Commonwealth of Massachusetts
Executive Office of Health and Human Services

Expedited Psychiatric Inpatient Admission (EPIA) Initiative 2.0

November 14, 2019
Purpose:

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

- Process convened by Secretary Sudders in 2016 to mitigate long waits in EDs for inpatient psychiatric admission (days to weeks)

- Expedited Psychiatric Inpatient Admission (EPIA) Initiative
  - Started on February 1, 2018
  - Escalation process applies to those waiting more than 24 hours in EDs for a psychiatric inpatient bed
  - Process has expectations of Insurance Carriers, Provider Hospitals, EDs, ESPs and State Agencies (DOI, DPH, DCF, DMH, DDS)

- Stakeholders developed an Escalation process by consensus

- Ongoing meetings of the EPIA Implementation Workgroup to identify problems through data analysis and work on solutions

- EPIA 2.0 is the result of more than 1 year of experience, data, and best practices
This process was developed, implemented and redesigned based on data analysis and problems encountered over the last two years by the Stakeholder group convened by DMH and members include:

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

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

- Create shared responsibility among stakeholders
- Escalation Protocol used by all stakeholders
- Maximize partnership with DOI
- Collect data to measure effectiveness
- Enhance licensing authority through regulatory change & subregulatory bulletins:
  - Clinical competencies
  - Medical Director sign off of rejected admissions
  - Unit acuity data
  - Payer mix reporting
EPIA First Year Summary Statistics
Total Number of Referrals – 510

- **Age**
  - Under 18 yo: 258 (51%)
  - Adults between 18 & 64 yo: 212 (41%)
  - Adults over 65yo: 40 (8%)

- **Gender**
  - Female: 169 (33%)
  - Male: 325 (64%)
  - Transgender: 12 (2.5%)
62 Different Boarding Emergency Rooms

23 ERs sent only 1 DMH request

14 ERs had 10 or more DMH requests

Outcome after DMH Referral (N=510):
  - 45 were discharged home & 34 LOC changed (15%)
  - 431 DMH EPIA admissions accomplished (85%)

54 Admitting Inpatient Facilities (3 Out of State)
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%

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%
EPIA First Year Summary Statistics
Total Number of Referrals – 510

Referrals by Insurance Type Ages 18+
April 2018 - March 2019
N= 252

- Commercial (Commercial - In State, Commercial - Out of State, Tricare) – 53% = 132
- Uninsured (Uninsured, Medicaid - Out of State) – 28% = 71
- Managed Medicaid (MBHP PCC Plan, MassHealth ACO/MCO) – 14% = 36
- Unmanaged Medicaid (Health Safety Net, MassHealth Fee for Service, MassHealth Unspecified, Medicare Only, Medicare-Medicaid) – 5% = 13
Diagnoses
(in descending order of prominence)

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

- **Top 5 Diagnoses for those 18 yo & older (N=252)**
  - Depression
  - Schizophrenia
  - Bipolar
  - Schizoaffective
  - Dementia
Of the total State Agencies Involved:

- DCF  97 or 51.6%
- DMH  53 or 28.2%
- DDS  30 or 16.0%
- DYS  2 or 1.1%
- IEP  6 or 3.2%
Barriers to Placement (N=510)

All ages

- Bed Availability (8%)
- Lack of Insurance (13%)
- Aggression (9.2%)
- Medical (6.3%)
- Acuity (unit) (4.5%)
Summary: What we learned

- Disproportionate Child/Adolescent issue
  - Under 13: bed availability critical
  - Over 13: disposition, aggressive or complicated presentations

- Adults have long boarding stays if
  - No insurance
  - Unmanaged insurance
  - Medical, developmental, and/or aggressive presentation

- State Agency involvement mostly about youth
  - Majority DCF
  - Youth and Adults equally represented in DDS and DMH involvement

- Need for more efficient Bed Search Processes
- Need Better Communication
- Need to prevent insurance lapses
- Help adults get insurance (preferably managed care)
Changes for EPIA 2.0 Protocol - Principles

- Escalation process MUST start by 24 hours
- Special Services Billing Codes for single room, 1:1 or extra staff etc required for admission by a facility adhered to by Carriers and authorization documented
- For timely clinical communication, a point person MUST be identified for each shift at the ED and ESP level
- Use of a standard bed search protocol by all
- When family preference limits bed search, DMH will still get involved at 96 hours
- DMH will consider pre-96 hour escalations on a case by case basis due to complexity, history of previous long ED stay etc
Changes for EPIA 2.0 Protocol--Carriers

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

Use of the Standard Bed Search Protocol for bed searches

Use of Adobe when submitting referral to DMH

ED and/or ESP clinical and administrative leaders will contact clinical and administrative leaders at the Provider Facilities

Expectation that senior leaders work within their hospital network/system to place boarder

Active efforts by the ED to assist in the application for MassHealth for those uninsured

Escalation efforts by the ED and ESP will be documented and sent to DMH when escalating to DMH for help
How does it work – the first 24 hours

- When a person in need of inpatient psychiatric hospitalization goes to an ED, they are seen by the ED staff, and in some cases by an ESP provider.

- The ED and/or ESP determines that a person needs to be hospitalized and works to find an appropriate placement.

- If the person is not placed within 24 hours, the ED/ESP must let the person’s Insurance Carrier know that they are looking for a placement which activates Carrier assistance:
  - The Carrier uses its internal processes for finding a placement and provides any useful information to the ED/ESP including recent hospitalizations.
  - The Carrier is expected to decrease barriers to admission including but not limited to authorizing and paying for special services and going out of network.
  - The Carrier works within, and if needed, outside of its contracted network, to secure an appropriate placement.
How does it work – 24 to 96 hours

If the person is not placed by 24 hours:

- The ED/ESP makes a formal Request for Assistance to the insurance Carrier
  - This Request may be made before 24 hours but MUST by 24 hours
  - The Carrier responds within 2 hours during business hours and by the next day when contacted after hours or on weekends
  - The Request gives the carrier information about the person’s condition, what has been done so far, and the barriers to finding a placement

- The Carrier works closely with the ED/ESP to determine the best placement options for the person

- The Carrier works with leadership at inpatient units and provides specialing and single room authorization, etc to ensure admission
How does it work – by 96 hours

If the person is not placed by 96 hours:

- The Carrier contacts DMH by submitting an online referral using the latest Adobe software through a secure web site.
- The Carrier provides detailed information about what has happened so far and the person’s current situation and barriers to placement.
- Ongoing bed search work is coordinated and pursued by all parties.
- DMH coordinates calls with senior clinical & administrative staff from the Carrier and hospital(s) to identify and resolve clinical barriers to placement.
- Barriers related to payment, coverage or network access are referred to MassHealth or to DOI, as appropriate.
- DMH initiates ongoing calls with involved parties, including other state agencies, as appropriate, until placement.
Some insurance Carriers are regulated by the state and some are not
- They are regulated by other states or the federal government

The Carriers regulated by MA will be required to use these processes

EDs/ESPs will use the same process with all Carriers whenever possible

<table>
<thead>
<tr>
<th>Regulated by Massachusetts</th>
<th>Not Regulated by Massachusetts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• MassHealth (Medicaid)</td>
<td>• Other states’ Medicaid plans</td>
</tr>
<tr>
<td></td>
<td>• Medicare</td>
</tr>
<tr>
<td>• In-state commercial carriers</td>
<td>• Self-Funded / ERISA plans*</td>
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<tr>
<td><strong>Examples:</strong></td>
<td>• Other states’ commercial carriers</td>
</tr>
<tr>
<td>• Blue Cross Blue Shield (BCBS) of MA</td>
<td><strong>Example:</strong></td>
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<tr>
<td>• Tufts Health Plan</td>
<td>• Blue Cross Blue Shield of Minnesota</td>
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<tr>
<td>• Harvard Pilgrim</td>
<td>• National Insurance Carriers</td>
</tr>
<tr>
<td>• National Insurance Carriers offering fully insured products in Massachusetts: e.g. some Cigna, Aetna, UnitedHealthcare offerings</td>
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</tbody>
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* Some of these plans are through in-state commercial carriers (e.g. BCBS of MA). Even when that is true, they are not regulated by the MA Division of Insurance (DOI)
If a Carrier isn’t involved

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

- The ED/ESP will continue to look for a bed while activating their leadership’s help through an *Internal Escalation Protocol*

- At 96 hours, if there is not a secured bed, the ED/ESP contacts DMH by submitting an online referral using the latest version of Adobe software using a secure web site and provide the same information that a Carrier would receive and send in this process

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

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

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

Please send additional questions to:
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