Massachusetts Behavioral Health Partnership
Written Comment to the
Department of Mental Health's
Inpatient Study Commission
June 19, 2009

The Massachusetts Behavioral Health Partnership (MBHP) has served as the behavioral health vendor for MassHealth's Primary Care Clinician (PCC) Plan since 1996. In that role, we manage a statewide network of behavioral health providers (all levels of care) who serve over 100,000 persons a year. MBHP also manages the Emergency Services Programs in most areas of the state.

MBHP Cost and Service Utilization Data for DMH Involved Persons

As shown in the table below, in FY 2008 there were an average of 5,508 persons who were receiving services from DMH who were also enrolled in the PCC Plan, and as a result received their behavioral health benefit through MBHP. MBHP expended $47.7 million providing behavioral health services to these DMH involved persons during FY 2008. Nearly six out of every ten dollars ($28.3M or 59.3%) expended by MBHP for services on behalf of DMH involved persons were for Inpatient (IP) services in acute care hospitals.

Cost and Service Utilization Data for DMH Involved Persons With MBHP Managing Their Behavioral Health Benefit FY 2008	
Average Number of DMH Involved Persons Enrolled with MBHP	5,508
Number of DMH Involved Persons Using BH Services Funded by MBHP in FY 2008*	5,788
Total Cost of BH Services for DMH Involved Persons	$ 47,749,848
Average Cost per DMH Involved Person Who Used BH Services Funded by MBHP	$ 8,250
Cost of Inpatient Services Used by DMH Involved Persons	28,318,468
Number of DMH Involved Persons Using Inpatient (IP) Services	1,494
Number of IP Units of Service Used by DMH Involved Persons	41,938
Average Number of IP Days per User of IP Services	28
Average Cost per DMH Involved Person Who Used IP Services	18,955

* Due to movement into and out of the PCC Plan during the course of the year, the total number of DMH Involved Persons utilizing services paid for by MBHP is greater than the average number of DMH Involved Persons enrolled with MBHP on a given day.

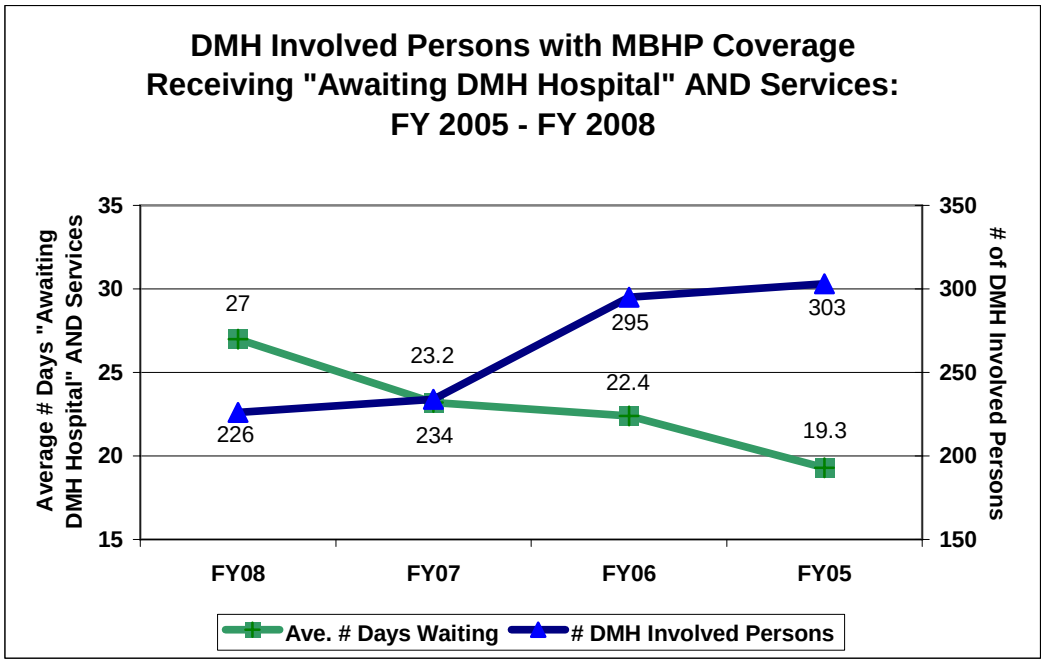
Fifteen percent (226 of 1,494) of the DMH Involved population who used IP services during FY 2008 received some services under a category known as "Awaiting DMH Hospital" Administratively Necessary Day (AND) Services. The vast majority (95%) of persons receiving services under this category were adults.

This category of service is reserved for MBHP members who have been in an acute inpatient hospital and a determination has been made that they will need DMH continuing care services in a community-based program or hospital. In FY 2008 there were 226 DMH Involved Persons who received such services funded by MBHP. The average length of stay in these services was 27 days.

Cost and Service Utilization Data for DMH Involved Persons Awaiting DMH Community Based or Hospital Placement Administrively Necessary Day (AND) Services FY 2008	
Number of DMH Involved Persons Using Administratively Necessary Day (AND) Services	$ 226
Cost of Administratively Necessary Day (AND) Services for DMH Involved Persons	$ 3,683,301
Number of Administratively Necessary Day (AND) Services Used by DMH Involved Persons	$ 6,104
Average Number of Administratively Necessary Day (AND) Services per User of These Services	$ 27

In addition to the 226 DMH Involved Persons awaiting placement in a community based or hospital placement, there were 51 MBHP members who were not yet receiving DMH case management services but were awaiting placement in an acute setting for a DMH funded community based or hospital program. These persons averaged 19 days in an acute setting while awaiting DMH placement.

The chart below illustrates that the number of MBHP members who are DMH Involved Persons and who have been awaiting placement in a DMH continuing care service in a community-based program or hospital has decreased by 25% over the past four years: from 303 persons in FY 2005 to 226 in FY 2008. This downward trend in the number of persons awaiting placement has been offset by a near 40% increase in the average number of days awaiting placement: from 19.3 days in FY 2005 to 27 days in FY 2008.



These figures are for DMH involved persons who receive behavioral health services through MBHP. Some DMH involved persons may have other insurance so DMH figures on persons waiting and number of days waiting will necessarily differ. MBHP does not have information on these persons.

MBHP works closely with DMH Central and Area Offices to coordinate DMH services with those offered through MBHP.

Changes in type or amount of services delivered by one entity impact all other services and the consumers who depend on them. In the past several years, both DMH and MassHealth (through MBHP) have worked to substantially strengthen community-based, recovery oriented services. MBHP has also worked with many stakeholders to both ease access to acute IP care when needed, and assure that no one stays in an inpatient setting longer than necessary. Helping persons move more easily through the IP system has, effectively, produced increased acute IP capacity. These activities and approaches, detailed below, may be interesting to the Commission in your deliberations as you consider how to best support the DMH continuing care system.

Potential Impacts/Pressure Points if DMH Inpatient Capacity Changes

Most consumers entering the DMH continuing care system do so at the conclusion of a course of treatment in an acute IP setting. DMH has worked very hard with the inpatient units providing that acute care to improve the timeliness of the intermediary care assessments and DMH eligibility assessments that must be completed and also the response of DMH case managers.

Data provided by DMH to the Commission show that the average days on the waitlist moved from 33 days in July 2007 to 12 in April 2009. If substantially fewer DMH beds were available the DMH must continue its commitment to reduction in wait time and number of people awaiting services

Longer waits in acute settings impact both consumers and treating providers in many ways. Members who are evaluated for DMH services and an intermediary care bed carry a hospital length of stay significantly longer than a member who is discharged directly to the community. This has both programmatic and financial impact on network hospitals.

Financial:

- MBHP's payment structure for IP facilities is weighted by a hospital's average length of stay (ALOS). Expected LOS for a hospital is derived from analysis of a number of risk factors associated with the consumers they serve, including: age; MassHealth aid category: DMH eligibility; and Department of Children and Families eligibility. Homelessness, medical diagnoses, need for specific treatments and other factors also are included.
- DMH clients being considered for DMH services remain at IP acute level longer than members discharged directly to the community and this is factored into the analysis.
- Members awaiting placement are placed on a reduced daily rate.

Programmatic:

- Hospital day programs and milieu treatment are designed for brief focused treatment. Members remaining on a unit while awaiting a different level of care are not necessarily receiving services geared to meet the treatment goals of an intermediary placement.
- The newly reprocured Emergency Service Programs are expected to add further strength to community-based treatment approaches and decrease demands for acute inpatient care. As more care moves into community based settings, acute care providers may adapt their programs to meet the needs of the persons who can only be treated in the acute IP setting.

Increasing Capacity by Facilitating Ready Access to the Correct Level of Care

Timeliness of access to DMH continuing care beds is integral to ensuring access to acute care and to the overall movement of consumers through the larger behavioral health system. Much effort has been made in the past several years to improve movement through the Emergency Services Programs and hospital emergency departments as well as increase access to acute mental health services. These efforts have included DMH's streamlining of the referral process to their continuing care services; work by Department of Children and Families (DCF) and other agencies to decrease the number of children in 24-hour care settings awaiting resolution and disposition (CARD list); and MBHP's Access to Care Workgroup.

Since October 2006, through the MBHP Access to Care Workgroup, approximately 30 representatives from hospital emergency departments (EDs), inpatient mental health

providers, Emergency Service Providers, and trade organizations have worked collaboratively with MBHP to improve the flow of behavioral health consumers through the emergency services system and into acute behavioral health care. MBHP and its partners have implemented many strategies to improve the flow through the ESPs and EDs and access to inpatient care. Through these efforts, we have **maximized availability in the acute system** as evidenced by the following two indicators:

Bed Availability Data
Average daily bed availability has increased in 2009 as compared to the previous two calendar years as displayed in the following table,

Average Daily Bed Availability within The Acute Care System 2007 - 2009		
CY	**Beds on Child/Adolescent Units**	**Beds on Adult Units**
2009	89	129
2008	51	88
2007	52	96

- Child bed availability: 75% increase in bed availability from January to March in 2009 compared to the same months in 2008. (inclusive of inpatient mental health, Intensive Community Based Acute Treatment and Community Based Acute Treatment)
- Adult bed availability: 47% increase in bed availability from January to March in 2009 compared to the same months in 2008. (inclusive of inpatient mental health only)

Individuals Waiting, Usually in an ED, Admission to an Inpatient Psychiatric Unit
As shown in the table below, 14% fewer individuals were reported as having difficulty accessing an inpatient admission during the three month period of February through April 2009, compared to the comparable period a year earlier:

Individuals Reported by Emergency Services Programs (ESP) as Waiting for an Inpatient Admission After All Hospitals Were Called and No Admission Was Secured February through April 2008 vs. February through April 2009 All Payer Sources			
Indicator	**2008**	**2009**	**Difference**
Individuals Reported	1055	905	-150 (-14%)
Average # Identified Per Day	18	15	-3

The reduction in wait time breaks down as follows by age of person waiting placement:

- 38% fewer children
- 32% fewer adolescents
- 9% fewer adults
- 50% more elders (though “n” was small- 20 in 2008 vs. 30 in 2009)

The cumulative impact of the efforts made by DMH, providers and MBHP to improve timely access to all levels of care, from emergency, through acute, and onto community-based or continuing care has increased the capacity of the acute IP system

Strategies to Mitigate Potential Impacts of Changes to the DMH Continuing Care System and Support Continued Movement to a Community Based System of Care

Access and Movement Through the System
Admissions and discharge processes must work efficiently and effectively at each level of care throughout the behavioral health continuum of care so that individuals are able to move through the services they need, at the time they need them, to meet their needs and to ensure that services are accessible to the next person. Of particular relevance to this Commission are the movements:

- Out of acute care and into continuing care
- Out of continuing care and into the community

Consumers can encounter delays in both of these moves as well as in the emergency setting. These delays lead to increased costs and frustrations for consumers, families and providers.

Some of the strategies that MBHP has employed to ensure the efficiency of admissions and discharge processes and the overall flow through the acute care system include the following:

- Multi-stakeholder engagement to identify problems and potential solutions
- Access/admissions process re-engineering and monitoring
- Utilization Management and maximizing capacity

Without knowing specifically the approaches DMH has underway, MBHP, based on the experience described below, offers the following for consideration as DMH look**s** to maximize their continuing care capacity.

Multi-stakeholder Engagement in System Change

- Engagement of providers – Effectively engaging the hospitals at multiple key levels has been critical in identifying and implementing improvements.
- Multi-stakeholder forums: MBHP's Access to Care Workgroup – Bringing together stakeholders from multiple systems, particularly form the various levels of care, has been very effective in improving access to acute care. ESPs, EDs and inpatient providers had not previously worked together on these problems. Cross-systems education was a critical first step. This was followed by an analysis undertaken by team members to understand how coordination and integration between the various parts of the system could improve the movement of consumers through various components of the continuum of care. This work cannot be done in isolation.
- Regional meetings - Meetings in each region that included inpatient providers, ESPs, EDs, DMH and MassHealth have helped educate all parties about the flow through the system and to address issues on a local level.

Access/Admissions Processes
The multi-stakeholder Access to Care Workgroup developed network management strategies to assist inpatient providers in improving their intake/admissions/triage processes. Additionally, as part of MBHP's Utilization Management we worked with providers on treatment and discharge planning processes that contribute to both effective treatment and timely movement to the next level of care.

Accomplishments of inpatient providers to date include:

- Intake forms were reviewed and modified in an effort to streamline the intake process
- Staffing has been adjusted to coincide with high volume times
- One facility decreased the number of staff required to make an admission determinations; Leadership has empowered the admissions team to accept Members without consulting with the units
- MDs are doing the physicals on the units. This process has increased the psychiatrists' comfort with admitting people without medical clearance
- Single room added
- Facility has provided training on how to work more effectively with children who have a PDD diagnosis

Inpatient Provider "Access to Care" Best Practice Forums
In order to share best practices emerging in the acute inpatient system relative to access and flow through the system, MBHP and the Massachusetts Association of Behavioral Health Services cosponsored several training events. The agenda included presentations from three inpatient providers focusing on strategies they have employed to: increase the number of positive admissions decisions; shift the cultures in their facilities to be more responsive to access for our Members; and work with their EDs to minimize medical clearance requirements and procedures. Best practices from the acute system could be shared with the continuing care system, and vice versa, as some would be applicable across systems.

Utilization Management
Treatment capacity can be preserved even if bed capacity is reduced by improving the efficiency of the movement through the system of a majority of members. Reducing the length of stay of most members by a relatively small number of days would increase the treatment capacity of the remaining hospitals. While stays within the continuing care system are substantially longer than in the acute system, helping consumers move more quickly to community based care would help preserve capacity.

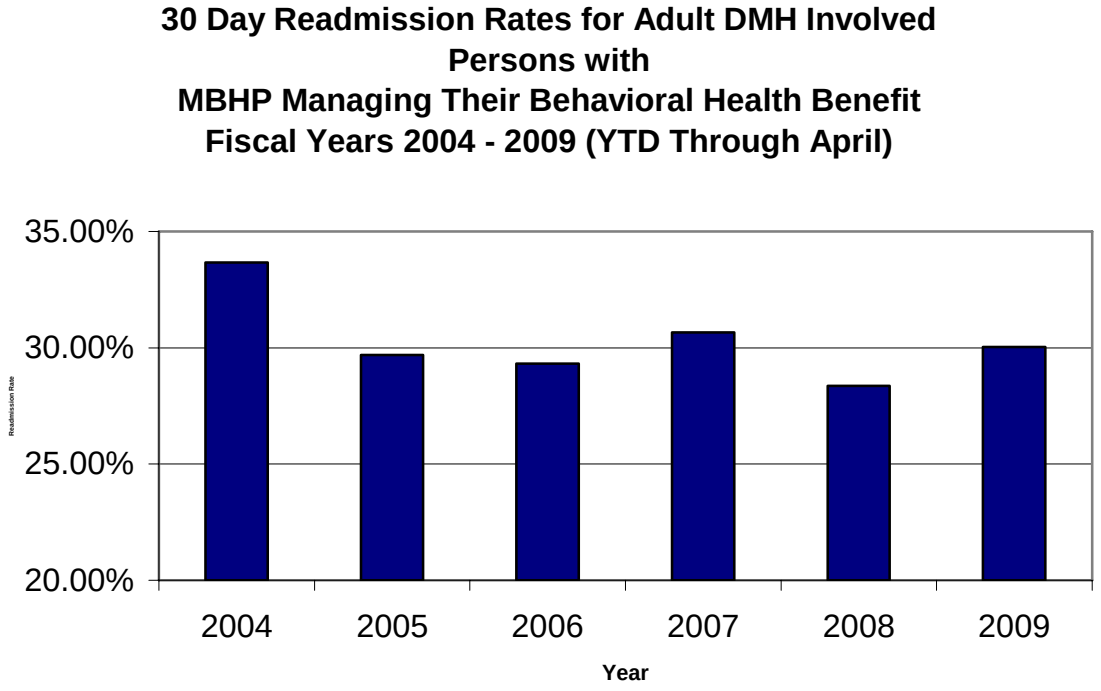
MBHP has taken this UM management approach and has focused on reducing the LOS of the majority of hospitalized members rather than simply focusing on those with the longest lengths of stay. MBHP and our partner hospitals have spent considerable effort improving the efficiency of the IP treatment process. Focused treatment planning , early family contact, early collateral provider collaboration, early discharge planning all done at the beginning of a hospitalization have reduced the length of stay at most hospitals and has actually improved the outcome of the hospitalization as measured by readmission rate. This finding is in contrast to conventional thinking that longer stays always produce better outcomes.

MBHP hospitals are compared directly to one another through a case mix adjustment formula. This comparison is a focal point of our hospital rate strategy.

Rather than simply measuring a hospital ALOS we have found that looking at the % of members discharged with short, moderate, mid range, extended, and outlier lengths of stay provides the best picture of a hospital's treatment efficiency. See attachment 1

Such a system could be adapted to the state hospital system.

Since most members admitted to an intermediary care bed are placed from an acute care hospital, an additional strategy to preserve bed capacity would be to reduce the demand on beds through the reduction of the re-admission of DMH members to acute inpatient hospitalizations. DMH and MBHP began a statewide learning collaborative with the goal to reduce the 30 day readmission rate of DMH members enrolled in MBHP. This project began in April of 2005 and formally ended in November 2007. The 2004 pre-intervention readmission rate was 33.67%. As shown in the chart below, data from 2005 and subsequent years demonstrate a significant drop in DMH readmission rates. The primary intervention was a process by which MBHP notified the DMH regional office of a member's admission to a MBHP network inpatient hospital within one business day of admission. This notification facilitated prompt intervention by the DMH regional team and resulted in better coordination between the acute hospital and community discharge disposition and treatment. At the request of DMH and MassHealth, this notification process has since been adopted across all Managed Care Entities as a best practice.



We have here presented data and suggestions related to increasing access to care, managing length of stay and working collaboratively across agencies, providers and payors to promote effective and efficient use of the acute and continuing care systems. We have not commented on the equally important role of the availability of recovery-oriented, consumer driven community based services in supporting DMH involved persons in their recovery. It is these services that sustain individuals and, when most effective, allow persons to live and thrive in the community and decrease all levels of hospitalization.

Appendix: Bed Availability 2007-2008