpler regulatory and contractual arrangements are ongoing discussions among stakeholders that will continue through the recommendations.

1. Enhance community based diversion and treatment options to address accessibility and service continuity for discharged clients. These include development of urgent care capacity, enhanced specialty capacity, care coordination for high utilizers, and, for DMH clients, housing. Improved communication across payers and state agencies with providers will be addressed.
2. In order to ensure that there is adequate expertise in our current hospital system, DMH Licensing will develop a mechanism and a set of standards to assess the capacity and competence of care for specialty populations defined in this RFI. These standards will be developed in collaboration with providers and will be utilized as part of the application for and annual renewal process for licensure.

3. Mass Health will contract to provide specialized inpatient unit(s) for the care and treatment of developmentally disabled children and adolescents on the Autism Spectrum and will expand access to include transition age youth in the adult developmental disability treatment programs. Enhanced community based services to both divert from inpatient care and to assure discharge options will be developed as part of a continuum for this population.

ATTACHMENT 1

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF MENTAL HEALTH

25 Staniford Street
Boston, MA 02114



Request for Information (RFI)

RFI No. BD-17-1022-DMH08-8210B-00000009836

Acute Psychiatric Inpatient Services for Special Populations

Released: SEPTEMBER 15, 2016

RESPONSE DEADLINE: Responses must be received by OCTOBER 14, 2016, by 5:00 PM EST

Commonwealth of Massachusetts – Request for Information
Department of Mental Health (“DMH”)

Psychiatric Inpatient Services for Special Populations

Respondents to this Request for Information (RFI) are invited to respond to any or all of the questions in this document. Responses to this RFI shall serve solely to assist the Commonwealth in exploring policymaking options related to access to quality treatment for

ATTACHMENT 1 (CONTINUED)

special populations described herein. Feedback is sought from individuals and organizations with experience and/or an interest in providing services to these special populations, and from other interested parties. This RFI does not in any way obligate the Commonwealth to issue or amend a solicitation or to include any of the RFI provisions or responses in any solicitation. Responding to this RFI is entirely voluntary, does not bind or obligate any Respondent to commit to any further action. A response will in no way affect the Commonwealth's consideration of any proposal submitted in response to any subsequent solicitation, nor will it serve to advantage or disadvantage the Respondent in the course of any RFR or RFQ that may be subsequently issued or amended. This RFI is for informational purposes only, with the goal of improving the behavioral health delivery system in Massachusetts.

Responses must be received by OCTOBER 14, 2016, by 5:00 PM EST

I. PURPOSE OF RFI

The Department of Mental Health (DMH)¹ is seeking information from individuals and/or organizations regarding the need for, design, and use of psychiatric inpatient services. This includes services provided through inpatient psychiatric units within general hospitals and freestanding psychiatric hospitals or other specialty inpatient psychiatric units for individuals with particular diagnoses or complications, who may remain waiting in the Emergency Department (ED) of acute care hospitals for inpatient admission.

The purpose of this RFI is to provide the DMH and other stakeholders with information about what services may be necessary to best meet the treatment needs of certain populations identified below, including specialty units, if applicable, and the associated operational logistics and costs. The DMH seeks information that will guide future policymaking discussions around access to quality inpatient treatment for the populations described herein.

A. BACKGROUND: ED BOARDING

ED visits related to behavioral health represent a growing share of all ED visits at acute care hospitals. The Health Policy Commission (HPC) has found that the number of ED visits at Massachusetts acute care hospitals associated with primary behavioral health diagnoses

¹ DMH, as the State Mental Health Authority, promotes mental health through early intervention, treatment, education, policy and regulation so that all residents of the Commonwealth may live full and productive lives. The Department of Mental Health, as the State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work and participate in their communities. The Department establishes standards to ensure effective and culturally competent care to promote recovery. The Department sets policy, promotes self-determination, protects human rights and supports mental health training and research. This critical mission is accomplished by working in partnership with other state agencies, individuals, families, providers and communities.

ATTACHMENT 1 (CONTINUED)

increased by 24% between 2010 and 2014, accounting for a total of 7% of total visits.² Behavioral health conditions are more prevalent among frequent ED users (5+ visits in a year) than other ED users, at 11% versus 5%.³ Many patients who present to the ED with a behavioral health diagnosis spend considerable time waiting for placement in an appropriate treatment setting.

The term “boarding” refers to the time a patient spends waiting in an ED for an inpatient hospital admission or for transfer to another inpatient facility.⁴ In its recent work to address ED boarding the Executive Office of Health and Human Services (EOHHS) has defined boarding as the event in which a patient remains in the ED for 12 hours or more after a decision to admit has been made. While other definitions exist,⁵ and while boarding is often used to refer to patients who do not require inpatient services but who remain in the ED for extended periods of time, the EOHHS has adopted this definition to facilitate standardized monitoring and tracking of data across the Commonwealth. The 12 hour wait time is the standard historically employed by the Department of Public Health (DPH) to monitor and report ED boarding for all health conditions.

Boarding due to a lack of available inpatient beds is particularly problematic for patients with behavioral health diagnoses, both nationwide⁶ and in Massachusetts.⁷ Because the issues that contribute to psychiatric ED boarding are multifaceted and complex, a comprehensive and coordinated strategy will be necessary to effectively address the problem. One aspect of the psychiatric ED boarding issue that has become clear during the recent work of a task force assembled by the EOHHS is that patients with complex conditions and/or co-occurring disorders are at higher risk of boarding, and on average board for longer than other patients.⁸ According to HPC’s analysis of the FY’2014 Outpatient Emergency Department database from the Center for Health Information Analysis (CHIA), nearly 6% of children are boarded for 4 or more days, while only 1.7% of adults boarded this long with teens making up 79% of child ED boarders. Compared to the non-boarding mental health ED population, more mental health ED boarders were homeless. Both children and adults with assaultive behavior/homicidal ideation have remained in the ED for 2 or more days. The Massachusetts Behavioral Health Partnership (MBHP) reports that, for calendar year 2015, 21.9% of MBHP members boarding for 24 hours or more were “assault risks”. The HPC further reports that 55% of Boarders in

² 2015 Health Policy Commission Cost Trends Report. <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-cost-trends-report.pdf>. Accessed March 1, 2016

³ 2014 Health Policy Commission Cost Trends Report. <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/2014-cost-trends-report.pdf>. Accessed March 1, 2016

⁴ Alakeson, V., Pande, N., & Ludwig, M. (2010) A plan to reduce emergency room ‘boarding’ of psychiatric patients. *Health Affairs*, 29(9), 1637-1642.

⁵ American College of Emergency Physicians (ACEP) Psychiatric and substance abuse survey 2008 (2008).

⁶ Claudius, I., Donofrio, J., Nok Lam, C., & Santillanes, G. (2014). *Hospital Pediatrics*, 4(3), 125-132.

⁷ HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014.

⁸ Massachusetts Behavioral Health Partnership (MBHP) Emergency Services report and analysis of ED Boarders. EOHHS boarding task force, 2016.

ATTACHMENT 1 (CONTINUED)

FY'2014 were frequent ED users with more than half having been to the ED 5 or more times and almost one third 10 or more times. The DMH recognizes that the lack of available resources may be symptomatic of a current service delivery and payment model where staffing and reimbursement structures are uniform regardless of the complexity of the patient occupying an inpatient psychiatric bed. The EOHHS task force recommended, in part, the development of specialty services to address this issue.

B. SPECIALTY INPATIENT SERVICE NEEDS

Through data analysis, the EOHHS ED boarding task force identified four subpopulations who often spend a longer amount of time in the ED awaiting appropriate care placement, and for whom the solution may include developing and supporting specialty inpatient care capacity. This is a unique opportunity to prospectively design inpatient services for a specialty population and identify appropriate service levels and rates for care, rather than trying to make services fit within pre-existing structures. There is expertise in best treatment practices and approaches for specialty populations in the Commonwealth. This RFI is intended to allow the DMH to leverage that expertise to better serve some of the Commonwealth's most vulnerable citizens. In parallel with this process, the EOHHS is working to estimate the inpatient psychiatric capacity required to meet the needs of each subpopulation.

Identified specialty populations include children and/or adults with acute psychiatric illness and the following symptoms or co-occurring presentations/conditions:

1. Autism or other Intellectual and Developmental Disabilities (IDD);
2. Severe behavior/assault risk;
3. Substance use disorder; and/or
4. Physical illness/condition requiring medical and nursing care.

The questions below seek to solicit information on the resources required to appropriately and safely serve these patients (e.g., operational, payment, and human resource needs). The DMH welcomes answers to any or all questions, as appropriate given each Respondent's area of expertise.

ATTACHMENT 1 (CONTINUED)

II. QUESTIONS FOR RESPONSE

Contact/Name: _____

Organization Name (if applicable): _____

Tel#: _____

Email: _____

Indicate whether or not you are currently treating and/or would consider developing specialty inpatient services to treat one or more of the four subpopulations with complex conditions. A unit might be able to serve more than one group (i.e. a mixed child and adolescent autism/IDD unit). The DMH is interested in understanding why some organizations have difficulty treating these patients, as well as why they would or would not consider developing specialized services. Please complete this grid as thoroughly as possible using the key below. For example, an organization would fill in 2a in each box under “children” if the hospital’s units serve adult patients only. The DMH is also interested in information on any other populations that providers are challenged to accommodate; please expand the grid as necessary to provide additional information.

Key for grid:

1-Yes, would consider.

2-No, would not consider.

- a. Our organization does not serve this age group;
- b. Our organization does not have required expertise to serve these special needs groups;
- c. We do not think this is financially viable;
- d. Other.

	Children	Adolescents	Adults	Comments
Acute psychiatric illness and co-occurring autism or IDD				
Acute psychiatric illness and co-occurring substance use disorder				
Acute psychiatric illness and co-occurring serious physical illness				
Acute psychiatric illness and severe aggressive behavior				

ATTACHMENT 1 (CONTINUED)

General Questions

1. Is there a continuum of care that would best facilitate delivery of acute inpatient treatment to one or more of the above subpopulations (i.e., a combination of more intensive and less intensive services within the same facility)?
2. Please describe any barriers to admission and appropriately treating each of the subpopulations.
3. Please describe any anticipated barriers to discharge of any of the above subpopulations that result in beds being occupied longer than medically necessary. Please include any information on how such barriers might be alleviated (e.g., by payers, providers, or regulation).
4. What particular qualifications does your organization have that allows you or could allow you to provide treatment for any of the above subpopulations? How do they meet or exceed what you view as the minimum qualifications for serving these populations?
5. Please describe any non-hospital services/interventions that may enable the named populations to be treated in the community.

For each subpopulation that your organization currently serves or would consider serving, please answer the following questions. Feel free to add pages and include attachments, as needed.

6. Type of Care (check all that apply)
 - ☐ **Acute psychiatric illness and co-occurring autism or IDD**
 - ☐ Currently serves acute psychiatric illness and co-occurring autism or IDD
 - ☐ Would consider serving acute psychiatric illness and co-occurring autism or IDD
 - ☐ **Acute psychiatric illness and co-occurring substance use disorder**
 - ☐ Currently serves acute psychiatric illness and co-occurring substance use disorder

ATTACHMENT 1 (CONTINUED)

☐ Would consider serving acute psychiatric illness and co-occurring substance use disorder

☐ **Acute psychiatric illness and serious physical illness**

☐ Currently serves acute psychiatric illness and serious physical illness

☐ Would consider serving acute psychiatric illness and serious physical illness

☐ **Acute psychiatric illness and severe assaultive behavior**

☐ Currently serves acute psychiatric illness and severe assaultive behavior

☐ Would consider serving acute psychiatric illness and severe assaultive behavior

Age of population currently served (check all that apply)

☐ Child ☐ Adolescent ☐ Adult ☐ Other age range (specify) _____

7. Service Description

☐ The service is/should be part of a stand-alone unit.

☐ The service is/should be integrated into an existing unit: describe _____

☐ The service is/would need to be in a locked unit.

☐ Other: describe _____

8. Total number of beds: current# _____ ideal# _____

Number of current single occupancy rooms: ____

Number of current double rooms: ____

9. Volume/Average Daily Census needed to maintain the financial viability of the service: ____

10. Describe the location and other important features of the facility that would facilitate care for the identified population.

11. Do you/would you arrange for the provision of schooling/education services to patients?

☐ No. Please explain.

☐ Yes. Please describe education plan.

ATTACHMENT 1 (CONTINUED)

Staffing Pattern

12. Describe your current or ideal staffing pattern(s) for treating one or more of the above subpopulations. Please provide detailed information by shift, FTE level, and staffing position / education / licensure level (e.g., nurse, psychiatrist, internist, social worker, occupational therapist, physical therapist, applied behavior analysts, psychologist, mental health worker, family partner, peer specialist, recovery coach, teacher, nutritionist, security personnel, etc.). Please expand the template below as necessary.

Position title / shift	Total FTEs	Description of role

13. Describe your proposed plan/and suggested strategies for dealing with anticipated/and often predictable seasonal and other fluctuations in census.
14. Describe the pre-service and in-service training requirements for staff.
15. Describe opportunities and challenges for recruitment and retention of a diverse workforce that includes people with lived experience.

Service Model

16. Admissions:
- If sufficient financial and staffing resources existed, describe any additional barriers to admission within reasonable time, and what would be needed to address these barriers (e.g., regulatory or policy changes or regionalization of services to address transportation issues).
 - Describe procedures / plans for obtaining information about an incoming patient's previous hospitalizations and treatment plans. Discuss current barriers to acquiring this information that would need to be addressed.

ATTACHMENT 1 (CONTINUED)

17. Services:

- c. Describe the specifics of the model of care to be delivered including anticipated average length of stay, expected outcomes, use of evidence-based practices and strategies for engagement of patients, families and caretakers, as well as supports for recreation, education (classroom and facilities for grade school / high school students), and social needs.
- d. Are there gradations of unit design and objective measures / clinical standards for assessing change in level of care that would better facilitate delivery of comprehensive inpatient treatment to one or more of the above subpopulations?
- e. What types of group programming are/should be provided to meet the needs of subpopulations. Please include topic areas recommended therapeutic approaches to take/or avoid.

18. Discharge:

- f. Describe plan / approach for discharging patients (e.g. pre-discharge and ongoing family and school supports, transition of care to community based services) with specific focus on strategies that promote engagement in the service and resources identified to best match planning to support resilience and recovery. What services/supports must be in place prior to discharge?
- g. What strategies would improve medication adherence?
- h. Please describe any increase in access to residential, step-down / partial hospitalization supports that would facilitate timely discharge of any of the above subpopulations and include the rationale for the recommended volume change.

19. Describe your recommended performance improvement plan.

20. Based on the requirements described, above, what are the estimated total administrative and operational expenses associated with providing the service described above on a per patient per diem basis?

21. Describe other considerations or requirements that must be taken into account which are not outlined in the previous questions.

ATTACHMENT 1 (CONTINUED)

III. RESPONSE INSTRUCTIONS

A. Response Format

Please include each question you are answering above each answer. Respondents are not required to respond to every question; respond to as many as you elect to address. Attachments to the response must be clearly labeled and referenced by name and number in the RFI response. Please consecutively number all pages of the response.

Do not include marketing or promotional material with your response. This information will be disregarded on review. Please keep your responses to key points to help facilitate review.

B. Responses Due Date and Submission Format

Responses to this RFI are due no later than OCTOBER 14, 2016, by 5:00 PM EST. Respondents must submit their response through [COMMBUYS](#). If a respondent has any issues with responding through [COMMBUYS](#), it should contact the COMMBUYS Help Desk at COMMBUYS@state.ma.us or call during normal business hours (8AM – 5PM Monday – Friday) at 1-888-627-8283 or 617-720-3197.

All responses must include a completed RFI Cover Sheet containing the following Information:

- Title of RFI: Request for Information-Psychiatric Inpatient Services for Special Populations
- For Individual response: Name and Mailing address
- For Entity/Organization response: Name of Entity/Organization (please list any parent entity/organization as well), mailing address, and contact name, including title and e-mail address

Useful Links:

- **Job aid on how to submit a response:**
<http://www.mass.gov/anf/docs/osd/commbuys/create-a-quote.pdf>
- **Webcast:** [How to Locate and Respond to a Bid in CommBuys](#), will familiarize respondents with COMMBUYS terminology, basic navigation, and provide guidance for locating bid opportunities in COMMBUYS and submitting an online quote.

ATTACHMENT 1 (CONTINUED)

C. Reasonable Accommodation

Respondents with disabilities or hardships who seek reasonable accommodations in responding to this RFI must communicate such requests by e-mail to Eric Pilsmaker at Eric.Pilsmaker@MassMail.State.MA.US. Requests for accommodation will be addressed on a case by case basis. The DMH reserves the right to reject unreasonable requests.

IV. ADDITIONAL RFI INFORMATION

A. Use of Information

Responses to this RFI may be reviewed, evaluated and shared by and with any person(s) at the discretion of the DMH, including but not limited to other agencies within EOHHS and independent consultants.

The issuance of this RFI does not obligate the DMH, EOHHS, or the Commonwealth in any way. The DMH, EOHHS, and the Commonwealth are not obligated to adopt any recommendations contained in a response, reconfigure of services, issue contracts, adjust rates, or issue any RFR. A response to this RFI is entirely voluntary and will not affect the DMH's consideration of any proposal submitted in response to any future RFR or RFQ that may be issued by the DMH.

Responses to this RFI become the property of the Commonwealth of Massachusetts and are public records under the Massachusetts Public Records Law, M.G.L. c. 66, §10, and c. 4, §7(26).

B. RFI Access

This RFI has been distributed electronically using COMMBUYS and by email. COMMBUYS is an electronic mechanism used for advertising and distributing the Commonwealth of Massachusetts' procurements and related files. No individual or organization may alter (manually or electronically) the RFI or its components except for those portions intended to collect the respondent's response. Interested parties may access COMMBUYS at <http://www.commbuys.com>.

C. RFI Amendments

Interested parties are solely responsible for checking COMMBUYS for any addenda or modifications that are subsequently made to this RFI. The DMH accepts no liability and will provide no accommodation to interested parties who fail to check for amendments to the RFI.

ATTACHMENT 1 (CONTINUED)

D. Costs

Any cost incurred in responding to this RFI, or in support of activities associated with this RFI, are the sole responsibility of respondent. The DMH shall not be held responsible for any costs incurred by respondents in preparing their respective responses to this RFI.

E. Questions about the RFI and Response Instructions

Questions Concerning the RFI. The “Bid Q&A” provides the opportunity for respondents to ask written questions and receive written answers regarding this RFI. All respondents’ questions must be submitted through the Bid Q&A found on COMMBUYS. Questions may be asked only prior to September 30, 2016.

Questions submitted after the date and time specified above will not be considered for a response.

Respondents are responsible for entering content suitable for public viewing, since all of the questions are or will be accessible to the public. Respondents must not include any information that could be considered personal, security sensitive, inflammatory, incorrect, collusory, or otherwise objectionable, including information about the Respondent’s company or other companies. The DMH reserves the right to edit or delete any submitted questions that raise any of these issues or that are not in the best interest of the Commonwealth.

Locating Bid Q&A: Log into COMMBUYS, locate the Bid (RFI), acknowledge receipt of the Bid, and scroll down to the bottom of the Bid Header page. The “Bid Q&A” button allows respondents access to the Bid Q&A page.

Informational Sessions: There will be no informational sessions associated with this RFI.

F. Thank You

The DMH appreciates the time and consideration you invest in responding

Attachment 2

List of Hospitals, Hospital Systems and Organizations that responded to the RFI

1. Anna Jacques Hospital
2. Arbour Health Systems
3. Association for Behavioral Healthcare Foundation
4. Baystate Medical Center
5. Beacon Health Options Inc.
6. Berkshire Medical Center
7. Beth Israel Deaconess (BIDMC)- Plymouth
8. Brockton Hospital
9. Cambridge Health Alliance
10. Children's Hospital
11. Cooley Dickinson Hospital
12. Department of Youth Services
13. Franciscan Hospital
14. Hallmark Health Hospitals
15. Heywood Hospital
16. High Point Hospital
17. Lahey Health Behavioral Services
18. Massachusetts Association of Behavioral Health Systems
19. McLean Hospital
20. MHA MACEP MPS MMS – Combined response
21. North Shore Medical Center
22. Providence Behavioral Health
23. Southcoast Behavioral Health
24. Tufts Medical Center
25. UHS of Westwood Pembroke Inc.
26. UMass Medical Center

Attachment 2 (continued)

RESPONSES BY CATEGORY

1. Autism or other Intellectual and Developmental Disabilities (IDD)

- Arbour Hospital System- (adults)
- Baystate Medical Center- (all)
- Boston Children's Hospital- (children)
- Cambridge Health Alliance- (children/adolescents)
- Franciscan Hospital- (children)
- High Point Hospital- (adults)
- Northshore Medical Center- (children)
- UMass Medical Center- (children)
- UHS of Westwood Pembroke, Inc.- (adolescents)

2. Severe behavior/assault risk

- Anna Jacques Hospital - (all)
- Baystate Medical Center- (adults)
- BIDMC- Plymouth- (adults)
- Brockton Hospital- (adults)
- Cambridge Health Alliance- (adolescents adults)
- Department of Youth Services- (children/adolescent)
- Hallmark Health System- (adults)
- Lahey Health Behavioral Services- (adults)

3. Substance use disorder

- Anna Jaques Hospital- (adolescents/adults)
- Arbour Health System- (adults)
- Baystate Medical Center- (adults)
- BIDMC- Plymouth- (adults)
- Cambridge Health Alliance- (adolescents/adults)
- Cooley Dickinson Hospital- (adults)
- Hallmark Health System- (adults)
- Heywood Hospital- (adolescents/adults)
- High Point Hospital- (all)
- Lahey Behavioral Health Services- (adults)
- McLean Hospital- (adults)
- Northshore Medical Center- (adults)
- UHS of Westwood Pembroke Inc.- (adults)

Attachment 2 (continued)

RESPONSES BY CATEGORY (CONTINUED)

4. Physical illness/condition requiring medical and nursing care.

- Anna Jaques Hospital - (adolescents/adults)
- Baystate Medical Center- (adults)
- BIDMC- Plymouth- (adults)
- Boston Children's Hospital- (children/adolescents)
- Cambridge Health Alliance- (adolescents/adults)
- Hallmark Health System- (adults)
- Heywood Hospital- (adults)
- Lahey Behavioral Health Services- (adults)
- Northshore Medical Center- (adults)
- Tufts Medical Center- (adults)

Attachment 3

A total of eight (8) meetings were held with State Agency stakeholders and select experts for each of the four (4) subpopulations during the week of November 14, 2016. **These meetings included a focus on both child/adolescent and adult age groups.**

Meeting Attendees by Category:

5. Autism or other Intellectual and Developmental Disabilities (IDD)

1. Kathy Sanders, MD (DMH)
2. Janet Ross (DMH)
3. Sheila Lee (DMH)
4. Barbara Evangelista (DMH)
5. Carey Lambert (DMH)
6. Christina Fluet, MPH (DMH)
7. Lee-Anne Jacobs (EHS)
8. Janet George, EdD (DDS)
9. Nandini Talwar, MD (DMH)
10. Donna Frates (Beacon Health Options)
11. Carolyn Langer, MD, MPH (EHS/Mass Health)
12. Robert Turillo (DYS)
13. Wynne Morgan, MD (DCF)
14. Kenneth Mitchell, MD (DMH)
15. John Julian, MD (Partners)
16. Ken Duckworth, MD (Blue Cross Blue Shield of Massachusetts)
17. Christie Pearl (EHS/Mass Health)

6. Severe behavior/assault risk

1. Kathy Sanders, MD (DMH)
2. Janet Ross (DMH)
3. Barbara Evangelista (DMH)
4. Carey Lambert (DMH)
5. Kenneth Mitchell, MD (DMH)
6. Kevin Huckshorn, Ph.D, MSN, (consultant)
7. Donna Frates (Beacon Health Options)
8. Carolyn Langer, MD, MPH (EHS/Mass Health)
9. Lee-Anne Jacobs (EHS)
10. Linda Sagor, MD (DCF)

Attachment 3 (continued)

11. Elizabeth Kelley (EHS)
12. Cynthia Berkowitz, MD (DMH)
13. Robert Turillo (DYS)
14. Emily Sherwood (DMH)

7. Substance use disorder

1. Kathy Sanders, MD (DMH)
2. Janet Ross (DMH)
3. Sheila Lee (DMH)
4. Barbara Evangelista (DMH)
5. Carey Lambert (DMH)
6. Beverly Presson (DMH)
7. Anthony Riccitelli (DMH)
8. Robert Turillo (DYS)
9. Jonna Hopwood (Beacon Health Options)
10. Kenneth Mitchell, MD (DMH)
11. Erica Piedade (DPH)
12. Janet George, EdD (DDS)
13. Janice LeBel, EdD, PhD (DMH)

8. Physical illness/condition requiring medical and nursing care

1. Kathy Sanders, MD (DMH)
2. Janet Ross (DMH)
3. Sheila Lee (DMH)
4. Carey Lambert (DMH)
5. Ellen Flowers (DMH)
6. Cynthia Berkowitz, MD (DMH)
7. Janet George, EdD (DDS)
8. Elizabeth Kelley (EHS)
9. Kenneth Mitchell, MD (DMH)
10. Nandini Talwar, MD (DMH)
11. Carolyn Langer, MD, MPH (EHS/Mass Health)
12. Robert Turillo (DYS)
13. Lee-Anne Jacobs (EHS)
14. Laura Conrad (EHS)

Attachment 4

Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Autism or Other Intellectual and Developmental Disabilities (ASD/IDD)

1. Coordination of Care:

- Many respondents felt the state should develop separate infrastructures for latency-aged (10 years and under) and adolescents that includes outpatient providers, group homes, respite and other step down services (e.g., foster care, home supports, residential facilities, Community-Based Acute Treatment (CBAT, for children/adolescents), Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP), medication management, etc.).
- Collaborate with the Executive Office of Education (EOE) to ensure that the school system continues to provide appropriate special education services.
- Work with families and guardians to expedite completion of paperwork and enhance family support services throughout the continuum.
- Identify barriers to diversion to subacute settings which results in longer lengths of stay.
- Foster improved communication between funding sources (i.e., DCF, DMH, DDS, Mass Health, and school systems) as this process is slow and extends the length of stay due to funding and community placement determination.
- Assistance is needed in offering education and training to advocates and liaisons working with individuals with developmental disabilities to better understand the disorders and how to interact in a supportive and helpful manner.
- There is limited access to step down programs such as Group Living Environments, Supported Housing and care coordination with support services to meet specific population needs.
- Patients between the ages of eighteen and twenty-two are aging out of the child DDS and EOE systems with no adult services established, and many in this age group are experiencing behavioral destabilization, sometimes leading to Emergency Department (ED) visits and boarding.
- Maximize use of continuum of care by accepting admissions 24/7 directly from the community and partnering closely with complementary programs throughout the state.
- This population should not go through the ED; improve collateral supporting information coming from referral sources confirming diagnoses.
- Suggest designing a simple referral form with key information required for an admission decision to be made.
- Create a system that ensures information sharing among care managers and outpatient services; especially given that transitions tend to be difficult for youth with ASD. Ideally the same team members would work with these youth as they move across the care continuum.

Attachment 4 (continued)

2. Enhancement of Non-Hospital Services/Interventions:

- Many respondents felt the state should provide training to families and community providers (i.e., residential programs, schools, collateral treaters, etc.) to reduce length of stay (LOS) and readmission rates. Examples of needed training include de-escalation techniques, use of sensory items, management of medication and behavioral interventions.
- Develop non-hospital level respite programs specifically designed for the transitional age ASD/IDD population in order to respond to the issues unique to this age group.
- School systems should be accountable for special education services. Access to appropriate speech and language and occupational therapy (OT) services vary by what school district youth is in and these services are key to help stabilize youth in the community/ school setting.

3. Review and Revise Regulatory/Contract/Program Requirements:

- Collect data regarding best practices for behavioral management skills.
- Develop tools to define and standardize the assessment of acuity of psychiatric populations which may strengthen treatment options.

4. Inpatient Unit Structure/Staffing Redesign for Specialty Services:

- Assess regions within the state to determine the need for units (including the number of beds) specific to this subpopulation (e.g., Berkshire County has no child or adolescent acute inpatient beds of any kind).
- Experts who are versed in construction of units for this population should be consulted to ensure the units are constructed in such a way that there is ample patient space available (i.e., additional Sensory Rooms, Calming Rooms, single bedrooms, etc.).

5. Availability of Appropriately Trained Staff/ Workforce Development:

- A specialized unit should have a strong emphasis on Applied Behavior Therapy (ABA) therapy with access to a psychologist well versed in ABA to help supervise and support front line staff implementing various behavior plans.
- An ASD/IDD continuum of care should have a multi-disciplinary approach to treating these youth. Medications are only one tool to help youth with ASD/IDD stabilize; and the treating team should include a speech and language pathologist and OT.
- This population benefits from higher staff to patient ratio. However, staffing recruitment and retention is an ongoing problem. Encourage the state to incentivize universities, faculties, and students to pursue specialties in their trainings and develop specialized therapies. Clinical professionals (i.e., psychiatrists, nurses, direct care staff, Allied Professionals, etc.) have limited training and exposure to ASD/IDD disorders).

Attachment 4 (continued)

- Ongoing trainings and demonstration of competencies including hands on experience with a variety of functional levels of patients with ASD/IDD is critical to reduce harm.

6. Financing/Payer Issues:

- Given the significant issues around transitions for this population, educate the insurance companies to recognize the benefit of a continued stay even if a patient is exhibiting safe behaviors so that facilities can work with families and other caregivers before discharge to potentially reduce the recidivism.
- Improve interagency communication to facilitate a better understanding of the potential discharge problems for youth under twenty two years of age if the funding source is a school system that has to agree to pay for a residential program. Consider school/ parent conflict when placement issues arise.
- State should examine the continuum of care available for community supports in order to strengthen group and foster homes' ability to manage those they serve within a community setting and provide additional funding if needed.
- Standardize the approach and statewide centralization of funds not dependent of domicile address thus creating a fair system for placement in impoverished communities.
- State should consider offering capital investment support to those facilities who are willing to serve this population with a newly constructed specialty unit.
- Facilities which had recommendations and expertise that was sensitive to the needs of ASD/IDD population didn't have the capacity to open a separate ASD/IDD unit for children and adolescents.

Attachment 5

Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Severe Behavior/ Assault Risk

1. Coordination of Care:

- Many of these patients lose their community placements in DMH-contracted Group Living Environments (GLE) or independent living programs. This is caused by chronic destabilization, requiring frequent acute inpatient admission. Unstable housing/ homelessness and co-existing developmental disabilities are reported to be barriers to discharge. There are not enough beds/ facilities that effectively treat complex needs. Inpatient facilities are reluctant to accept this population based on not trusting historical information, resulting in critical information being unavailable at the time of admission.
- Assess the current continuum of care including those settings that struggle with serving this population. This may be alleviated by more long term locked facilities and/or specialized group homes.
- Improve interagency communication and collaboration with managed care plans, state agencies (including but not limited to DMH and DYS), and the legal system to foster successful outcomes. Wraparound community services must be in place with the ability of staff to attend systems meetings and individuals served to get/fill medications, access transportation to appointments, stable housing, and case management. This may include a psychiatric transition service allowing follow- up appointments to be scheduled within 5-7 days of discharge, having a controlled environment with public safety officers available, a psychiatrist who specializes in treating such patients, and an outpatient medication/injection clinic.
- There is a continued need to address medication compliance including the possibility of Community Rogers orders as coordinated by Community-Based Flexible Support (CBFS)/Psychiatric Acute Community Team (PACT). Community could provide long acting injectable medication with close monitoring and authorization by a psychiatrist to minimize recidivism and potential ED visits. This may also help those who are homeless and/or in shelters.
- Determine if the referral process to continuing care beds in state hospitals for this population can be expedited from application to transfer.

2. Enhancement of Non-Hospital Services/Interventions:

- Verification of current patient condition is challenging because of limited access to the patient's record, including information known by insurers. Facilities report that they may not receive a complete patient history, including historical episodes of violence or criminal history. It may be beneficial to have access to a system wide electronic medical record (EMR) to share patient information within the network of their providers including insurance payers.

Attachment 5 (continued)

- Some facilities expressed that there needs to be an avenue by which law enforcement agencies understand the need to have timely and consistent interventions (i.e., law enforcement is unwilling to consider arrest for violent acts in an inpatient setting that would be an automatic arrest if the person were in the community). Education and collaboration of facility staff and law enforcement personnel should be offered to more clearly understand when a patient needs to be removed from the unit for the safety and wellbeing of staff and others which may prevent an unsafe milieu settings and/or halting of new admissions.

3. Review and Revise Regulatory/Contract/Program Requirements:

- It is noted that patients being referred to acute care units increasingly have current involvement with the legal system, and there are no alternative settings in which to manage them. Exclusionary criteria currently in place at many community inpatient facilities (e.g., those identified by MBHP and MCOs, and/or memorandums of understanding with communities) often prevent admission of individuals with current charges or histories of homicide, aggravated assault, rape.
- Some patients are identified as “antisocial,” assessed by a psychiatrist as not able to benefit from an inpatient level of care. These patients are also perceived to have an adverse effect on the milieu, and it is believed that there is a more proactive way for alternative placements to be used, including discussions with the MCO, involved state agencies, and patient collaterals.
- Some facilities requested that local law enforcement be more active and willing to arrest patients when asked to do so.
- The role of the Committee for Public Counsel Services (CPCS) for providers seeking commitment can result in delays because of requests for Independent Medical Examinations (IME). This may in turn further delay medication for the patient for weeks which may increase aggressive behaviors and then result in longer lengths of stay.
- Review and revise the proposed “no reject” policy to ensure that it is an effective way to address the ED boarding issue. These placements may adversely affect the milieu and compromise other patients, staff, and their own safety, raising serious liability issues and impacting care and safety for all. One respondent felt that consideration should be given to treating no more than two highly aggressive/assaultive (HA/A) patients per unit. Otherwise, the system could change the clinical model of care around a person with HA/A to a correctional model and create multiple programs with smaller number of patients per program and geographically accessible.

Attachment 5 (continued)

4. Inpatient Unit Structure/Staffing Redesign for Specialty Services:

- Staff (including physicians, nurses, social workers, group therapists/OT team) should have experience, training, and interest in caring for this patient population. Some respondents thought this population tends to respond poorly to Trauma Informed Care (TIC) concepts and milieus (particularly those individuals with antisocial character pathology or behavioral dysregulation from brain injury etc), require private rooms, and may not respond to psychiatric medications and treatments. Determine the level of need for special observation/single rooms, higher staffing ratios (when specializing is requested oftentimes approval is delayed or the request for additional payment from the payer is not approved). It is recommended that these be spacious facilities with specialized group programming.
- For adolescents exhibiting assaultive behavior, many times the only placement option is on an adult unit with a 1:1 and/or single room and spending long hours with limited developmentally appropriate programming. This highlights the need for individualized, developmentally appropriate treatment options.
- Assess regions within the state to determine the need for beds for this subpopulation. The concept of transporting patients from one region to another could defeat the most earnest attempts at both treatment and discharge planning.
- Experts who are versed in construction of units for this population should be consulted to ensure that new units are built or renovated in such a way that there is ample patient space available (e.g., additional Sensory or Calming Rooms, single bedrooms, etc.). Single rooms and segregated areas (pods) that offer visual/auditory separation between agitated patients and others on the unit can provide a more intensive level of treatment and monitoring. This allows for more intensive nursing care, 1:1/2:1 staffing, increased security presence, specialized psychopharmacology interventions, and active work with the patient to identify and practice behavioral skills to gain greater control. The patient could move to the regular section of the milieu when able to tolerate more stimulation.
- Aggressive, assaultive patients may benefit from behavior management plans, anger management, relaxation techniques, OT, social skills development. Consultation with behavior specialists should be readily available.
- Consideration to include of Peer Support Specialists as an active member of the treatment team is urged.
- Current DMH minimum staffing expectations to facilitate engagement and treatment are not adequate to manage a consistently larger number of HA/A patients.
- Need for psychiatry, nursing, and ancillary staff with specialized skills for treating these patients.

Attachment 5 (continued)

- Some suggested adopting a model of care for this population that is similar to the DMH inpatient model of longer term stabilization as a means to decrease re-hospitalization. This would involve longer lengths of stay and should include meaningful employment and education/ training opportunities that would facilitate the individual's ability to internalize socially acceptable behavioral norms.

5. Availability of Appropriately Trained Staff/ Workforce Development:

- Determine and research the need for new medication and treatment protocols for this population.
- Ensure all staff receive additional education and maintain current trainings and certifications (i.e., upon hire, as needed, and annually) to work with and care for these patients.
- This population definitely benefits from a higher staff to patient ratio. However, staffing recruitment and retention is an ongoing problem. Encourage the state to incentivize universities, faculties, and students to pursue specialties in their trainings and develop specialized therapies. Ongoing trainings and demonstration of competencies in verbal de-escalation, motivational interviewing, mindfulness, anger management, strength-based interventions, including hands on experience is critical to reduce harm.
- Affiliation with a university/medical center and training site is recommended.
- Redefine the role of the security specialists/officers.

6. Financing/Payer Issues:

- Admission and ongoing insurance reviews should include a more proactive approach to rapidly identify when a patient will be authorized for a special or single room. The payer must allow the facility the discretion to determine the need for specials and LOS. Patients who have been seriously assaultive or violent on the unit should be reviewed with the MCO and collaterals prior to discharge for crisis plan development as they may require a forensic evaluation, direct admission to continuing care beds, or specialized housing as part of that plan.
- Collaborate with insurance companies to ensure adequate financial reimbursement necessary to adequately work with this population.
- State could consider offering capital investments to those facilities willing to serve this population and construct specialty areas within their existing units.
- It is reported that during the wait time for a DMH continuing care bed, the payer reduces the rates. Improve communication with insurance companies to allow longer LOS in this population.
- There is a perception that public payers have the best continuum of care. If this is accurate and valid, determine the best practices to be implemented to offer more equitable services across all payers.

Attachment 6

Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Substance Use Disorder

1. Coordination of Care:

- Mandate Bureau of Substance Abuse Services (BSAS) certification for opioid treatment, detoxification, clinical stabilization, and transitional support.
- Determine if accessing Community Stabilization/Step Down Services (CSS) and Transitional Support Services (TSS) or step down to subacute level of care is problematic.
- Some increased Emergency department (ED) boarding may be caused by lack of access to Enhanced Acute Treatment Service (EATS) or Dual Diagnosis Acute Residential Treatment Service (DDART) levels of care. The perception by many payers that these services are underfunded discourages providers from expanding this level of care. Consider conducting a survey of the new beds coming on line in the state to see which will be providing EATS or DDART.
- Discharge plans should be reviewed and contain realistic resources and referrals to currently available outpatient to reduce “revolving door” admissions.
- Assess facilities’ ability to institute or maintain opiate agonists.
- Determine the need for additional Sober Houses.
- Access to means such as housing, financial assistance for medication copayments, transportation to non-24-hour programs as lack of such services can be a deterrent to successful discharges.
- Closed referral systems should be evaluated for parity.
- Appropriate levels of care and continued coverage by providers should be available for people to step down to other levels of care instead of going to a shelter.
- Step-down programs often require patients to have a one-month supply of medications and refills. This whole system of care around medication management and clinical oversight should be reviewed for changes that will facilitate continuing stabilization and not contribute to early discontinuation of successful medications started during an acute inpatient hospitalization. Barrier include: lack of insurance coverage, lack of state support for medication for non-insured, lack of government issued ID card, pre-authorization for medications, and safety issues around medication administration in community programs. Medication management with clinical oversight should be more available in the community-based programs.

Attachment 6 (continued)

- Evaluate the need to develop an Initial Assessment Unit, enhanced transition services, and/or Partial Hospital Program (PHP) to provide other levels of care other than utilizing ED Service and inpatient psychiatry services.
 - Consider forming contractual relationships with Substance Use Disorders (SUD) treatment providers to enhance continuum of care.
 - Some patients with DMH services are not candidates for straight SUD treatment as don't "clinically fit". Stigma towards mental illness is part of the chasm between transitional SUD treatment and the mental health system of care. Hence, a standardized definition of "clinically fit" should be agreed upon to facilitate the state hospital referral process, during which payers often cut off benefits.
2. Enhancement of Non-Hospital Services/Interventions
- Determine the need for Navigators or bridge care coordinators who are familiar with services and resources, to help patients transition back to the community.
 - Assess and revise the process for "bridge" prescriptions for Suboxone (and other medications) until outpatient appointments can be attended.
 - Challenges of the opioid crisis and decreased inpatient and crisis beds in community should continue to be assessed to determine if having dedicated team looking at throughput, triage, and challenges of working through evaluation, insurance approval and referral processes prove to be successful.
 - Assess the need for alternative living situations for children and adolescents with addictions and residential programming for mothers with minor children.
3. Review and Revise Regulatory/Contract/Program Requirements
- Sufficient time may be needed to address co-occurring psychiatric disorders once detox protocols have been completed and/or patients requiring medical screening before acceptance to detox units require increased time and resources. Payers may not reimburse facilities for these days needed for continued care for safe discharge. Rates of pay should be reviewed.
 - Review and assess licensing regulations to determine if they would apply to the operation of EATS within hospitals.
 - Definitions for acuity levels are needed in order to develop standards or best practices for both the mental health and substance use treatment systems.
 - Leverage Determination of Need (DoN) regulations to require new acute care services to have dual diagnosis beds.

Attachment 6 (continued)

4. Inpatient Unit Structure/Staffing Redesign for Specialty Services

- Consider the development of a 24-hour consultation team that includes a psychiatrist trained in addictions medicine that could provide support and consultation to the two treatment teams, and provide cross training to support the growth of this service.
- Some systems requested “virtual private rooms” with full reimbursement by insurance at double occupancy rate due to lack of private rooms.
- Consideration could be given to having more locked dedicated units to provide a more sustained treatment approach for adults with a capacity of 18-24 beds. Staff should include Licensed Alcohol and Drug Abuse Counselor (LADC) or Certified Alcohol and Drug Abuse Counselor (CDAC) credentialed staff with psychiatric experience.
- Assess the need for services for LGBTQ population so that hospitals can accommodate the unique needs of this population.
- BSAS rates should be reviewed to include psychiatrists or mid-level practitioners.
- Assess the need for more resources dedicated to non-English speaking patients, among other things mentioned by others.
- Assess regions within the state to determine need for units specific to this subpopulation. Patients may be placed far from current medical providers when encouraged to accept “first available bed”.

5. Availability of Appropriately Trained Staff/ Workforce Development:

- Staff may need specialized cross-training in addictions medicine including but not limited to Trauma Informed Care (TIC).
- There is a universal need for training staff and program/policy makers concerning state of the art treatment approaches to those with co-occurring mental illness and SUD. This will allow more readily available treatment services that meet the needs of this growing population.
- The state could incentivize universities, faculties, and students to pursue specialties in treating dually diagnosed individuals and develop specialized therapies. Clinical professionals (e.g., psychiatrists, nurses, direct care staff, allied professionals, etc.) have limited training and exposure to SUD. Mindfulness, motivational interviewing, stages of change theory, Cognitive Behavior Therapy (CBT), cultural sensitivity, peer recovery, TIC, Clinical Institute Withdrawal Assessment for Alcohol (CIWA), and opiate replacement therapies, among others, are all areas of expertise that can be developed within institutions of higher learning. Ongoing trainings and demonstration of competencies including hands on experience is critical to improving care for this population.
- Encourage facilities to offer Mindfulness training programs for clients and staff.

Attachment 6 (continued)

- Assess the need for additional step down outreach and drop-in centers for people struggling with and affected by SUD. Have integrated outpatient and community opioid follow up within 48 hours.
- Education and collaboration with local law enforcement agencies to best serve this population should continue to be explored.
- Training should be developed and offered regarding how to engage, inform, and support parents and guardians of minors with SUD.
- Consideration should be given to including Substance Use Recovery Coaches within staffing models.

6. Financing/Payer Issues:

- Provision of appropriate medications for persons with psychiatric and medical conditions regardless of the level of care (not reimbursed), should be ensured.
- Rates should be finalized which would allow the provision of all three FDA approved medications for opioid use disorder.
- High copays and deductibles should be reassessed.
- To reduce the wait time in the ED, the need for preauthorization for this population should be assessed.
- Patients with exhausted healthcare coverage should be reviewed on an individual basis for appropriate placement and services.
- Review reimbursement rates for unique and the various levels of care (e.g., Partial Plus programs) for this population.
- Continued cooperation and coordination between DPH (DHCQ and BSAS), DMH, MassHealth, MBHP, and others to ensure that advocacy for services for this population is sustained.

Attachment 7

Synopsis of RFI Issues, Barriers and Proposed Enhancements Regarding Physical Illness/ Condition Requiring Medical and Nursing Care

1. Coordination of Care:

- Coordinate the cross training of medical/psychiatric home care services organizations.
- Review the expectations and capabilities of Community-Based Acute Treatment (CBAT, for children/adolescents) providing care for patients with contributory medical illness, not requiring active treatment.
- Verify and understand why DPH requires skilled nursing facilities etc to decrease antipsychotic medication after 90 days even when the discharging facility is recommending that such changes could lead to readmission to inpatient level of care.
- Assess and determine the process for admission to programs (e.g., short term skilled nursing facilities and home care services organizations) in order to determine the feasibility of direct admissions from an ED.
- Improve the coordination between referring facilities (e.g., nursing or group homes) and inpatient psychiatric units regarding discharge expectations for those patients with dementia. Some nursing and group homes decline to take patients back after their behavior has stabilized. It can be difficult to place patients in lower levels of care when this occurs.
- Provide or arrange transportation so that patients will be able to participate in treatment after discharge.
- Inclusion of tele-psychiatric outpatient services may prevent the need for admission for some with physical illnesses.

2. Enhancement of Non-Hospital Services/Interventions

- Verifying the existing patient condition may be challenging because of limited access to the patient's record, including information provided by insurers. It may be beneficial to have access to a system-wide EMR to share patient information within the network of their providers including insurance payers.
- Assess regions within the state to determine need for units specific to this subpopulation (e.g., development of rehabilitation settings with greater psychiatric expertise). Suggest modified, regional approach; and identify the need for additional partial hospital programs (PHP) for children and adolescents in any region.
- Work with court system and families to determine a way to expedite the process of appointment of a guardian or health care agent.

Attachment 7 (continued)

- Develop and coordinate a more comprehensive, community-based system, with strong connections with day programs, elder and disabled housing, home care services organizations, palliative care, etc.
3. Review and Revise Regulatory/Contract/Program Requirements
 - Review and revise DMH regulations to ensure Licensing has the authority to insist that hospitals have adequate resources in place to care for this population.
 - More clearly define and standardize the term “medically cleared.”
 4. Inpatient Unit Structure/Staffing Redesign for Specialty Services
 - The exclusionary criteria for acute inpatient psychiatric admission often include infectious diseases, shunts, intravenous (IV)s, naso-gastric (NG), jejunostomy (J), or gastrostomy (G) tubes, central lines, oxygen, wounds requiring debridement, stage 3 & 4 decubitus, pumps for medications, tracheotomy, advanced dementia, Delirium tremens (DTs), morbid obesity (>350 lbs.), transdermal patches, and methadone tapers.
 - Assess and determine if the psychiatric care of patients with comorbid medical and psychiatric illness should be in general medical hospitals (i.e., determine if and when isolation rooms are needed for patients with Methicillin-resistant Staphylococcus aureus (MRSA) and other infectious illnesses) since freestanding psychiatric facilities lack medical resources.
 - Determine if there is a need to develop regional centers with additional physicians and medical resources for treating patients during late-stage pregnancy, those requiring dialysis, or multi-system trauma from suicide attempts (to name a few) at an enhanced reimbursement rate.
 - Determine the risk/benefits of having more private rooms and/or rooms that are retrofitted with medical equipment in order to be available to serve this population in any acute psychiatric setting.
 5. Availability of Appropriately Trained Staff/ Workforce Development
 - Determine if there is an increased need for additional hospitalists cross trained to work with psychiatric patients.
 - Ensure that a comprehensive medical and psychiatric overview is provided to medical-psychiatric unit staff and nurses at orientation, as needed, and annually.

Attachment 7 (continued)

- This population benefits from higher staff to patient ratio. The state could incentivize universities, faculties, and students to pursue specialties in their programs and develop specialized therapies. Topics to be considered include behavioral health care during pregnancy, end-stage renal disease, multi-system trauma from suicide attempts, diabetes, dementia, and palliative care, to name a few.
- Determine the need for cross training between medical and psychiatric units' nursing staff to decrease the repeated transfers between psychiatric and medical units which may lead to longer stays in the hospital.
- Ensure that psychiatric units have or are able to quickly access required medical equipment.
- Consider requiring Nurses Improving Care of Health System Elders (NICHE) certification for nurses working with older adults.
- Provide training for staff in rehabilitation and nursing/group home settings that require skills in order to serve patients with recent acute psychiatric and medical needs.

6. Financing/Payer Issues

- Work with insurance companies to determine if and why insurance companies won't reimburse for two kinds of care on the same day (e.g., explaining that while it may be more expensive due to equipment, testing, staffing ratios, and other physician involvement as consultants, the patient is receiving a more comprehensive service on a psychiatric unit).
- There would be a need for a different payment mechanism, other than global per diem rates, and increased payment which would allow psychiatric units to fully cover the costs of care provided.
- Determine if the process for obtaining authorization can be simplified and integrated when admitting a person in need of acute psychiatric hospitalization and ongoing medical care for complex medical comorbidity (e.g., having separate medical and psychiatric UR criteria which may take hours or days to resolve).
- Work with payers to individualize the length of stay for those patients in need of care for those with tubes, complicated wounds, infections, IV antibiotics, and hydration for short periods of time; with eventual reintegration into therapeutic milieu when physically well enough.