Expedited Psychiatric Inpatient Admission (EPIA)

Annual Summary & Next Steps

Department of Mental Health

May 30, 2019
Expedited Psychiatric Inpatient Admission

- February 1, 2018
- Multistakeholder Collaboration
  - MassHealth
  - Department of Mental Health (DMH)
  - Department of Public Health (DPH)
  - Division of Insurance (DOI)
  - Massachusetts Health and Hospital Association (MHA)
  - Massachusetts Association of Behavioral Health Systems (MABHS)
  - Massachusetts Association of Health Plans (MAHP)
  - Blue Cross Blue Shield of Massachusetts
  - Massachusetts Behavioral Health Partnership (MBHP)/Beacon Health Options
  - Children’s Mental Health Campaign (CMHC)
  - Participants from individual providers
Purpose:
- Establish baseline information for long stay ED boarders
- Decrease ED boarding for BH patients needing inpatient level of care
- Decrease the length of stay for ED Boarding individuals
- Ensure no one is boarding without an advocate

Interventions
- Enhance licensing authority through regulatory change
- Create partnerships and shared responsibility among stakeholders
- Develop operational protocols to escalate long stay patients
- Maximize partnership with DOI
- Collect data to measure effectiveness
- Clinical competencies
- Medical Director sign off of rejected admissions
- Unit acuity data
- Payer mix reporting
EPIA – Process Overview

0-48 hours

- Person with a behavioral health issue presents in ED
- Person is assessed by ED staff and/or ESP and needs inpatient level of care
- ED/ESP searches for a bed
- At 24 hours, ED/ESP notifies the insurance carrier that their member is in the ED and they are looking for the bed

48-96 hours

- By 48 hours, if there is no plan in place, ED/ESP submits a formal Request for Assistance to carrier
  If the carrier is MassHealth or an in-state commercial carrier:
  - The carrier receives the Request for Assistance and responds within 2 hours during business hours and the next morning if outside business hours
  - The carrier outreaches to hospitals identified as the most clinically appropriate for the person by the ED/ESP to try and place the person
  - At 96 hours, if there is not a plan in place, the carrier contacts DMH
  If the carrier is ERISA, out of state, or Medicare:
  - The ED/ESP reaches out to the carrier as above
  - If they cannot engage the carrier, the ED/ESP continues to pursue a bed for the person
  - At 96 hours, the ED/ESP contacts DMH

At 96 hours

- Carrier contacts DMH by submitting a referral request using a secure email
- DMH reviews the information and if the issue is clinical, initiates a “doc to doc to doc” conversation
- If the issue appears to be payment, DMH contacts MassHealth or DOI, as appropriate
- DMH will engage other EOHHS agencies, as appropriate
- Data will be collected for use in regulatory compliance
What does DMH do?

- Direct EDs and ESPs to available beds
  - Communication enhancement
  - Connect facilities with beds to ED/ESPs & Carriers
- Break down barriers case by case
  - Contact Directors of Admission, Directors of Nursing, Medical Directors, CEOs etc
    - Lack of Insurance, clinical competencies, acuity,
    - Support aftercare planning
  - Contact specific State Agencies for their involvement
  - Coordinate Agency involvement (conference calls)
  - Follow up with all these activities until placed
EPIA Demographics
510 Requests for Assistance
April 2018 - March 2019

- **Age**
  - 258 or 51% under 18 yo
  - 212 or 41% between 18 and 64 yo:
  - 40 or 8% 65+ yo:
- **Gender**
  - Female: 169 (33%)
  - Male: 325 (64%)
  - Transgender: 12 (2.5%)
- **Race/Ethnicity**
  - White: 51%
  - Black/African American: 13%
  - Asian: 2%
  - Hispanic Latino: 14%
  - Other: 22%
  - Blank: 9%
- **Average time from DMH referral to placement (days)**
  - Overall Average = 1.99
  - Under 18 = 2.19
  - 18 and over = 1.78
Demographics (continued)
510 EPIA Requests in last 12 months

- 62 Different Boarding Emergency Rooms
  - 23 ERs had only 1 DMH request
  - 14 ERs had 10 or more DMH requests
  - St Luke’s 55, Children’s 32, Brockton 25, South Shore 24, Sturdy 23, Milford 22, MGH 21, Lowell 21, Lawrence 20, Charlton 18

- 45 were discharged home, 34 LOC changed
- 431 DMH EPIA admissions
- 54 Admitting Inpatient Facilities (3 Out of State)
  - Cambridge 45, TaraVista 33, Arbour 33, Southcoast 31, Providence 18, Anna Jaques 18, High Point 17, MetroWest 15, Fuller 10, Harrington 10
Expedited Psychiatric Inpatient Admission Dashboard
April 2018 - March 2019 Summary Statistics
Total Number of Referrals – 510

Referrals by Insurance Type All Ages
April 2018 - March 2019

- Commercial (Commercial - In State, Commercial - Out of State, Tricare) = 13%
- Uninsured (Uninsured, Medicaid - Out of State) = 16%
- Managed Medicaid (MBHP PCC Plan, MassHealth ACO/MCO) = 42%
- Unmanaged Medicaid (Health Safety Net, MassHealth Fee for Service, MassHealth Unspecified, Medicare Only, Medicare-Medicaid) = 29%
Expedited Psychiatric Inpatient Admission Dashboard
April 2018 - March 2019 Summary Statistics
Total Number of Referrals – 510

Referrals by Insurance Type Ages 0-17
April 2018 - March 2019
N = 258

- Commercial (Commercial - In State, Commercial - Out of State, Tricare) = 21%
- Uninsured (Uninsured, Medicaid - Out of State) = 4%
- Managed Medicaid (MBHP PCC Plan, MassHealth ACO/MCO) = 69%
- Unmanaged Medicaid (Health Safety Net, MassHealth Fee for Service, MassHealth Unspecified, Medicare Only, Medicare-Medicaid) = 6%
Referrals by Insurance Type Ages 18+
April 2018 - March 2019
N= 252

- Commercial (Commercial - In State, Commercial - Out of State, Tricare) = 5%
- Uninsured (Uninsured, Medicaid - Out of State) = 28%
- Managed Medicaid (MBHP PCC Plan, MassHealth ACO/MCO) = 14%
- Unmanaged Medicaid (Health Safety Net, MassHealth Fee for Service, MassHealth Unspecified, Medicare Only, Medicare-Medicaid) = 53%
Diagnoses
(in descending order of prominence)

• Top 5 Diagnoses for those under 18 yo (N=258)
  o PTSD (24%)
  o Impulse Control/Conduct Disorder (17%)
  o Depression (16%)
  o Autism Spectrum Disorders (9.3%)
  o ADHD (9.3%)

• Top 5 Diagnoses for those 18 yo & older (N=252)
  o Depression (18%)
  o Schizophrenia (16%)
  o Bipolar (16%)
  o Schizoaffective (15%)
  o Dementia (8%)
Uninsured 81 of 510 (16%)

- 90% were 18 yo or older
- Male 66%; Female 30%; Transgender 1%
- Top Diagnoses
  - Schizophrenia, depression, bipolar, other psychotic, schizoaffective
- Top Boarding EDs
  - Mt Auburn, Milford, St. Luke’s, BID Boston, MGH, Sturdy, Brockton, Lawrence, Leominster and SouthShore
- Top Placement facilities
  - Arbour, Southcoast, Harrington, High Point, Anna Jacques, Marlborough, MetroWest, Bayridge, Carney
Barriers to Placement (N=510)

All ages

- Bed Availability (48%)
- Lack of Insurance (13%)
- Aggression (9.2%)
- Medical (6.3%)
- Acuity (unit) (4.5%)
State Agency Involvement
Total N = 188 (37%)

Of the total State Agencies Involved:

- DCF 97 or 51.6%
- DMH 53 or 28.2%
- DDS 30 or 16.0%
- DYS 2 or 1.1%
- IEP 6 or 3.2%
What are we learning?

- Disproportionate Child/Adolescent issue
  - Under 13: bed availability critical
  - Over 13: disposition, aggressive or complicated presentations
- Adults have long boarding stays if
  - No insurance
  - Unmanaged insurance
  - Medical, developmental, and/or aggressive presentation
- Substance Use comorbidity not an obvious issue
- State Agency involvement mostly about youth
  - Majority DCF
  - Youth and Adults equally represented in DDS and DMH involvement
- Need for more efficient Bed Search Processes
- Need Better Communication and Continuity in acute care
- Need to prevent insurance lapses
- Help adults get on insurance (preferably managed care)
Next Steps – EPIA 2.0

- Revise and improve current written protocol
- Improve communication – reliable & electronic
- Standardize Bed Search Protocol after first 24 hours
- Centralize Bed Search System for long stay patients
- Increase level of intervention below 96 hours prior to DMH escalation
- Monitor and enforce DMH Licensing new regulations:
  - Clinical Competencies
  - Medical Director sign off of refusals when there are beds
  - Unit conditions
  - Payer Mix of psychiatric units