Commonwealth of Massachusetts

Executive Office of Health and Human Services

ED Length of Stay Issues for Behavioral Health Patients

January 2, 2013

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Overview

- EOHHS is aware that behavioral health patients in emergency departments can face long delays waiting for disposition to appropriate settings for behavioral health care
- EOHHS has reviewed information on this topic, including information provided by stakeholders, data reported by hospitals to the Department of Public Health, and studies published in the academic literature
- EOHHS has identified strategies that could potentially improve the care system for behavioral health patients, and would like to obtain input on these strategies

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Outline

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

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Background

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

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Data from Massachusetts

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

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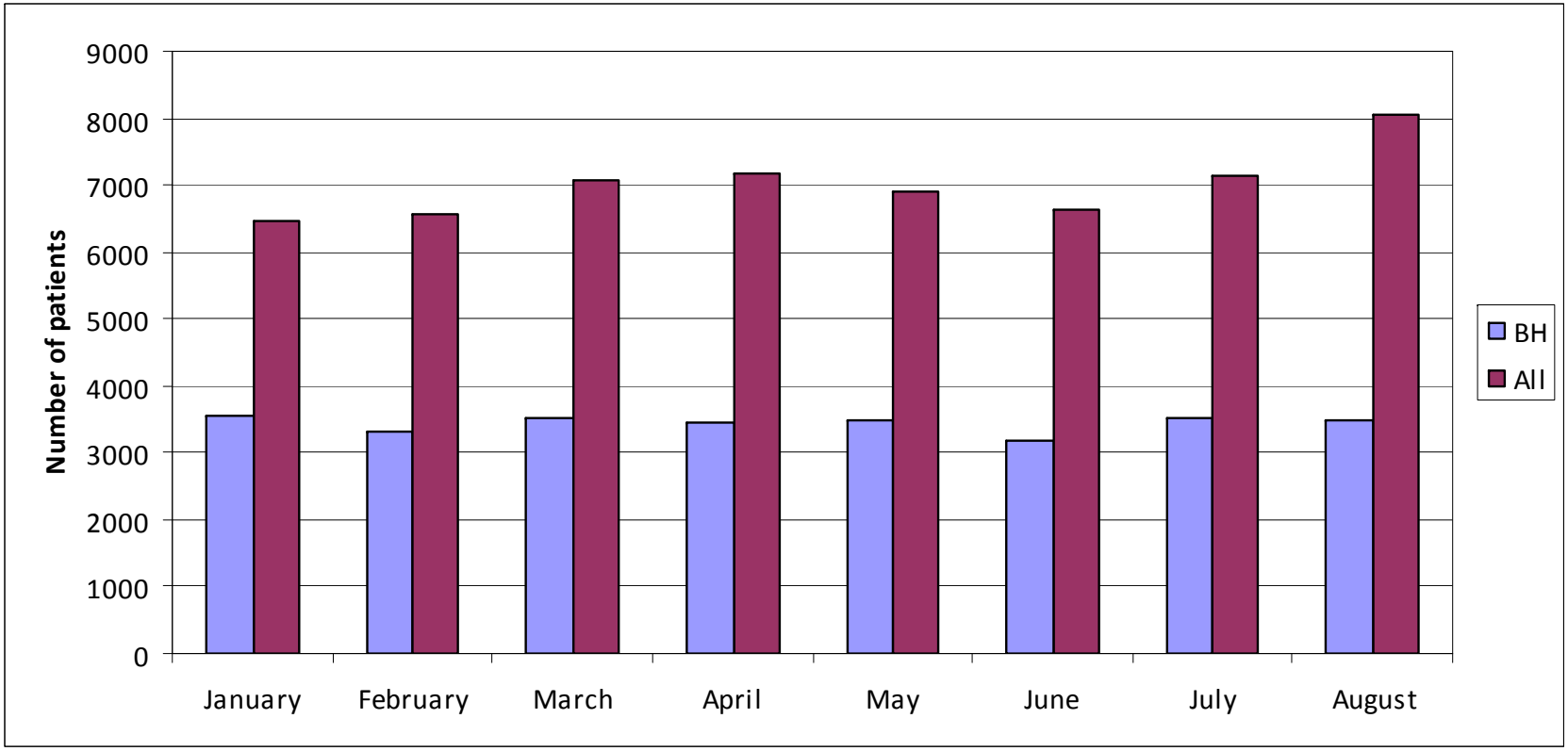
ED patients waiting 12 or more hours after a disposition decision (2012)



Care system for behavioral health patients

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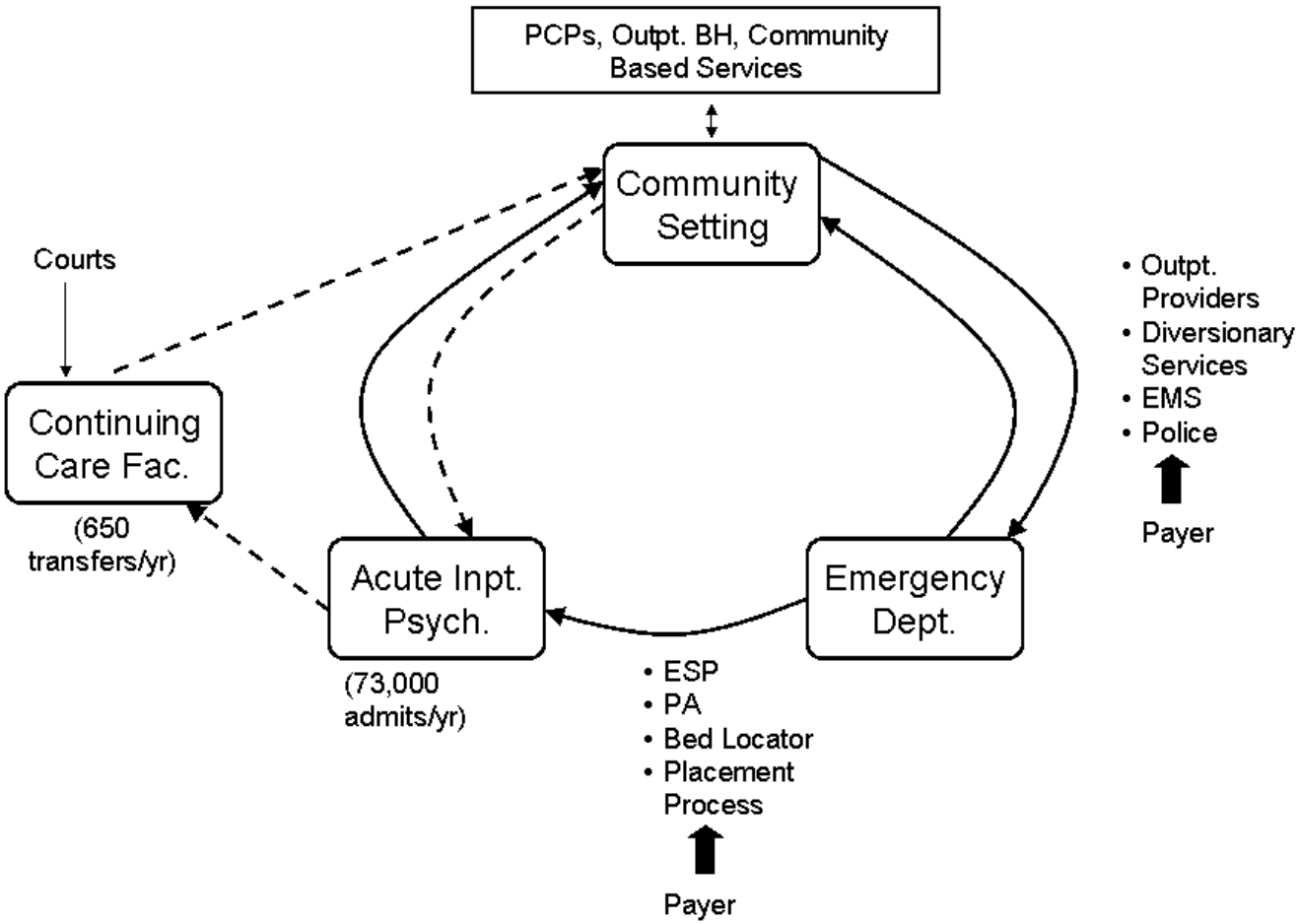
- Delays for patients awaiting discharge from the ED to appropriate settings for behavioral health care reflect only one point in a complex system



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Proposed policy statement

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

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Current activities

EOHHS and its agencies have been committed to addressing the issue in a serious and multi-faceted way. Activities include:

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

Principles and expectations for moving forward

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

Strategies for your input and feedback

- EOHHS has identified eight strategies that could potentially improve the care system for behavioral health patients, and would like to obtain your input on these strategies

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1. Create a mechanism for capturing information about facilities that show a pattern of declining patients

- We propose to establish a mechanism to receive reports from plans and providers who notice a pattern of refusal on the part of a facility
- Reports will be reviewed and will help the Commonwealth understand the context for refusals
- If warranted, reports can lead to review to ensure that facility is meeting current licensing requirements
- In addition, MassHealth is working with all MCEs to ensure that the contractual “no reject” policy is being enforced

2. Prohibit prior authorization requirement in MCE contracts

- MassHealth seeks to contractually prohibit any requirement by the MCE's for ESPs to obtain prior authorization from the MCE for inpatient psychiatric admissions.

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3. Strengthen community-based intervention

- ESPs play an important role in community-based intervention.
- ESPs currently report data on the percentage of visits they provide in community-based settings. We propose to work with MCEs and other payers to increase this percentage, and to potentially link payment incentives to this measure.
- To be successful, this strategy would require education of patients and providers about the availability of ESP services and partnership with a wide range of stakeholders to raise awareness about the role of ESPs in the community.

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

- To facilitate the discharge of patients from acute inpatient psychiatric facilities that are referred for continuing care, we will assign DMH staff to assist with discharge planning for all patients who are referred to DMH continuing care hospitals.
- This will help identify patients earlier who might potentially be better served with appropriate community placements as well as to prevent delays in the transfer process for those patients who do require continuing care.

5. Restructure MassHealth rapid admission incentive

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- MBHP pays hospitals an incentive payment for rapid admissions; however, the impact of this incentive appears to be limited.
- MassHealth would like to explore with providers how this incentive could be restructured to be more effective.

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6. Expand use of bed-finding tool

- MBHP has a web-based system to track availability of acute care beds and other behavioral health services.
- We would like to partner with providers to educate about the availability of bed finding tool.

7. Evaluate payment structure for psychiatric care

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- Evaluate payment structure to consider introducing risk adjustment or adjustments based on complexity
- This process should include significant stakeholder consultation and research and analytics to understand the impacts of these changes

8. Review licensing requirements for psychiatric units

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- Review potential for use of licensing authority to address admission delays including making changes to regulations where warranted
- This process should include significant stakeholder consultation and research and analytics to understand the impacts of these changes

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Discussion

- Feedback
- Next steps

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Selected Reference List

National statistics:

- Slade EP, Dixon LB, Semmel S. Trends in the duration of emergency department visits, 2001-2006. *Psychiatr Serv*. 2010; 61:878-884.
- American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey 2008. Psychiatric Boarding Summary. Available at: http://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/PsychiatricBoardingSummary.pdf.
- Owens PL, Mutter R, Stocks C. *Mental Health and Substance Abuse Related Emergency Department Visits Among Adults in 2007*. HCUP Statistical Brief 92. Agency for Healthcare Research and Quality; 2010. Available at: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf.

Recent studies:

- Chang G et al. Characteristics of adult psychiatric patients with stays of 24 hours or more in the emergency department. *Psychiatr Serv*. 2012; 63:283-286.
- Weiss AP et al. Patient and practice-related determinants of emergency department length of stay for patients with psychiatric illness. Annals of Emergency Medicine 2012; 60(2): 162-171.e5

Summary reports:

- Government Accountability Office. Hospital emergency departments: crowding continues to occur, and some patients wait longer than recommended time frames. GAO 09-347. 2009. Available at: http://www.gao.gov/assets/290/289048.pdf
- Bender D, Pande N, Ludwig M. A Literature Review: Psychiatric Boarding. The Lewin Group. October 29, 2008. Available at: http://aspe.hhs.gov/daltcp/reports/2008/psybdlr.htm