The Commonwealth of Massachusetts

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February 11, 2025

Kate Walsh, Secretary of Health and Human Services
Joint Committee on Mental Health, Substance Use and Recovery
Joint Committee on Health Care Financing

On behalf of the Expedited Psychiatric Inpatient Admission (EPIA) Advisory Council, pursuant to Section 26 of Chapter 177 of the Acts of 2022, I am pleased to submit the Department's 2023 Annual EPIA Advisory Council Report.

The Council was charged with investigating and recommending policies and solutions regarding the emergency department boarding of patients seeking mental health and substance use disorder services. The attached report summarizes the data collected on the number of patients boarding in emergency departments identified by age, gender identity, race, ethnicity, insurance status, diagnosis and reason for the delay in admission; and includes recommendations for reducing boarding in emergency departments and any suggested legislative or regulatory action to implement those recommendations, which shall include, but not be limited to, requirements for the delivery system to operate on a 24 hour a day, 7 days a week basis for admissions and discharges and penalties for noncompliance.

Please do not hesitate to contact me if you need additional information.

Sincerely,

Brooke Doyle

Brooke Doyle, M.Ed., LMHC
Commissioner

cc: Katherine O'Reilly, Budget Director

THE OFFICE OF

GOVERNOR MAURA T. HEALEY

LT. GOVERNOR KIMBERLEY DRISCOLL

Kathleen E. Walsh
SECRETARY OF THE EXECUTIVE OFFICE
OF HEALTH AND HUMAN SERVICES

Brooke Doyle
Commissioner

2023 Annual Expedited Psychiatric Inpatient Admission (EPIA) Advisory Council

February 2025

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

Annual Report to the Legislature from the

Expedited Psychiatric Inpatient Admission (EPIA)

Advisory Council

December 31, 2023

Introduction

Formation of the Advisory Council and Its Charge

This is the first annual report of the Expedited Psychiatric Inpatient Admission (EPIA) Advisory Council, which was established within the Department of Mental Health by Chapter 177 of the Acts of 2022. The Council and its responsibilities are described in Chapter 177 as follows:

(a) This Council is charged to investigate and recommend policies and solutions regarding the emergency department boarding of patients seeking mental health and substance use disorder services. The advisory council shall:

(i) implement the expedited psychiatric inpatient admissions (EPIA) protocol, as established by the department;

(ii) collect data on the number of patients boarding in emergency departments and the reasons for extended wait times, including capacity constraints; and

(iii) make recommendations for measures to reduce the wait times for admissions.

(b) The advisory council shall consist of the following members: the commissioner of mental health or a designee, who shall serve as chair, the commissioner of public health or a designee; the director of the office of Medicaid or a designee; the commissioner of insurance or a designee; a representative from the Massachusetts Association of Health Plans, Inc.; a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; a representative of the Massachusetts Health and Hospital Association, Inc.; a representative of the Massachusetts College of Emergency Physicians, Inc.; a representative of the Association for Behavioral Healthcare, Inc.; a representative of the National Alliance on Mental Illness of Massachusetts, Inc.; a representative of the Massachusetts Association of Behavioral Health Systems, Inc.; a member representing emergency services providers; and a consumer representative with lived experience boarding in an emergency department. See attached Council Membership (Appendix #1).

(c) Annually, not later than December 31, the advisory council shall file a report with the secretary of health and human services, the joint committee on mental health, substance use and recovery and the joint committee on health care financing. The report shall:

(i) summarize the data collected on the number of patients boarding in emergency departments identified by age, gender identity, race, ethnicity, insurance status, diagnosis, and reason for the delay in admission; and

(ii) include recommendations for reducing boarding in emergency departments and any suggested legislative or regulatory action to implement those recommendations, which shall include, but not be limited to, requirements for the delivery system to operate on a 24 hour a day, 7 days a week basis for admissions and discharges and penalties for noncompliance.

Boarding of Persons in Emergency Departments (EDs)

Each day residents of the Commonwealth in need of inpatient psychiatric hospitalization wait in hospital emergency departments (EDs) for extended periods of time, a situation known as ED Boarding. State Agency Partners (the Executive Office of Health and Human Services (EOHHS), its Department of Mental Health (DMH), Department of Public Health (DPH) and Office of MassHealth and the Executive Office of Economic Development (EOHED) and its Division of Insurance (DOI)), are committed to addressing the Commonwealth's ongoing crisis of ED boarding. These partners support the EPIA Protocol that identifies and resolves barriers to psychiatric admission on a case-by-case basis.

This Protocol is the product of the 2017 Expedited Admissions Task Force which was comprised of state agency leaders, emergency department clinicians, hospital and insurance trade organizations and was formed to establish clear steps and responsibility for escalating cases to senior clinical leadership at Insurance Carriers, Inpatient Psychiatric Providers, and ultimately to DMH. The resulting EPIA protocol was issued in the Division of Insurance (DOI) Bulletin 2018-01: **Prevention of Emergency Department Boarding Patients with Acute Behavioral Health and/or Substance Use Disorders Emergencies** co-signed by the DOI, DPH, and DMH Commissioners. This Bulletin was updated in DOI Bulletin 2021-07 (See **Appendix #2**). The protocol provides for active intervention and escalation of ED Boarding cases along prescribed time frames, with particularly difficult cases ultimately escalated to DMH for assistance. The collaboration of the Task Force continues through the work of the Council whose members and other key constituents work closely together to decrease the length of time behavioral health patients board in EDs waiting admission to an inpatient psychiatric hospital. This effort relies on early and continuous communication by all parties involved.

This report outlines the ED Boarding data collected and analyzed by the Council during the reporting period and provides recommendation for further action to address the ongoing phenomenon of ED Boarding.

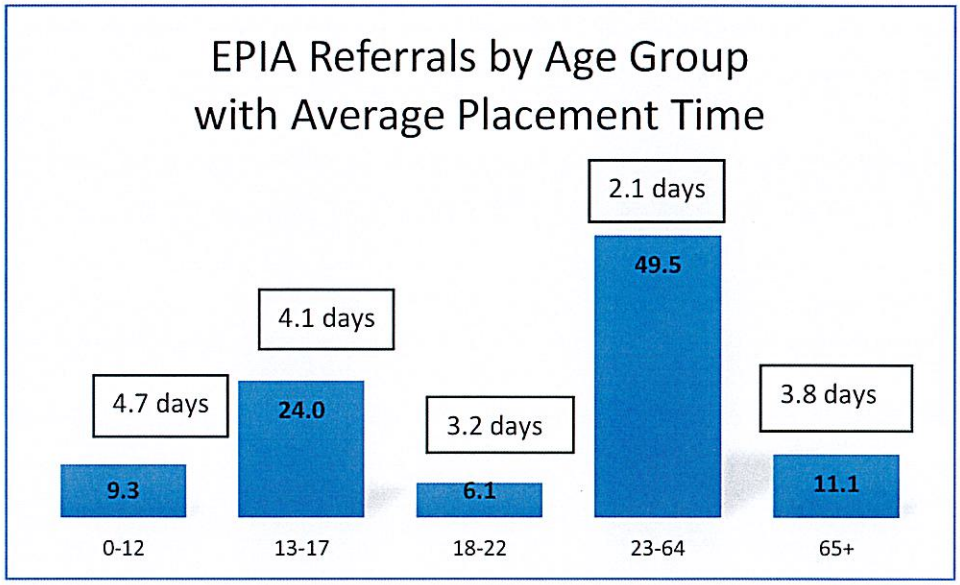
Data Review

CY2023 Data limited to February through September 2023

Starting in February 2023, EPIA referral and data collection moved to a web-based application, which allows for real time data collection and analysis. Additionally in February 2023, EPIA increased the scope of referrals per Chapter 177 of the Acts of 2022. See **EPIA Protocol 2023** (**Appendix #3**). Youth under 18 years old are escalated to DMH within 48 hours of boarding while adults are referred to DMH at 60 hours; further any youth or adult admitted for medical care and then requires inpatient psychiatric level of care will be escalated to DMH comparable to those boarding in EDs. Data from February 2023 through September 2023 is presented herein. Overall numbers of referrals during this 8-month period are disaggregated by age and other demographic characteristics to better understand the youth and adult populations in terms of the requirements for this report.

Data Summary

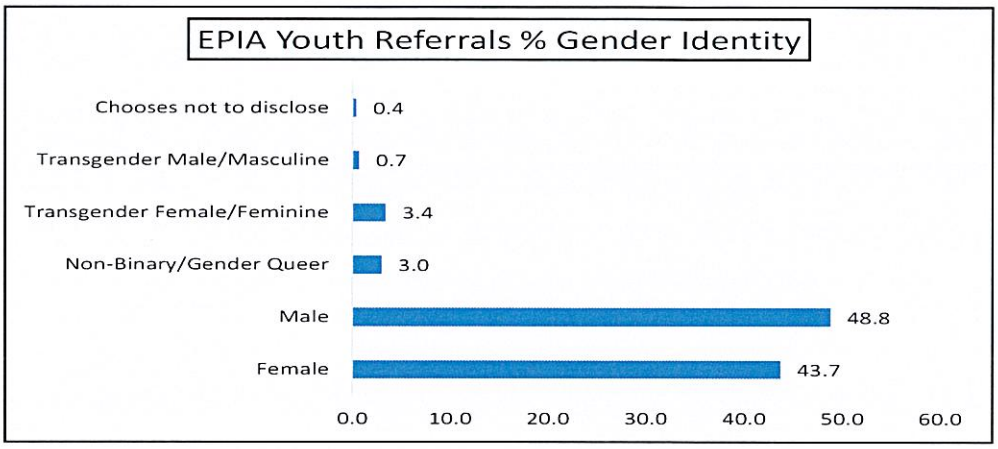
There was a total of 3,745 referrals for EPIA assistance over the 8-month period. One-third (33.3%) of the referrals were for youth under 18. The largest proportion of referrals are aged 23-64. The average placement time was 3.1 days. As displayed below, the age group (23-64) with the largest percentage of referrals (49.5%) had the shortest time to placement (2.1 days). All youth referrals had placement times higher than the 3.1 day referral average.



The data summary sections following describe the youth and adult referrals by gender identity, race, Hispanic ethnicity, insurance status, diagnosis, and the barriers to placement responsible for extended wait times. Further, the average wait time is examined by diagnosis and by barriers to placement separately for youth and adults.

EPIA Youth Referrals

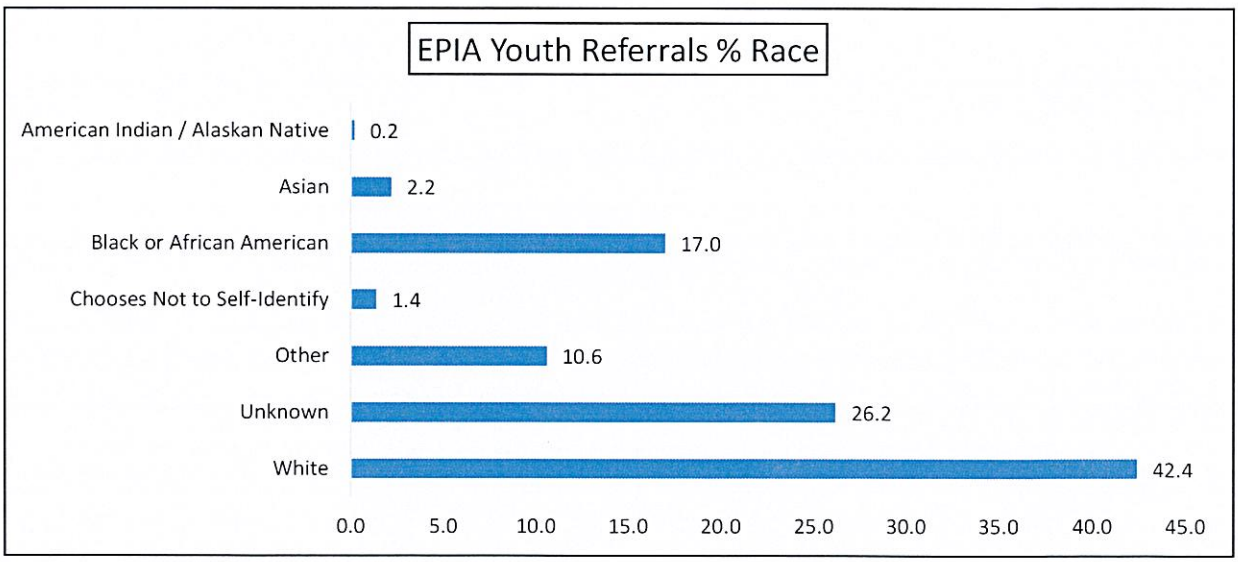
Gender Identity



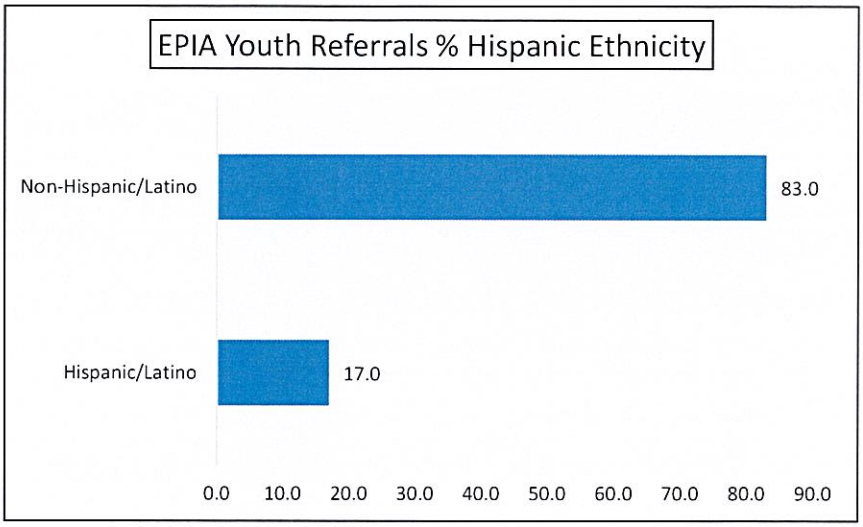
When disaggregating data by Gender Identity, generally, referrals for youth under 18 are closely equivalent in number and percentage (545 female and 608 male; 43.7% and 48.76% respectively). Non-binary or gender queer youth make up 3% of referrals. Transgender youth represent a total 4.1% of referrals.

Race and Ethnicity

Youth whose cases were referred to EPIA, are predominantly White (42.4%), 17% are identified as African American, and 2.2% are identified as Asian. These percentages can only be presented for those referrals whose racial identity was recorded. Unfortunately, 38.2% of the EPIA referrals did not record race in the demographic questions. Because of the high rate of non-reporting of race, it is more difficult to understand how this data compares to the Massachusetts population and thus advise EPIA health equity efforts.

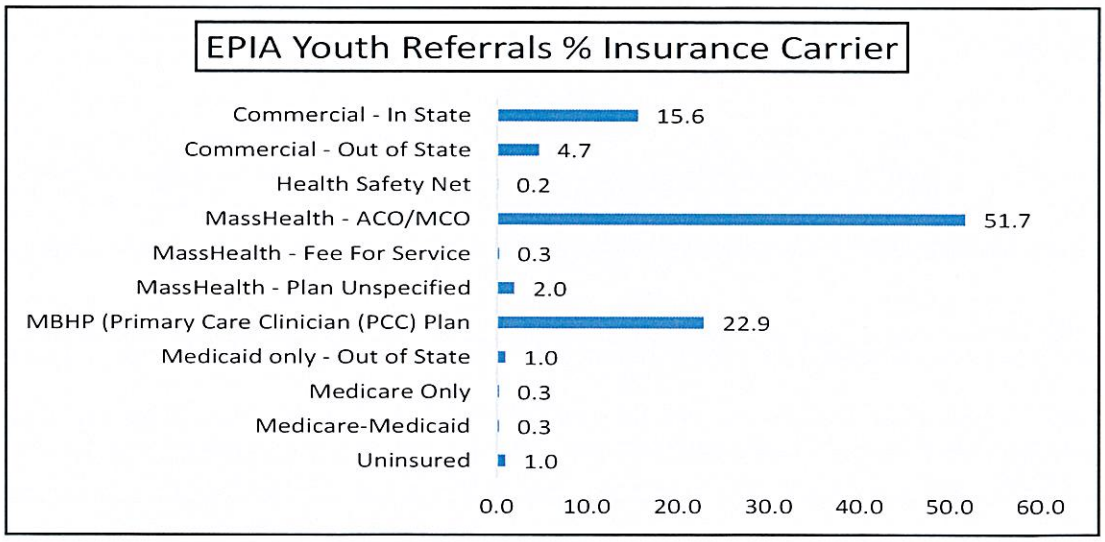


17% of youth referred to EPIA referrals identify as Hispanic or Latino.



Type of Insurance Coverage

The EPIA protocol requires that Insurance Carriers have a mechanism of being informed by EDs that one of their constituents is boarding while waiting for an inpatient psychiatric admission. This notification to the Insurance Carriers must occur within 24 hours of an ED Boarding episode. This allows the carriers to work with ED Behavioral Health Evaluation Teams and their administrative leaders to compile the information that may help with getting a successful admission or to work with the administration of both the Evaluation team and the Insurance Carrier's network of provider hospital clinical administration teams to advocate for admission of each individual boarding in the ED.

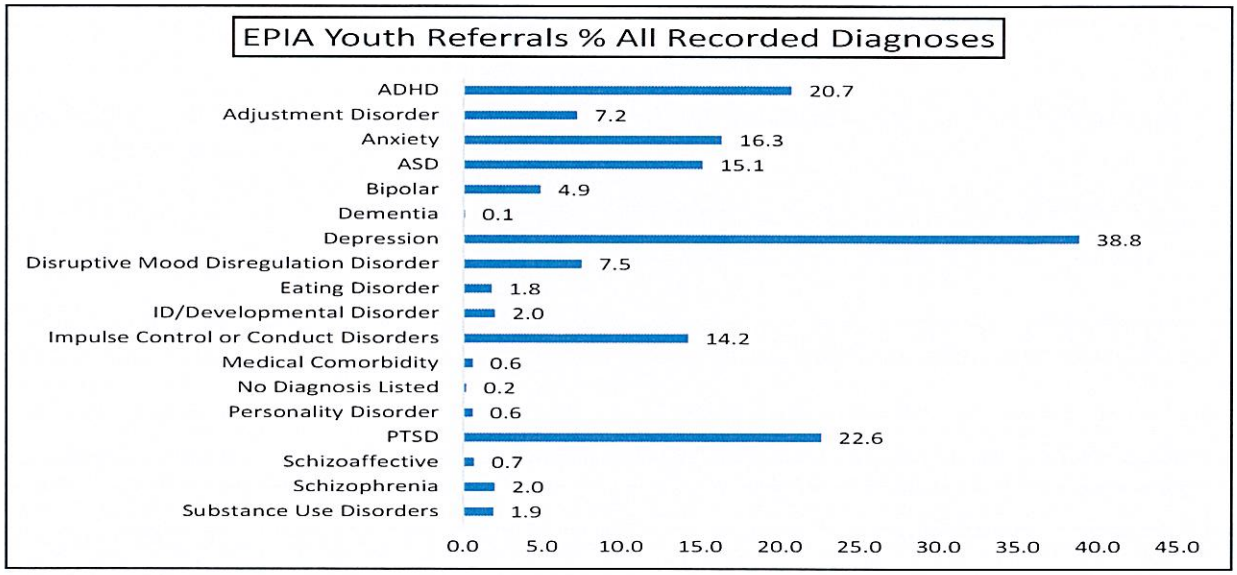


For the youth cases referred to EPIA and boarding in EDs for two days or longer, a total approximating 78% were primarily covered by Managed Medicaid while 20% were covered by

Commercial Carriers (including both insured health plans and self-funded employment-sponsored plans).

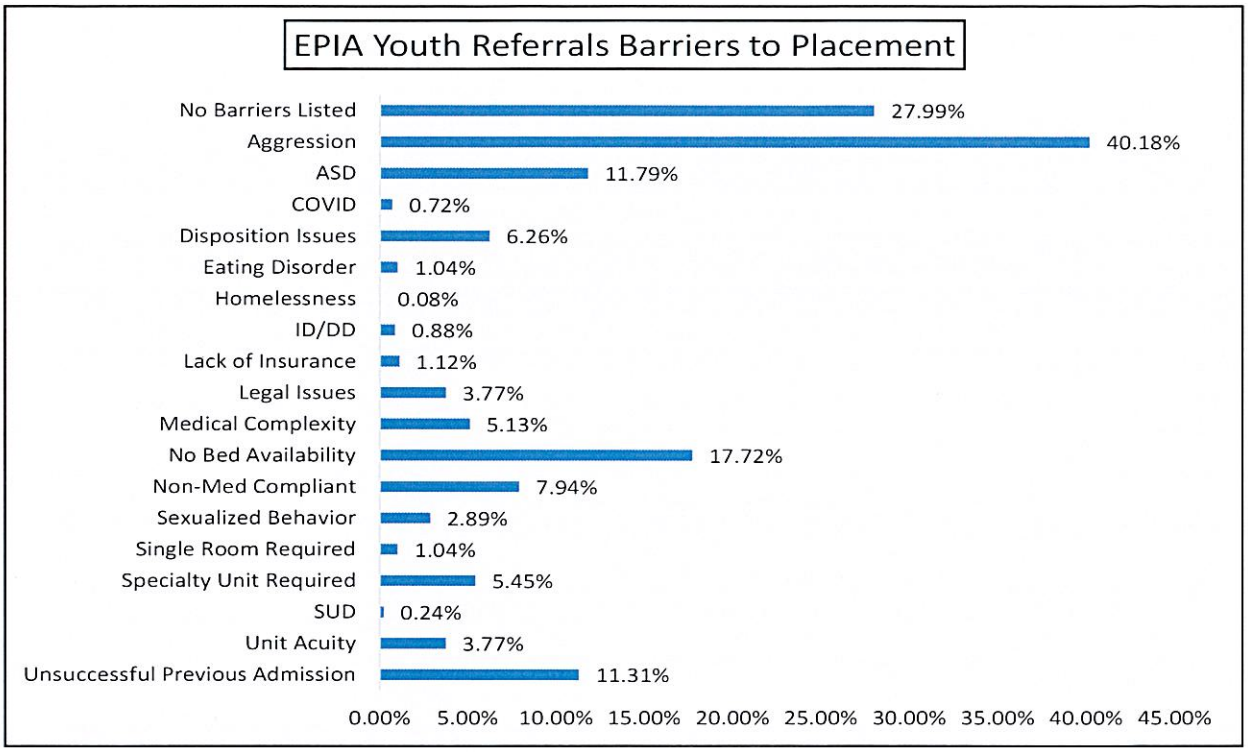
Diagnosis

Since more than one diagnosis can be recorded, each diagnosis is presented here as the percentage of the total times any diagnosis was recorded. This approach displays the relative importance of each diagnosis for youth referred to EPIA. As seen below, the diagnoses most often recorded include (in descending order of frequency): Depression (38.8%), PTSD (22.6%), ADHD (20.7%), Anxiety (16.3%), Autism (15.1%), and Impulse Control/Conduct Disorder (14.2%).



Barriers to Placement (Reason for Delay in Admission)

For youth, barriers to placement in descending order of frequency include Aggression (40.2%), No Barrier identified (28%), No bed Available (17.7%), Autism (11.8%), and Unsuccessful previous admission (11.3%). Surprising were "no barrier" and "no bed available". These two prominent barriers to admission reflect more a system's problem and are not related to the individual youth's need for acute services.



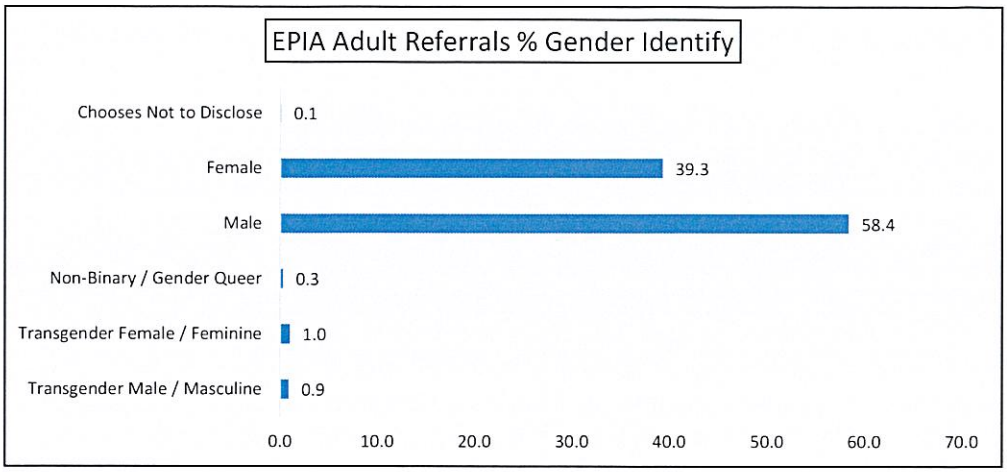
The relationship between the presence of these barriers and time to placement is explored for youth and adults following the description of adults referred to EPIA (see pages 11 and 12).

EPIA Adult Referrals

Adults comprise two-thirds (66.7%) of EPIA referrals, with most falling in the 23-64 age grouping. While the same EPIA protocols apply except for time to escalation to DMH which is 60 hours of ED Boarding (compared to 48 hours for youth under 18 years old), differences are seen in diagnoses as well as in barriers to placement, which are reflected in the charts below on pages 11 and 12.

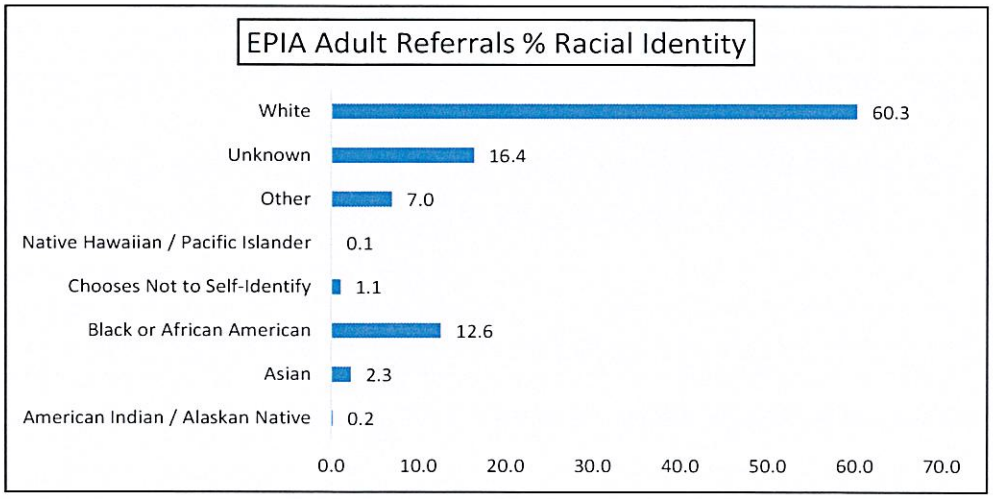
Gender

As compared with Youth EPIA referrals (48.9%) more adults identify as Male (58.5%) and fewer adults identify as Female (39.3% versus 43.7%). Those who are non-binary or transgender reflect a combined 2.2% of the adults served (as compared to 7.1% in youth).

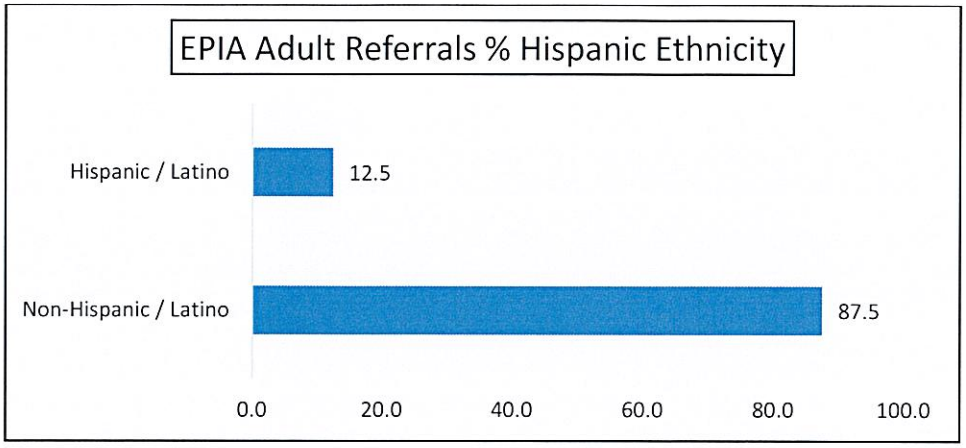


Race/Ethnicity

For adults whose cases were referred to EPIA, approximately 60.3% were identified as white, 12.6% were identified as African American, and 2.3% were identified as Asian. As with Youth these figures represent those with a racial identify recorded. However almost 25% do not have a specific racial identity recorded, limiting use of the data to address health equity issues. The largest proportion of adult EPIA referrals identify as White.

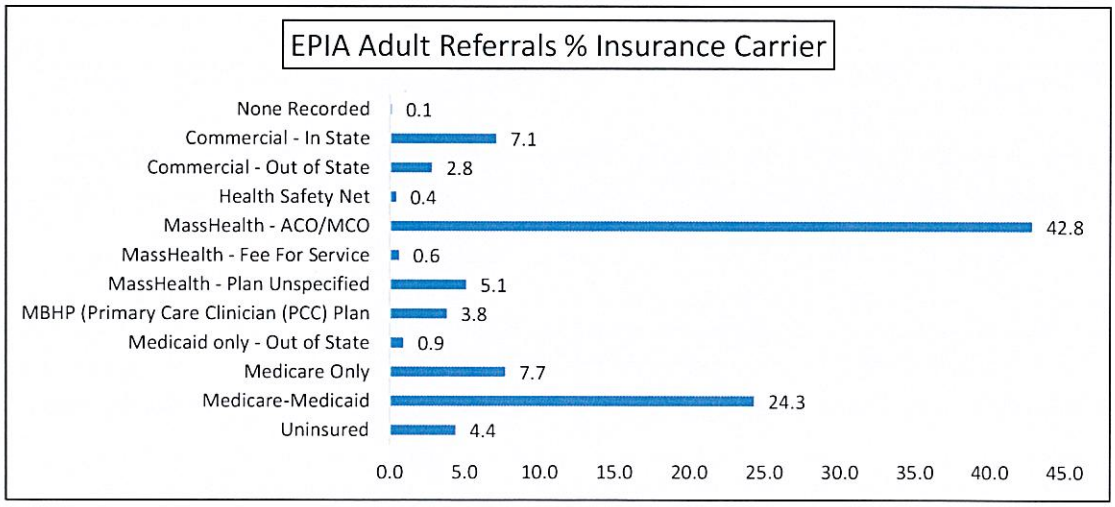


12.5% of adult EPIA referrals identify as Hispanic or Latino, a lower percentage than was seen with youth referred (17.2%)



Type of Insurance Coverage

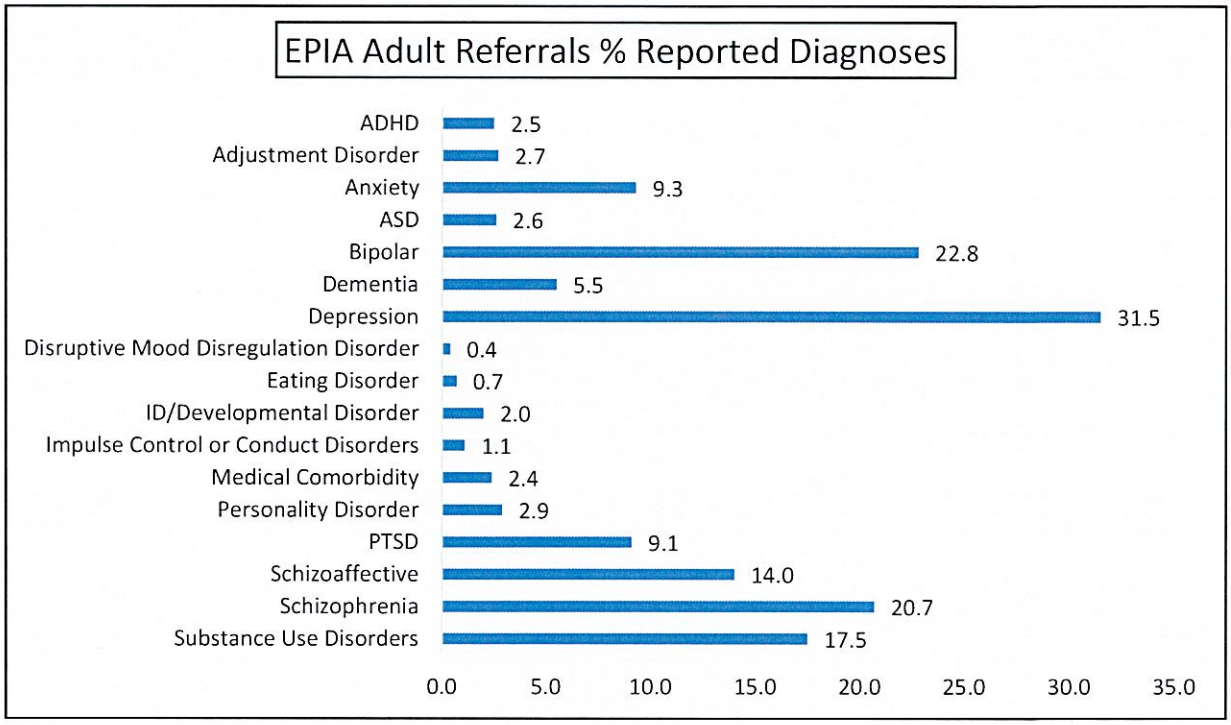
Of the adults referred to EPIA, who board in EDs longer than 60 hours, approximately 63% were primarily covered by Managed Medicaid, 24% were covered by Medicare, 7% were covered by Commercial Carriers (including both insured health plans and self-funded employment-sponsored plans) and 4.3% were uninsured. A total 87% of adults referred to EPIA were persons covered under either the public Managed Medicaid or Medicare Programs. As was seen with the youth referred, the highest percentage have public insurance.



Diagnoses

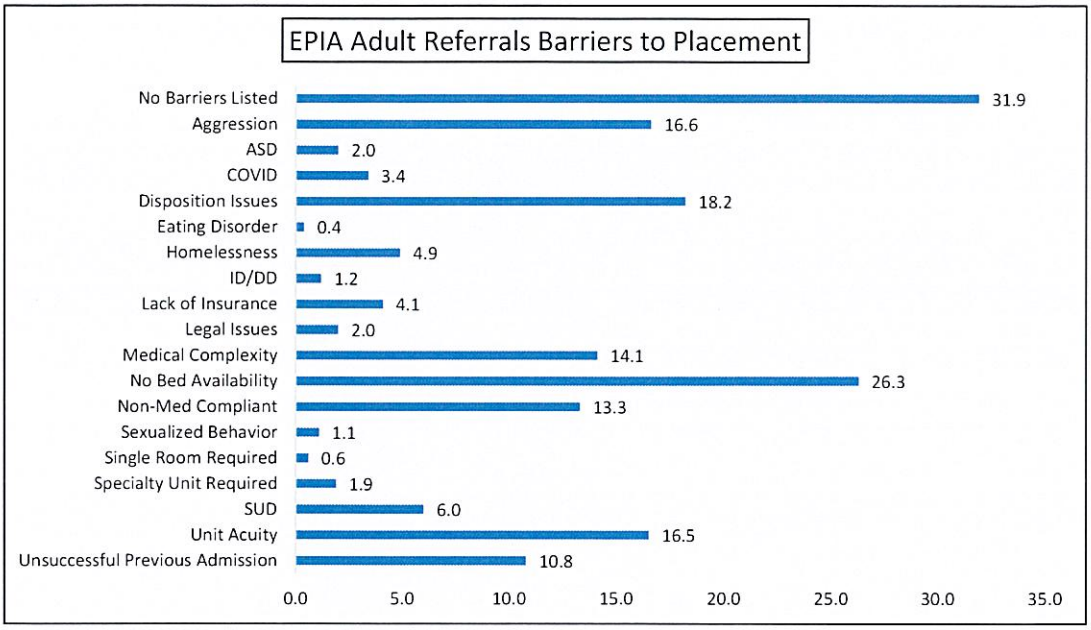
For adults, diagnoses cited most frequently in descending order include: Depression (31.5%), Bipolar Disorder (22.8%), Schizophrenia (20.7%), Substance Use Disorders (17.5%), Schizoaffective disorders (14.0%), Anxiety (9.3%) and PTSD (9.1%). While Depression was reported for 38.8% youth referred, other diagnoses seen in higher percentages among adults

were reported in lower percentages for youth (bipolar disorder 4.9%, Schizophrenia 2.0%, Substance Use Disorders 1.9% and Schizoaffective disorders 0.7%).



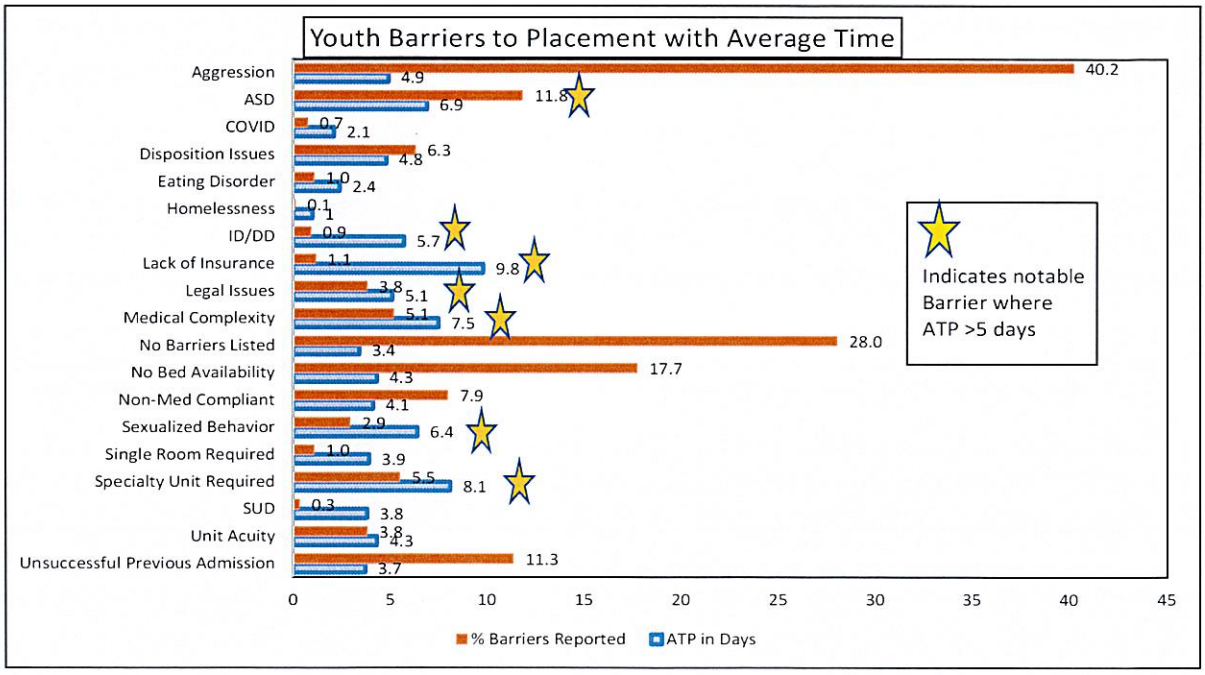
Barriers to Placement (Reasons for Delay in Admission)

Many more barriers were noted for adults than for youth. The choice, No Barrier, was most frequently cited (31.9%). The other barriers in descending order of frequency include: No Bed available (26.3%), Disposition Issue (18.2%), Aggression (16.6%), Unit Acuity 16.5%), Medical Complexity (14.1%), Medicine Non-compliant 13.3%), and Unsuccessful Previous Admission (10.8%). As with youth, barriers to admission most frequently noted for adults also reflect system problems more than an individual's particular clinical presentation. System problems can be seen in No Barrier (and yet still taking days to get admitted to an inpatient psychiatric bed), No Bed Available, Disposition Issue, and Unit Acuity.

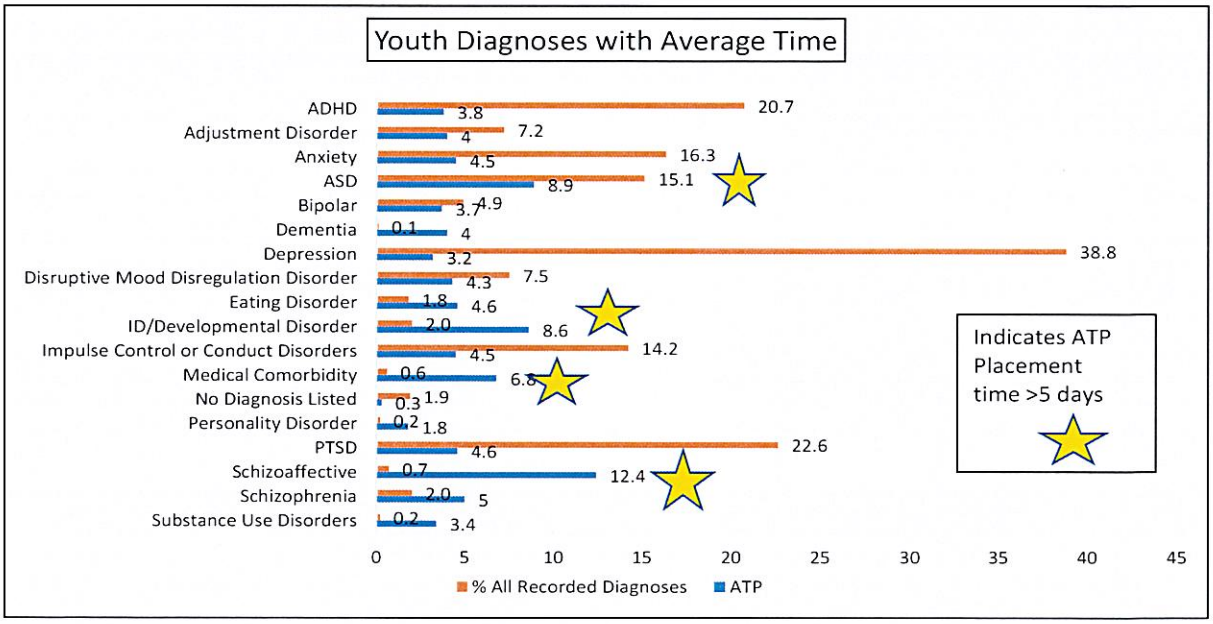


Reasons for Extended Wait Times (Barriers) by comparing Average Time to Placement (ATP)

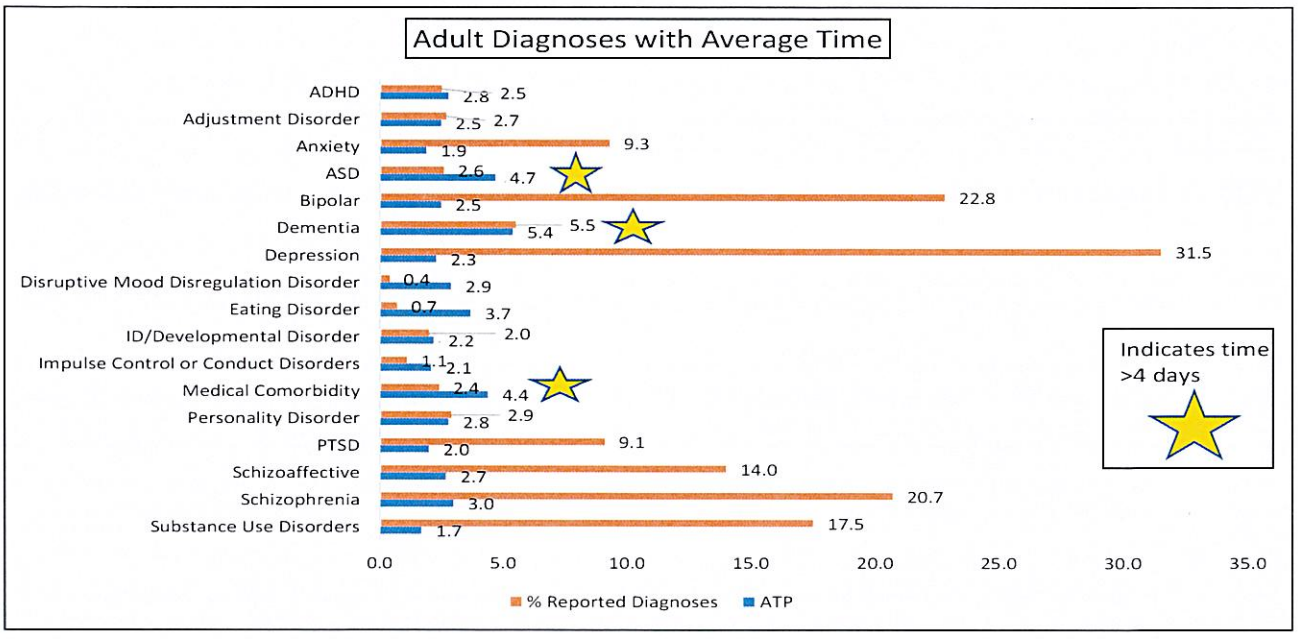
In aggregate, once referred to EPIA, it took an average of 3.1 days before discharge from the ED occurred (either transfer to a psychiatric inpatient hospital or discharged home). Reviewing the Average Time to Placement (ATP) with diagnostic and barrier factors allow us to see specific reasons that are associated with longer waits for placement. The graphs below include the ATP with each diagnosis and barrier for the youth and adult populations.



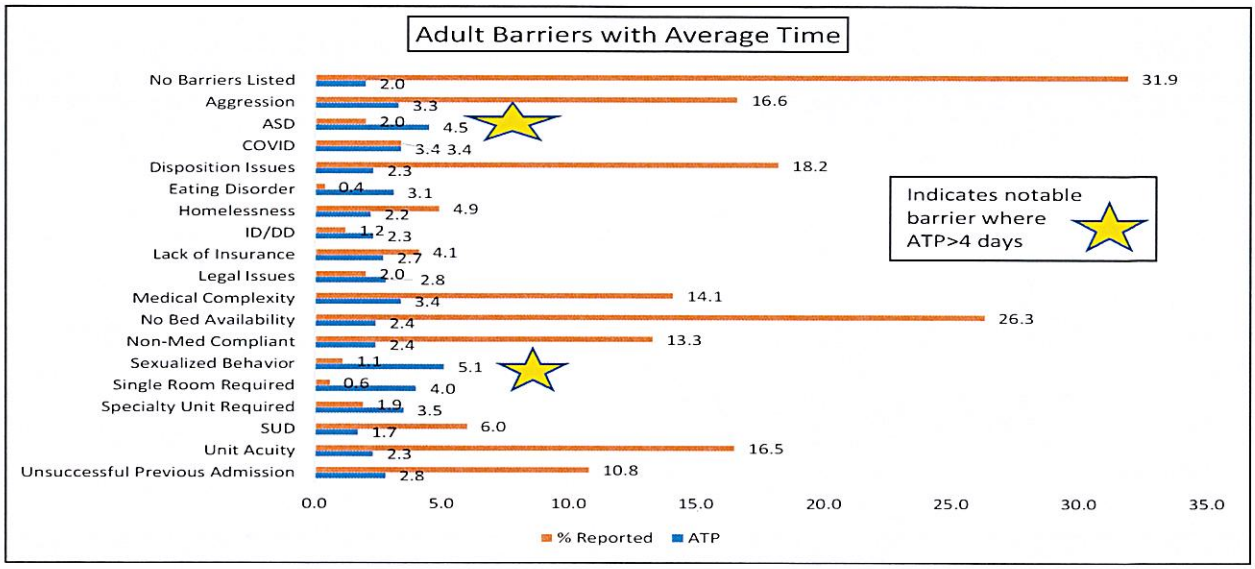
Beginning with youth, both diagnoses (Autism, Developmental Disorders, Medical Complexity and sexualized behaviors) and system barriers (lack of insurance, legal issues, schizoaffective, and a specialty unit required) are factors noted for youth who wait longer than 5 days in the ED before placement. Using greater than five days as the ATP for these diagnoses and system barriers reflect one full day longer than the aggregated ATP for those under 18.



For the adult referrals, when examining the ATP of diagnoses autism, dementia, and medical comorbidity are highlighted by being 4 days, two days longer than the ATP for the aggregated adults. These diagnoses take double the time to placement as the average adult.



The system barrier impacting placement for adults was the presence of Sexualized Behavior, which is associated with an average time of 5.1 days, or more than 2 days longer than the average ATP for adults. An additional barrier of some significance is the "single room required" for the admission. This barrier doubles the ATP to 4 days.



Trends (See Appendix #4)

1. Volume: Trend data shows that during 2021, ED behavioral health boarding volumes remained high; during 2022 the volume leveled off and during 2023, volume is showing a decrease. This is particularly true when looking at youth under 18 since the summer of 2022, the volume peaks have lessened compared to 2021 volume peaks. For adults, the last significant peak volume was in September 2022 and shows a steady decrease through 2023.

2. Average Time to Placement: Trend data for ATP does not show a similar trend. Rather, ATP remains stable with monthly fluctuations. For adults, Average ATP hovers between 2 and 3 days and for youth under 18 years of age, ATP continues to range between 3 and 6 days. This has remained relatively constant for the past several years (2021-2023).

3. Percentage of Boarders who have a Level of Care change and no longer need inpatient admission: In this eight-month data analysis, 33% of those referred to DMH in the EPIA protocol no longer required inpatient level of care. A similar percentage of patients had a level of care change with each extra day of boarding demonstrating that interventions in the ED contribute to stabilization of patients that allow for community or outpatient-based care upon discharge from the ED. Youth were slightly more often given a Level of Care change (35%) compared with adults (32%).

Council Review

The Council met six times over the past year to review and analyze EPIA Boarding data. The Council discussed issues highlighted by the data review and members of the Council contributed information and opinions from their respective constituencies what factors continue the ongoing phenomenon of ED Boarding.

Initiatives Introduced to Address Acute Behavioral Health Needs

1. The Commonwealth has put multiple resources into the Behavioral Healthcare Delivery system in recent years. These resources include increased MassHealth rates, ED Boarding billing codes for care, and enhanced inpatient rates for acuity, single room required, and providing for additional reimbursement for needed special care (e.g. 1:1 staffing). Both DMH and MassHealth have built ED Diversion Teams that work with patients and their families to provide urgent care and support in the home rather than admission to an inpatient facility.
    a. In January 2023 there were significant resources devoted to the behavioral healthcare system to provide more community resources and services so that patients would be able to get help before the need for ED care is required. The Behavioral Health Roadmap is designed to provide a coherent payor blind front door to the behavioral healthcare system during a crisis. This front door includes 26 Community Behavioral Health Centers (CBHCs) located throughout Massachusetts, a Behavioral Health Helpline (BHHL) accessible 24/7, Mobile Crisis Intervention teams (MCIs) based in the CBHCs, and Respite expansion. It is too early in the implementation to assess how the above services and system have decreased some of the volume of behavioral health ED Boarding during 2023.

2. Massachusetts health plans, in both the Medicaid and commercial programs, have implemented a variety of measures to address ED boarding, including:
    - Having dedicated teams to implement internal policies and protocols for the EPIA, to find appropriate placements for their members, reduce wait times in the ED, support members and families in crisis, and ensure that members have access to the care that they need.
    - Providing 24/7 telephone access as part of the EPIA process to respond to notifications of ED boarding and requests for assistance.
    - Authorizing and paying for special services such as single rooms, extra staffing, one-to-one care, and high-cost medications.

- Partnering with Applied Behavior Institute to offer up to eight hours of autism consultation to families waiting in an emergency department for autism spectrum disorder services.
- Implementing care management services to coordinate care following a discharge.
- Working with EDs to establish payment mechanisms that ensure appropriate reimbursements for EDs providing BH treatment and services to patients while they are boarding.
- Partnering with network providers to expedite placement, provide diversion, and expand access to upstream treatment and services to prevent ED admissions.

Discussion/Findings

1. Behavioral Health ED Boarding for inpatient level of care, while still high, has begun to stabilize since the significant increase in demand during the COVID Pandemic. Early signs of an ED Boarding volume decrease during 2023 are noted in the EPIA data. This trend is still showing boarding numbers higher than pre-COVID pandemic which were already concerning.

2. EPIA has analyzed the referral data to understand how referrals may differ by age, gender, race & ethnicity, insurance coverage, diagnoses, and barriers to admission.

    a. Youth continue to be overrepresented in EPIA referrals for those who board in EDs more than 48 hours.
    b. Given the high percentage of non-identifying racial demographic responses, it would be easier to understand racial disparities if race/ethnicity questions were required data points in the EPIA referral.
    c. Commercial Insurance carriers cover 10-20% of the EPIA ED Boarding population. The public funded insurance coverage is the primary coverage for those waiting in EDs for inpatient psychiatric care. Public insurance ranges from 75% of the youth to 90% of adults.
    d. Youth have different diagnoses than the adults. It takes significantly longer time to place youth who are on the autism spectrum, have intellectual or developmental disabilities, schizoaffective or have medical comorbid conditions. For adults, the longest time to placement is also found in individuals with autism, dementia, and medical comorbidity. For both youth and adults, these diagnoses with longer time to placement represent a small percentage of patients, however, their prolonged stay in an ED waiting for

services delays the patients' access to needed treatment. These delays in timely access to treatment for patients may worsen their disease course as well as occupy needed bed space in EDs for other patients needing emergency care.

3. Barriers noted seem to reflect as much a systems problem as the diagnosis of the individual boarding. When "no barrier" is endorsed by the ED evaluation team and the person still requires two or more days to find an inpatient bed, it may reflect something in the bed search process we have not identified yet. Since the barriers demographic allows for multiple answers, "no barrier" may be confounded by "no bed available" during the initial bed search that does not find a ready bed for that individual.

4. Since EPIA referrals represent less than 10% of all admissions to psychiatric facilities, most individuals needing an inpatient psychiatric hospitalization are admitted within the first day or two of an emergency room visit. Those who wait longer for placement require multiple bed searches and frequent staff hand offs. The Council discussed the Behavior Health Treatment Referral Placement (BHTRP) program currently being built by EOHHS with multistakeholder engagement which will allow a better view of the first day or two activities between EDs and psychiatric facilities.

Recommendations

1. The Council agrees that for the inpatient behavioral health system's admission process to be effective, there needs to be timely, consistent, and ongoing communication among providers, families, payors and state agencies, especially for anyone waiting for several days before an admission is possible.
    a. Ongoing training, at least annually, about the EPIA process for all inpatient hospital clinical and administrative leaders associated with the Emergency Department, the administrative and clinical leaders of all insurance carriers and if applicable, the behavioral health managers. This includes training new staff how to escalate cases to internal leaders, an insurance carrier's EPIA dedicated staff, and the DMH's EPIA team to assist with bed searches and to share information about patients.
    b. It is expected that the BHTRP program referenced above (#4 in Discussion) will make communication faster and more efficient and effective during the bed search process among all involved stakeholders.

2. The Council recommends more widespread knowledge and acceptance of ED Diversion programs and the use of the Behavioral Health Roadmap services to meet the urgent and crisis needs of patients and families to avoid unnecessary utilization of ED resources. Consideration should also be given to expand ED Diversion programs as well as creating additional services and resources, including:
    a. Specialty inpatient and outpatient programs for patients with autism spectrum disorders and/or intellectual and developmental disorders.
    b. Training opportunities and educational resources for families with children and/or youth with behavioral conditions and co-occurring chronic medical conditions, including more information on community-based settings, youth crisis stabilization services and mobile crisis intervention.

3. Convene a short-term expert panel to define best practice models/approaches for patients displaying violent and aggressive behavior, patients with co-occurring behavioral and medical conditions and patients with developmental disorders or autism spectrum disorders and ways to make these best practices available when and where needed including in community-based and residential settings.

4. Based on the high rate of ED Boarding patients who have a change of level of care and no longer need an inpatient admission, the Council recommends the increased utilization of youth and adult crisis stabilization units, respite programs, peer specialists, and parent supports to better serve those in crisis who no longer meet hospital level of care.

5. Continued focus on efforts to fully implement the Behavioral Health Roadmap by all parties including requiring commercial carriers to cover all community-based services provided by community behavioral health centers. EDs and insurance carriers are encouraged to support, promote, and notify behavioral health patients of the behavioral health helpline and their local community behavioral health center.

6. The Council recommends that the Legislature oversee the full implementation of both the Mental Health ABC Act and the Cares Act provisions especially those on payment parity for behavioral health services, commercial coverage of annual behavioral health screens, psychiatric collaborative care models, and services provided to patients while they board which will address upstream prevention of crisis, thereby further reducing ED boarding.

7. Increase the ability of the system to have direct admissions from the community which is an important part of the Behavioral Health Roadmap roll out. This requires that pre-

admission medical screening performed at community sites are adopted and accepted by psychiatric hospitals.

8. The Council recommends that all psychiatric inpatient units admit and discharge patients 24 hours a day and 7 days a week. Incentives may include extra payment to psychiatric facilities that accept cases during weekends.

9. The Council recommends that work continue taking steps, including amending regulations, if necessary, to permit direct EMS transports to CBHC/MCI locations to safely transport people who can be clinically diverted from hospital EDs during their behavioral health crisis.

Appendices

Appendix 1

EPIA Advisory Council Membership

Appendix 2

DOI Bulletins 2018-01 & 2021-07: Prevention of Emergency Department Boarding for Patients with Acute Behavioral and/or Substance Use Disorders Emergencies

Appendix 3

EPIA Protocol 2023

Appendix 4

EPIA Trend Data 2023

Appendix 1

EPIA Advisory Council Membership

EPIA Advisory Council Membership

Department of Mental Health/Chair	Kathy Sanders MD
Department of Public Health	Estavan Garcia MD
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Blue Cross/Blue Shield	Paul Jones
Massachusetts Health & Hospital Association	Leigh Youmans
Massachusetts College of Emergency Physicians	Melissa Lai-Becker MD
Association for Behavioral Healthcare	Anne Parker
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Massachusetts Association Behavioral Health Systems	David Matteodo
Emergency Services Provider	Jennifer Brown MD
CBHC Representative	Donna Frates
Parent/Professional Advocacy League	Meri Viano and Tashena Marie
DMH Staff	Sherri DiBarri and Jill MacLeod

Appendix 2

DOI Bulletins 2018-01 & 2021-07:

Prevention of Emergency Department Boarding for Patients with Acute Behavioral and/or Substance Use Disorders Emergencies

COMMONWEALTH OF MASSACHUSETTS

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

BULLETIN 2018-01

To: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations

From: Gary Anderson, Commissioner of Insurance
Joan Mikula, Commissioner of Mental Health
Monica Bharel, Commissioner of Public Health

Date: January 3, 2018

Re: Prevention of Emergency Department Boarding of Patients with Acute Behavioral Health and/or Substance Use Disorder Emergencies

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The Division of Insurance ("Division"), the Department of Mental Health ("DMH"), and the Department of Public Health ("DPH" and together with the Division and DMH, the "Agencies") jointly issue this Bulletin to provide information to Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations ("Carriers") offering insured health coverage in the Commonwealth of Massachusetts about the Agencies' expectations regarding changes to Carriers' systems for coordinating inpatient admissions from Emergency Departments ("EDs").

Emergency Department Boarding

Individuals who are in psychiatric crisis are often brought to general hospital EDs for medical clearance and screening to determine whether psychiatric hospitalization is necessary. Patients requiring inpatient psychiatric hospitalization usually wait within the ED until a bed is found for the admission and transfer arrangements are completed.

Too frequently behavioral health patients requiring inpatient hospitalization or other diversionary disposition have remained within EDs for extended periods of time, often many hours and days. – referred to as ED Boarding – even after the ED has determined the appropriate discharge disposition. This happens most often when the patient requires an inpatient admission. The reasons for such boarding situations vary, but the data shows the most frequent reasons given are: high behavioral acuity (of the patient or the receiving units); specialty needs (most often for patients with intellectual or developmental disabilities, substance use disorder, or co-occurring medical conditions); or age (most often children and youth).

DMH, in collaboration with representatives from MassHealth, DPH, commercial payers, and hospital providers, is developing regulations and guidelines that establish the expectation that any patient meeting the criteria for psychiatric hospitalization under M.G.L. c. 123, § 12 will be admitted to an appropriate inpatient psychiatric facility within a reasonable period of time. Under these guidelines, inpatient psychiatric facilities will be expected to admit all such patients, so long as they have the capacity (an available bed) and the capability (ability to meet the clinical needs of the patient). As the licensing authority for inpatient psychiatric facilities, it is DMH's expectation that there will be few situations where a clinical determination is made that the facility does not have the capability to accept an admission. Carriers will be expected to arrange payments for all medically necessary care for these patients within the inpatient psychiatric facilities, including such care as may be required to enable the facility to accept a patient with specialty needs (such as a 1:1 staff member/patient ratio, payment to convert a double occupancy room into a single, etc.).

Coverage for Behavioral Health Care

Carriers offering insured health plans in Massachusetts are mandated to include coverage for medically necessary behavioral health treatment according to the requirements of M.G.L. c. 175 §, 47B; M.G.L. c. 176A, § 8A; M.G.L. c. 176B, § 4A; and M.G.L. c. 176G § 4M. In addition, behavioral health and substance use disorder coverage are Essential Health Benefits under the provisions of the federal Patient Protection and Affordable Care Act ("ACA").

Under the federal Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA," or the "federal parity law"), group health plans and insurers that offer insured behavioral health and substance use disorder benefits must provide coverage with no more quantifiable or non-quantifiable limits than would apply to non-behavioral health benefits in the same plan. The Division is required to enforce MHPAEA for insured health benefit plans according to M.G.L. c. 26, § 8K.

Medical Necessity in Relation to ED Boarding

Pursuant to M.G.L. c. 176O, §16(b), Massachusetts-issued insured health plans are required to provide coverage for health care services if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. Carriers that are accredited by the Division as managed care companies under M.G.L. c. 176O may employ utilization review systems for insured health plans in making decisions about whether services are medically necessary. Utilization review is defined in M.G.L. c. 176O as "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings." In establishing its utilization review criteria, the Carrier is expected to base the criteria on the following provisions of M.G.L. c. 176O, §16(b):

> A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as

> generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to insureds, prospective insureds and health care providers consistent with [M.G.L. c. 176O, §12(a)].

Covered members requiring hospitalization should not spend extended periods of time in hospital EDs while waiting for admission to an inpatient facility. Carriers may not have utilization criteria that could lead to a patient remaining in an ED for an excessive time while waiting for appropriate transfer to an inpatient facility. Carriers are expected to establish appropriate criteria that do not cause inappropriate delays or denials of inpatient admissions for covered members with acute behavioral and substance use disorder needs. Carriers shall not establish medical necessity criteria or procedures that may lead to delays in approval of inpatient treatment for patients with acute behavioral health conditions after the Carrier has received appropriate notification that the patient is in the ED and in need of inpatient treatment. The Carrier shall approve the patient's inpatient treatment unless the Carrier has secured alternative medically appropriate placement of the patient.

Due to the nature of their behavioral health conditions, certain patients may need special resources or accommodations at an inpatient psychiatric facility in order for treatment to be appropriate during the inpatient stay. As an example, some patients may present in the ED with such acute behavioral health and/or substance use disorder conditions that they may need an individual inpatient room or specially trained staff dedicated to their care. Carriers' medical necessity criteria will be considered acceptable only if they permit approval of such special services in accordance with accepted practice and/or federal and state standards.

Carriers shall establish minimum medical necessity criteria for members to be eligible for an individual psychiatric and/or substance use disorder inpatient admission, and such medical necessity criteria will be subject to the Division's review. Factors to consider should include, without limitation: the member's diagnosis and level of acuity, the level of care required for the member, the member's ability to benefit from treatment through participation in therapeutic programming.

When the member meets the Carrier's medical necessity criteria for an individual inpatient room or any other special services, then the Carrier shall arrange for these special services to be covered when provided to the member.

Assisting with Placement of Patients Requiring Inpatient Admissions

Each Carrier is expected to have identified staff or departments that will be responsible to coordinate communications between the Carrier and the ED for the placement of patients requiring inpatient admissions. Carriers will maintain lists for use by all Massachusetts EDs of these identified staff or departments and the best methods to contact these persons.

When an individual being evaluated within an ED by an Emergency Services Provider ("ESP") or other ED staff member who determines that the individual requires an inpatient psychiatric hospital level of care and the patient is waiting for an inpatient bed more than 24 hours after arrival in the

ED, the ESP/ED will notify the relevant Carrier that one of its members is still waiting for an inpatient bed at the 24-hour mark. At this point, the Carrier will cooperate with the ED to determine if there is useful information that can be provided to the ESP/ED in the placement process.

At any time after the decision to admit the individual to a psychiatric hospital level of care has been made, the ESP or ED may contact the Carrier with a Request for Assistance which will provide the Carrier with clinical information about the individual, barriers to admission, evidence of the bed searches to date and what individual psychiatric units said when asked to admit the individual. If this patient continues to be waiting in the ED by the 48-hour mark, then the ED/ESP is required to send a Request for Assistance to the Carrier. An appropriate person from the Carrier will respond to the ED's or ESP's Request for Assistance within a reasonable time – no later than two hours during normal working hours and no later than the next morning outside normal working hours – to identify that the Carrier is meaningfully engaged and to provide the name of the person who is coordinating the Carrier's activity to locate an acceptable hospital bed for the individual.

The purpose of the Request for Assistance is to engage the Carrier's help in determining the hospital(s) most appropriate to meet the needs of the member at that time and finding placement. The more targeted and specific the Request for Assistance is, the more efficient and effective the Carrier's response will be. As an example, the Request for Assistance can include the following information:

- Specific providers who may be willing to take the individual but require additional supports or resources
- A specific provider who does not have an immediate bed but will have one within the next 24 hours
- Authorization issues for successful placement are required
- Out of network requests
- Notification that the Carrier needs to call specific providers for bed availability

Once a Request for Assistance is sent to a Carrier, the Carrier is expected to provide assistance, working with the ED/ESP to avoid duplication, in the placement of the Carrier's member in the appropriate inpatient bed with appropriate additional supports or resources needed by specific facilities to allow for admission. The Carrier will be expected to use its own internal escalation process in an active and strategic advocacy process, including senior leadership and/or medical directors where appropriate, when engaging with appropriate high-level clinical and administrative leadership within network hospitals. If the specific hospital that is deemed most appropriate for the patient does not have an immediate bed, but will have one within 24-48 hours, the Carrier will seek priority for this bed. If there are not any network hospital beds anticipated to be available within the 24-48 hours after receipt of the Request for Assistance, the Carrier will seek placement in appropriate out-of-network facilities.

Once a Carrier has exhausted its network options and has explored all appropriate out-of-network options, or after another 48 hours has passed and the Carrier's member has not secured a placement in an inpatient psychiatric level of care, the Carrier is required to make an appropriate contact to DMH. The Carrier is also responsible for informing hospitals deemed appropriate to admit the individual that the process is being escalated to DMH.

When a Carrier contacts DMH, the Carrier is to use a standardized template to explain the clinical status of the patient, all the actions that the ED/ESP and then the Carrier have taken to identify an appropriate placement, and any barriers that have prevented the patient from obtaining appropriate placement. The Carrier shall use the standardized template so that DMH has all necessary information to understand the status and be able to consider next steps. The Carrier's medical director or designee should also be available to discuss the patient's status and initiate a clinical conversation as needed. If a payment concern is discovered, a discussion between the Carrier and the Division shall take place in order to allow for resolution to allow for the appropriate placement of the patient.

Network Adequacy and Carriers' Coordination of Placements

Managed care plans are expected under 211 CMR 52.03 to have networks of providers that provide adequate and available access to covered health services within a reasonable time. Managed care disclosure materials are required under M.G.L. c. 176O, §6(a)(4) to clearly explain "the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network..."

When the Division determines that a Carrier's provider network does not provide adequate and available access to facilities/practitioners to deliver certain types of care, a Carrier is required to cover treatment at the in-network benefit level for medically necessary services even when delivered by out-of-network providers until such time as the Carrier re-establishes what the Division considers to be adequate and available access to those certain types of providers.

When a Carrier's network is found to be inadequate and the Carrier's member is admitted to an out-of-network facility, the Carrier shall then be obligated to pay all in-patient hospital costs at the out-of-network facility until the member is discharged or until it is legally permissible and clinically appropriate to transfer the patient to a facility that is part of the Carrier's network.

Please note that this Bulletin is in no way intended to create any barrier that could limit or jeopardize access to behavioral health and substance use disorder treatment. Instead, these directives are intended to protect members for whom the normal emergency admissions process may break down. Carriers are advised that they should be prepared to implement the directives in this Bulletin by no later than February 1, 2018.

If you have any questions about this Bulletin, please contact the Division's Kevin Beagan, Deputy Commissioner for Health Care Access, at 617-521-7323 or Tracey McMillan, Director of Bureau Managed Care, at 617-521-7347.

COMMONWEALTH OF MASSACHUSETTS

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

BULLETIN 2021-07

To: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations; Hospital Providers; and Emergency Service Providers

From: Gary Anderson, Commissioner of Insurance
Brooke Doyle, Commissioner of Mental Health
Margret Cooke, Acting Commissioner of Public Health

Date: June 28, 2021

Re: Updated Protocols for Prevention of Emergency Department Boarding of Patients with Acute Behavioral Health and/or Substance Use Disorder Emergencies under Expedited Psychiatric Inpatient Admission ("EPIA") Protocols

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The Division of Insurance ("Division"), the Department of Mental Health ("DMH"), and the Department of Public Health ("DPH"), collectively referred to as the "Agencies", jointly issue this Bulletin to provide information to Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations ("Insurance Carriers") offering insured health coverage in Massachusetts, Emergency Departments (EDs) and the ED Clinicians including emergency service providers and mobile crisis intervention providers (hereafter referred to as the "ED Evaluation Team"), and Inpatient Psychiatric Providers about the Agencies' expectations regarding the coordination of inpatient psychiatric admissions from EDs in accordance with EPIA Protocol 3.0. This bulletin updates and replaces Bulletin 2019-08.

Problems Exacerbated by the COVID-19 Public Health Emergency

The number of individuals in crisis needing inpatient psychiatric treatment during the Public Health Emergency increased at the same time that inpatient bed capacity was reduced as a result of facility closures and necessary infection control measures. Consequently there have been increases to the number of behavioral health patients who remain in EDs for unacceptable periods of time despite the EPIA protocols. Too frequently behavioral health patients who require inpatient hospitalization or other diversionary disposition have remained within EDs for extended periods of time, often many hours and sometimes days – referred to as ED Boarding –after the ED Evaluation Team has determined the appropriate discharge disposition. This has happened most often when the patient requires an inpatient psychiatric admission. The reasons for ED boarding and associated placement challenges vary, including but not limited to shortage of inpatient beds (particularly child and adolescent beds), high behavioral acuity (of the patient or the receiving units); specialty needs (most often for patients with intellectual or developmental disabilities,

substance use disorder, or co-occurring medical conditions); or age (most often children and youth) and workforces challenges that may cause a reduction in operational capacity within hospitals and units. The medical director and senior administrator escalation procedures outlined in EPIA Protocol 3.0 are intended to address the above challenges.

Despite prior EPIA protocols developed to address this problem, the increase in ED boarding stemming from the pandemic requires that more must be done to ensure that patients have timely access to inpatient care. For this reason, the Agencies issue this bulletin to Insurance Carriers, EDs and their Evaluation Teams, and Inpatient Psychiatric Providers to reinforce the importance of the EPIA process, as described below and incorporated by reference:

- ED Evaluation Teams provide timely notification at the 24-hour mark to the Insurance Carriers when their covered members are boarding and make necessary information available at the 24-hour mark for Insurance Carriers so that Insurance Carriers have what is needed to actively search for available beds;
- Insurance Carriers are involved as early as possible to assist ED Evaluation Teams to move their covered members into appropriate admissions for inpatient treatment;
- Insurance Carriers and Inpatient Psychiatric Providers have medical directors or designees serving as medical directors[1] available each day when decisions regarding admissions are being made so cases are elevated to Insurance Carrier and Inpatient Psychiatric Provider leadership to prevent bed denials being made by admission and/or nursing staff;
- Insurance Carriers shall provide for any necessary arrangements to provide for a patient's special care needs as determined by the Inpatient Psychiatric Provider and Insurance Carrier medical directors or designees serving as medical director, and
- Inpatient Psychiatric Provider medical directors or designees serving as medical director shall accept patients for open beds on the basis that Insurance Carriers will agree to reimburse for special care needs.

Emergency Department Boarding

It is the Agencies' expectation that Insurance Carriers are proactively involved in bed searches when any of their covered members are behavioral health patients in EDs and that Insurance Carriers arrange payments for all medically necessary care for these patients admitted by Inpatient Psychiatric Providers, including such care as may be required to enable the facility to accept a patient with specialty needs (such as a 1:1 staff member/patient ratio, payment to convert a double-occupancy room into a single, high cost medications for complex co-morbid medical conditions,[2] etc.).

[1] The medical director's designee must be vested with the full range of the medical director's authority and responsibility in the medical director's absence.

[2] Medications which a provider is capable to administer in compliance with DMH requirements for clinical competencies. Carriers are permitted to require that such medications be obtained from a carrier's specialty pharmacy for prescription drugs.

In turn, and in accordance with EPIA 3.0, ED Evaluation Teams and Inpatient Psychiatric Providers are similarly expected to take all necessary action to ensure timely admissions for inpatient psychiatric treatment. DMH, in collaboration with MassHealth, the Division, DPH, Insurance Carriers, and Inpatient Psychiatric Providers, has developed regulations and guidelines that establish the expectation that any patient meeting the criteria for psychiatric hospitalization under M.G.L. c. 123, § 12 will be admitted by an appropriate Inpatient Psychiatric Provider within a reasonable period of time. Under these guidelines, Inpatient Psychiatric Providers are expected to admit all such patients, so long as they have the capacity (an available bed) and the capability (ability to meet the clinical needs of the patient) as provided in 104 CMR 27.05(3) (b) through (d).

It is the Agencies' expectation that Insurance Carriers and Inpatient Psychiatric Providers deliver better continuity of care for inpatient treatment in order to improve patient outcomes. Patients should be rehospitalized by the same Inpatient Psychiatric Provider to the maximum extent possible. The hospital where a patient is boarding should make every effort to procure a bed within its hospital system's network; similarly an Insurance Carrier for a boarding member should make every effort to procure a bed within its contracted hospital network. Inpatient Psychiatric Providers have no more than 2 hours to respond to an ED Evaluation Team, Insurance Carrier or EPIA with their decision whether to admit a boarding patient after they receive the complete admissions packet. A standardized admission packet should be used for bed searches and accepted by all Inpatient Psychiatric Providers.

To ensure timely communication needed for EPIA success, it is expected that ED Evaluation Teams and Insurance Carriers have a point person identified daily to communicate with each other and with the identified point persons for Inpatient Psychiatric Providers and use secured electronic means, where possible, to avoid excessive delays with telephone or fax machine communication methods.

Medical Necessity in Relation to ED Boarding

Despite the allowance under M.G.L. c. 176O for utilization review protocols, covered members requiring hospitalization should not spend extended periods of time in hospital EDs while waiting for admission to an Inpatient Psychiatric Provider. Insurance Carriers are expected to establish appropriate processes that do not cause inappropriate delays or denials of inpatient admissions for covered members with acute behavioral and substance use disorder needs after the Insurance Carrier has learned that the patient is in the ED and in need of inpatient treatment. The Insurance Carrier shall approve the patient's inpatient treatment unless the Insurance Carrier has secured alternative medically appropriate treatment for the patient which is agreed upon by the ED Evaluation Team.

Due to the nature of their behavioral health conditions, certain patients may need special resources or accommodations by the Inpatient Psychiatric Provider in order for treatment to be appropriate during the inpatient stay. As an example, some patients may present in the ED with such acute behavioral health and/or substance use disorder conditions that they may need an individual inpatient room or specially trained staff dedicated to their care, and including high cost mediations for complex do-morbid medical conditions.

When the member meets the Insurance Carrier's medical necessity criteria for an individual

inpatient room or any other special services, then the Insurance Carrier shall arrange for these special services to be reimbursed when provided to a member including means to obtain payment. When the Insurance Carrier and the Inpatient Psychiatric Provider have agreed to reimbursement for needed special services, there is an expectation that the Inpatient Psychiatric Provider admit the patient without delay.

Assisting Inpatient Admission Process for ED Boarding Patients Under EPIA Protocol 3.0

Each Insurance Carrier and Inpatient Psychiatric Provider is expected to have an identified point person responsible to coordinate communications between the Insurance Carrier and the Inpatient Psychiatric Provider for patients requiring inpatient admission. Insurance Carriers and Inpatient Psychiatric Providers are to make medical directors or their designees serving as medical directors available each day when decisions regarding admissions are being made to address ED behavioral health admissions. Insurance Carriers and Inpatient Psychiatric Providers will maintain up-to-date and accurate lists of medical directors and senior administrators for all Massachusetts ED Evaluation Teams and admissions staff to use when barriers are encountered and escalation is required.

When an individual being evaluated by an ED Evaluation Team is determined to require inpatient psychiatric care and is waiting for an inpatient bed, the ED Evaluation Team shall make an update to the patient's record using an appropriate code that properly records that the patient is waiting for admission by an Inpatient Psychiatric Provider and shall notify the relevant Insurance Carrier that one of its members is waiting for an inpatient admission by an Inpatient Psychiatric Provider within 24 hours of arrival in the ED.

Each Insurance Carrier will proactively begin the bed search when it becomes aware that a member is waiting for admission by an Inpatient Psychiatric Provider. In cases where a patient is covered by an Insurance Carrier and MassHealth, the Insurance Carrier is primary and is responsible for proactively coordinating the bed search. ED Evaluation Teams shall make an Insurance Carrier aware of clinical information about the individual, including: ***barriers to admission, evidence of the bed searches to date, and a summary of responses from hospitals who have denied admission.*** All clinical information about the individual shall be maintained in the patient record.

Once the Insurance Carrier learns about a covered patient waiting admission by an Inpatient Psychiatric Provider, the Insurance Carrier is to initiate a bed search on behalf of the patient. The Insurance Carrier will provide the ED Evaluation Team with the name of the person who is coordinating the Insurance Carrier's search for an acceptable hospital bed for the individual.

When contacting the ED Evaluation Team, the Insurance Carrier will request information from the ED Evaluation Team, including the following, to assist with its bed search:

- Specific Inpatient Psychiatric Providers who may be willing to take the individual but who require additional supports or resources
- A specific Inpatient Psychiatric Provider who does not have an immediate bed but who will have one within the next 24 hours
- Authorization issues for successful admission are required
- Out of network requests
- Notification that the Insurance Carrier needs to call specific Inpatient Psychiatric Providers for bed availability

Once it initiates its bed search, the Insurance Carrier is expected to provide active assistance, working with the ED Evaluation Team to avoid duplication of efforts procuring the appropriate inpatient bed with appropriate additional supports or resources needed to allow for admission. Insurance Carriers will be expected to arrange payments for all medically necessary care for these patients by the Inpatient Psychiatric Provider, including such care as may be required to enable the Inpatient Psychiatric Provider to accept a patient with specialty needs (such as a 1:1 staff member/patient ratio, payment to convert a double-occupancy room into a single, high cost medications for complex co-morbid medical conditions, etc.). Insurance Carriers will be expected to respond promptly regarding the Inpatient Psychiatric Provider's requests to address a patient's specialty needs. Insurance Carriers will provide written documentation of all specialty-need approvals and will provide clear instructions for the ways the Inpatient Psychiatric Provider may submit billing for these approved specialty services.

The Insurance Carrier will be expected to use its own internal escalation process in an active and strategic advocacy process, including senior leadership and/or medical directors where appropriate, when engaging with appropriate high-level clinical and administrative leadership within network. Inpatient Psychiatric Providers are expected under EPIA protocols to make medical directors or designees serving as medical directors available each day when decisions regarding admissions are being made to allow for coordination with Insurance Carrier medical directors.

If a specific hospital that is deemed most appropriate for the patient does not have an immediate bed, but will have one within 24-48 hours, the Insurance Carrier will seek priority for this bed. If there are not any network hospital beds anticipated to be available within the 24-48 hours after receipt of the Request for Assistance, the Insurance Carrier will seek admission in appropriate out-of-network facilities and will arrange appropriate reimbursement including Single Case Agreements for these facilities.

Once an Insurance Carrier has exhausted its network options and has explored all appropriate out-of-network options, or the patient has been boarding for 60 hours and an admission with an Inpatient Psychiatric Provider has not been secured, the Insurance Carrier must escalate to DMH for assistance per the EPIA Protocol. The Insurance Carrier is also responsible for informing the Inpatient Psychiatric Providers deemed appropriate to admit the individual that the process is being escalated to DMH.

When an Insurance Carrier contacts DMH, the Insurance Carrier is to use a standardized template to initiate an EPIA referral to DMH to explain the clinical status of the patient, all the actions that the ED Evaluation Team and the Insurance Carrier have taken to secure inpatient treatment, and any barriers that have prevented the patient from obtaining such admission.

The Insurance Carrier's medical director or designee serving as a medical director should contact DMH to discuss ongoing collaboration with DMH in continued coordination of the bed search process until an admission with an Inpatient Psychiatric Provider has been made. If ever an EPIA admission is being held up due to a question of reimbursement to an Inpatient Psychiatric Provider, a discussion between the Insurance Carrier and the Division shall take place in order to resolve such barrier to allow for the appropriate admission for the patient.

Network Adequacy and Insurance Carriers' Coordination of Inpatient Admissions

Managed care plans are expected under 211 CMR 52.03 to have networks of providers that provide adequate and available access to covered health services within a reasonable time. Managed care disclosure materials are required under M.G.L. c. 176O, §6(a)(4) to clearly explain "the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network...."

When the Division determines that an Insurance Carrier's provider network does not provide adequate and available access to facilities/practitioners to deliver certain types of care, an Insurance Carrier is required to cover treatment at the in-network benefit level for medically necessary services even when delivered by out-of-network providers until such time as the Insurance Carrier re-establishes what the Division considers to be adequate and available access to those certain types of providers.

When an Insurance Carrier's network is found to be inadequate and the Insurance Carrier's member is admitted to an out-of-network Inpatient Psychiatric Provider, the Insurance Carrier is obligated to pay all inpatient hospital costs at the out-of-network Inpatient Psychiatric Provider's rate until the member is discharged or until it is legally permissible and clinically appropriate to transfer the patient to an Inpatient Psychiatric Provider that is part of the Insurance Carrier's network.

Please note that this Bulletin is in no way intended to create any barrier that could limit or jeopardize access to behavioral health and substance use disorder treatment. Instead, these directives are intended to protect members for whom the normal emergency admissions process may break down. Insurance Carriers are advised that they should implement the directives in this Bulletin as of the date of this Bulletin.

Insurance Carriers Acting As Administrators

When Insurance Carriers are acting as administrators for employment-sponsored non-insured health benefit plans, the Division expects Insurance Carriers to encourage plan sponsors to take steps that are consistent with the provisions of Bulletin 2021-07. Plan sponsors should be made aware of the EPIA protocols, and Insurance Carriers should do all they can to encourage plan sponsors to agree to follow these protocols for non-insured health benefit coverage in Massachusetts.

If you have any questions about this Bulletin, please contact the Division's Kevin Beagan, Deputy Commissioner for Health Care Access, at 617-521-7323 or Niels Puetthoff, Director of Bureau Managed Care, at 617-521-7326.

Appendix 3

EPIA Protocol 2023

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health – Department of Public Health – Office of MassHealth and the Executive Office of Housing and Economic Development - Division of Insurance

Expedited Psychiatric Inpatient Admission Protocol
EPIA 2023
February 1, 2023

Escalation Protocol for Securing Appropriate Placement for Individuals Boarding in Emergency Departments who require Inpatient Psychiatric Hospital Level of Care

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Boarding of Persons in Emergency Departments (EDs)

Each day residents of the Commonwealth in need of inpatient psychiatric hospitalization wait in hospital emergency departments (EDs) for extended periods of time, known as ED boarding. For those waiting for a bed in psychiatric hospitals and units, if there is not a plan in place for them after 24 hours in the ED, there needs to be additional steps to facilitate their admission.

The Executive Office of Health and Human Services (EOHHS), its Department of Mental Health (DMH), Department of Public Health (DPH) and Office of MassHealth and the Executive Office of Housing and Economic Development (EOHED) and its Division of Insurance (DOI), are committed to addressing the ongoing crisis of ED boarding in the Commonwealth and supports this Protocol that identifies and resolves barriers to psychiatric admission.

This Protocol is the product of an Expedited Admissions Task Force, charged by EOHHS Secretary Marylou Sudders in 2017 to establish clear steps and responsibility for escalating cases, where an admission has not been achieved in a reasonable period of time, to senior clinical leadership at Insurance Carriers, Inpatient Psychiatric Providers, and ultimately to DMH. The Division of Insurance (DOI) issued **Bulletin 2018-01: Prevention of Emergency Department Boarding Patients with Acute Behavioral Health and/or Substance Use Disorders Emergencies** co-signed by DOI, DPH, and DMH. This collaboration continues and members of the Task Force work closely together to decrease the length of time behavioral health patients board in EDs waiting admission to an inpatient psychiatric hospital. This effort relies on early and continuous communication by all parties involved.

Expedited Psychiatric Inpatient Admissions Protocol Principles

- **Emergency Departments (EDs) and the ED Clinicians (hereafter referred to as the "ED Evaluation Team"), Inpatient Psychiatric Providers, Insurance Carriers (commercial and public payers), and the responsible state oversight agencies (DMH, DPH, MassHealth and DOI), are all partners in, and share responsibility for, assuring that Commonwealth residents in need of inpatient psychiatric hospitalization have access to services in a timely and geographically reasonable manner**
- ED Evaluation Teams have primary responsibility for identifying and securing inpatient psychiatric hospitalization for patients in psychiatric crisis who require that level of service, and must continue active and assertive efforts throughout the escalation process, particularly in assuring that clinical information is current and communicated, as described in the Protocol
- When a patient is in a medical/surgical bed for any reason and requires inpatient psychiatric hospital level of care once medically stabilized for transfer, the clinical team or whatever system is in place for ongoing evaluation, management and bed searching will have the primary responsibility for identifying and securing inpatient psychiatric hospitalization for such patients. This hospital staff must continue active and assertive efforts throughout the escalation process; particularly in assuring that clinical information is current and communicated as described in the Protocol. All guidance for "ED Evaluation Teams" is applicable to this inpatient clinical team or system.
- There is an expectation that Inpatient Psychiatric Providers will comply with DMH clinical competencies (as required by 104 CMR 27.03(5)(a) and DMH Bulletin #19-01) and shall make every effort to admit a patient with special needs addressed by these clinical competencies, when there is an open bed
- 24 hours is the maximum threshold for a patient boarding in an ED to initiate escalation steps to obtain admission
- At the 60 hour (or 48 in the case of youth) mark of an ED Boarding episode, DMH will receive escalation referrals and take geographic considerations, family preference, etc. into account but without further delay in procuring a bed
- Individuals under the age of 18 years should be escalated to DMH at 48 hours of boarding once insurance carrier and internal escalation has been made
- Any necessary authorization (for inpatient hospital level of care, 1:1 staffing or other specific needs associated with medical comorbidity such as high-cost medications and special equipment or resources) is provided and documented as soon as the need is known (See Division of Insurance Bulletin 2018-01 and Special Services

Coding Grid dated 8-02-19). **This DOI guidance concerning specialing is expected to be incorporated into contracts between Inpatient Psychiatric Providers and Insurance Carriers.** If an Inpatient Psychiatric Provider identifies a need for such special services and the Insurance Carrier authorizes coverage, the facility is expected to admit the patient

  - At the time of verbal authorization, Insurance Carriers should be able to provide written authorization, an authorization number, or other identification of services, so that if any issues occur during claims processing, the Inpatient Psychiatric Provider is able to reference that specialing was authorized
  - Insurance Carrier's billing and payment policies should be updated to reflect how the Insurance Carrier's specialing process works, how payment will be made to Inpatient Psychiatric Providers and also includes the specialing codes established in the coding grid that are required by the plan
  - Insurance Carriers must provide authorization of specialing as soon as the need is identified in order to reduce admissions wait time

- Early and continuous communication between the ED Evaluation Team and the Insurance Carrier throughout this process ensures that the most current information is available and that there is no duplication of effort in the bed search work
  - This communication must be reciprocal; Insurance Carriers and ED Evaluation Teams are expected to communicate as to the status of their efforts to secure admission as needed
  - To ensure timely communication needed for the EPIA Protocol's success, it is expected that **ED Evaluation Teams and Insurance Carriers have an identified point person as well as use electronic means to communicate** to avoid excessive delays with telephone or fax machine communication methods
  - When the boarding individual is affiliated with a State Agency, the Agency should be contacted as soon as possible for information, care management, treatment plans, or special services to aid in a successful admission
- Inpatient Psychiatric Providers, Insurance Carriers, ED Evaluation Teams and DMH (along with other stakeholders) are expected to use the standardized Bed Search Protocol that was developed with state agency and stakeholder consensus.
- If the constraint to finding a hospital bed is an individual or family preference, this protocol will be activated, and the ED Evaluation Team will continue to work on acceptance at those preferred placements
  - The ED Evaluation Team will also try to understand and alleviate any barriers that are limiting the scope of Inpatient Psychiatric Provider possibilities with the family
- At any time after the decision is made that an individual requires hospital level of care,

the Insurance Carrier should be notified immediately but no later than 24 hours into the boarding episode for assistance
    - When it is clear that a placement will not be identified by 60 hours of boarding time, DMH may be consulted by the ED Evaluation Team or Insurance Carrier on a case-by-case basis for acceleration of the Protocol
- All Insurance Carriers and ED Evaluation Teams must use the on line portal for submitting a request for help to DMH
- If the request for inpatient placement is withdrawn or there is a level of care change or the ED Evaluation Team acquires a placement after escalating the case, these Protocols no longer apply and all relevant parties (Insurance Carriers, EDs, Parent/guardian, DMH) are notified about this change

Guiding Principles for Bed Search Efforts

- The hospital where a patient is boarding should make every effort to prioritize and procure a bed within their hospital system's network

- The ACO/MCO for the boarding member should make every effort to prioritize and procure a bed within their hospital system's network

- Patients should be re-hospitalized by the same Inpatient Psychiatric Provider where they were most recently hospitalized to the maximum extent possible for continuity of care

- The Insurance Carrier and/or EPIA establish a working partnership with the ED Evaluation Team through the designated point person as soon as possible

- A standardized admission packet will be used for bed searches by all Inpatient Psychiatric Providers – please refer to *Appendix 1*

- Utilizing secure electronic transfer of clinical information is expected

- Inpatient Psychiatric Providers have 2 hours at maximum after they receive the complete admission packet to respond to an ED Evaluation Team, Insurance Carrier, or EPIA with their decision whether to admit a boarding patient

EPIA Protocol Escalation Steps

1. **First 24 hours after ED arrival**
   a. Any time after a patient is admitted to the ED, the ED Evaluation Team may notify the appropriate person at the Insurance Carrier that one of their members is in the ED waiting for a psychiatric hospital admission
   b. The Insurance Carrier will use its internal care management processes to determine if there is useful information for the ED Evaluation Team to assist with finding a bed
   c. At any time after the decision is made to admit the individual to an Inpatient Psychiatric Provider and no later than 24 hours from arrival to the ED, the ED Evaluation Team must notify the Insurance Carrier to Request Assistance

2. **If an admission bed has not been procured by 24 hours from a patient's arrival to an ED**
   a. The ED Evaluation Team must make a formal Request for Assistance to the Insurance Carrier if this has not already been done
   b. Within two hours of the submission of a Request for Assistance by an ED Evaluation Team during normal business hours, an employee of the Insurance Carrier will act on the request and initiate a process to facilitate the admission of the individual into an appropriate hospital
      i. When a Request for Assistance is made outside of normal business hours (e.g. after hours and on weekends or holidays), the Insurance Carrier shall acknowledge receipt of the Request no later than the morning of the next calendar day after the request is made, and shall proactively provide assistance
   c. The Request for Assistance must provide the Insurance Carrier with clinical information about the individual, updated clinical information, barriers to admission, evidence of the bed searches to date, and a summary of responses from hospitals who have denied admission to the individual
   d. The Insurance Carrier must work closely with the ED Evaluation Team point person to avoid redundancy in bed searches and to determine which hospital(s) is most appropriate to meet the needs of their member. Insurance Carriers must engage senior clinical and administrative officials at potential Inpatient Psychiatric Providers continuously until an admission bed is identified and agreed upon
      i. The Insurance Carrier in discussion with Inpatient Psychiatric Providers proactively offers, determines and authorizes payment for required supports or resources (i.e., single room, extra staffing, high-cost medications for complex comorbid medical conditions etc.) when such supports or resources are determined to be needed by the Inpatient Psychiatric Provider who also has the capability to provide such specialized resources to allow for admission. All authorizations are documented and provided to the ED Evaluation Team and to

the Inpatient Psychiatric Provider. A clear mechanism of how payment will be provided by the Insurance Carrier is included when making these specialing arrangements. When an Insurance Carrier authorizes these resources, the Inpatient Psychiatric Provider is expected to accept the patient

ii. The Insurance Carrier must mitigate any authorization issues that are presenting barriers to a successful admission acceptance and shall provide documentation of such authorization to the Inpatient Psychiatric Provider in a timely manner

iii. If a specific Inpatient Psychiatric Provider considered most appropriate by the Insurance Carrier to serve the individual does not have an immediate bed but will have one within the next 24-48 hours, the Insurance Carrier should seek to have the Inpatient Psychiatric Provider agree to prioritize the admission of the individual against the next discharge. However, the bed search continues and if another Inpatient Psychiatric Provider is found to have a bed prior to the preferred Inpatient Psychiatric Provider's availability, that readily available bed should be secured for the patient should all parties agree

iv. If an in-network bed is unavailable, the Insurance Carrier should seek placement in appropriate out-of-network facilities (considering services required by the individual, geography, etc.)

v. The Insurance Carrier actively seeks to obtain admission of the individual until an inpatient bed has been secured. This includes a review of the updated clinical referral packets and ongoing discussion with senior leaders of the Inpatient Psychiatric Providers to break down barriers to admission

vi. Once the Insurance Carrier has exhausted its network and appropriate out-of-network options, and when 60 hours of boarding time has elapsed and the individual still has not been accepted by an Inpatient Psychiatric Provider, the Insurance Carrier must escalate to DMH for assistance

vii. If at any time after the decision is made that an individual with co-occurring complexity requires psychiatric hospital level of care and it is clear that a placement will not be identified within 60 hours, Insurance Carrier (or, in the absence of an engaged Insurance Carrier, the ED Evaluation Team), may consult with DMH on a case-by-case basis for acceleration of the Protocol

viii. The Insurance Carrier is responsible for informing Inpatient Psychiatric Providers considered appropriate to admit the individual that the process is being escalated to DMH

3. **If an admission bed has not been identified by 60 hours from a patient's arrival to an ED**
   a. The Insurance Carrier (or, in the absence of an engaged Insurance Carrier, the ED Evaluation Team) MUST request assistance from DMH at 60 hours (or 48 hours if the

individual is under 18 years)

b. The Insurance Carrier (or, in the absence of an engaged Insurance Carrier, the ED Evaluation Team) MUST contact DMH by submitting an online referral as directed by DMH
   i. The Deputy Commissioner of Clinical & Professional Services or designee oversees the DMH team that ensures placement
   ii. The Insurance Carrier or ED Evaluation Team designates a senior clinical administrator to communicate with DMH
   iii. The internal DMH EPIA team will work with Insurance Carriers, ED Evaluation Teams and Inpatient Psychiatric Providers to determine next steps to ensure that psychiatric admission for the individual is accomplished
c. DMH works with ED Evaluation Teams, Insurance Carriers and Inpatient Psychiatric Providers to ensure up to-date information and clinical assessment is provided in a timely and effective manner until a bed becomes available
d. All parties involved agree to use the Standard Bed Search Protocol developed by the EPIA Multi-Stakeholder Implementation Workgroup (see page 13)
e. DMH engages senior clinicians and administrators of Inpatient Psychiatric Providers, Insurance Carriers and ED Evaluation Teams, as indicated, to understand and resolve any barriers to admission
f. If State Agencies' involvement is required to resolve barriers to admission, DMH will convene a conference call with the appropriate State Agency representatives, ED Evaluation Teams, Inpatient Psychiatric Providers, Insurance Carriers and others as needed to resolve such barriers
g. When network adequacy and payment issues create barriers to admission, DMH facilitates a discussion with the Insurance Carrier, MassHealth and DOI as appropriate
h. Data collected from this process is reviewed on a regular basis by both the DMH Licensing for use during regulated surveys for continuing licensure and the EPIA Advisory Council

4. Individuals who are uninsured or have a Carrier not regulated by the Commonwealth (DOI)

No individual boarding in an ED waiting placement in an inpatient psychiatric bed will wait more than 60 hours (or 48 hours if the individual is under 18 years) before DMH has been notified, including those who are uninsured or who have coverage not regulated by DOI. This includes but is not limited to those who are:

a) Not insured and not eligible for MassHealth benefits
b) Not insured and eligible for MassHealth benefits
c) Insured by unmanaged Medicaid
d) Insured by unmanaged Medicare/Medicaid

e) Insured by a self-funded ERISA Plan
f) Insured solely by Medicare or
g) Insured through an out-of-state insurance carrier (commercial or Medicaid)

The ED Evaluation Team will continue its efforts to locate an appropriate placement and to engage the identified payer (if there is one) for assistance as outlined above. If these efforts are unsuccessful, the ED Evaluation Team MUST submit a Request for Assistance to DMH at 60 hours (or 48 hours if patient is under 18 years). If at any time, it becomes clear that an inpatient bed will not be identified within 60 hours, the ED Evaluation Team may consult with DMH on a case-by-case basis for acceleration of the Protocol.

5. Active Role of the ED Evaluation Team for those without Insurance Carrier Support

It is expected that the ED Evaluation Team's clinical and administrative leadership play an active role during the daily (or more frequent) bed searches in the 60 hour (or 48 hours for a youth) period prior to submitting a request for DMH assistance.

a. The ED Evaluation Teams must have an Internal Escalation Protocol in place for any long-stay ED Boarding individual that involves ED Evaluation Team clinical and administrative leaders who will then escalate their search efforts to clinical and administrative leaders at the Inpatient Psychiatric Providers that have an available bed
b. This Internal Escalation Protocol is activated after the first 24 hours boarding in the ED
c. Protocols must be developed to assure active efforts to apply for MassHealth coverage for boarding individuals who may be eligible, including use of protocols for Hospital Presumptive Eligibility if applicable
d. Use of the Standardized Bed Search Protocol is expected
e. Full escalation prior to DMH involvement at 60 hours (or 48 hours in the case of a youth) includes but is not limited to involvement of the Hospital's senior clinical and administrative officials (including the ED Attending of record) where the individual is boarding
f. The Boarding Hospital's senior administrators are expected to seek placement within their hospital system's network to optimize these relationships on behalf of the boarding individual
g. The Boarding Hospital's senior administrators will contact similar senior leadership at Inpatient Psychiatric Providers with available psychiatric beds to advocate for their boarding patient's admission
h. ED Evaluation Teams must submit referral requests to DMH using the online RedCap portal
i. This Internal Escalation Protocol applies to all individuals without an Insurance Carrier advocate

6. **Active Role of the Inpatient Psychiatric Providers licensed by DMH**
    a. It is expected that all licensed Inpatient Psychiatric Providers maintain Admission Denial Logs signed by Medical Directors or designee serving as the medical director who are consulted on all admission denials when there is a bed available
    b. All inpatient units and facilities are expected to maintain a daily Unit Conditions log for review by DMH Licensing teams during scheduled and unannounced survey visits
    c. The daily emails from EPIA listing those currently expedited to DMH must be reviewed and taken into account when considering admissions for the day as well as planning against next discharges
    d. There must be an Inpatient Psychiatric Provider point person who is readily available to engage in timely discussions with ED Evaluation Teams, Insurance Carriers and the EPIA team concerning expedited ED Boarders
    e. Adherence to the Bed Search Protocol developed by the EPIA Multistakeholder Implementation Workgroup is expected
        - Use of the standardized admission packet
        - Decision whether to admit or not within 1-2 hours of receiving a complete admission packet
        - Assurance that all denials were reviewed by the Medical Director or designee serving as the medical director prior to the decision to deny
        - Work to admit those patients deemed appropriate by the Inpatient Psychiatric Provider against next discharge
    f. Regular admission of long waiting (14+ days) ED Boarding patients from the EPIA list should be prioritized and planned for by hospital leadership
    g. Electronic communication of clinical information from ED Evaluation Teams, Carriers and EPIA is expected

Summary for Insurance Carriers

Member Insurance	Proposed Process
MassHealth Involved	
MassHealth managed care	• ED Evaluation Team Request for Assistance to Insurance Carrier by 24 hours • Senior administrative & clinical leaders are actively involved with bed finding • Insurance Carrier outreaches to DMH by 60 (48 for youth) hours
MassHealth non-managed care (FFS, HSN, duals)	• ED Evaluation Team activates their Internal Escalation Protocol by 24 hours • ED Evaluation Team leaders outreach to DMH by 60 (48 for youth) hours
Commercial Coverage	
Insurance Carrier regulated by DOI	• ED Evaluation Team notification and Request for Assistance to Insurance Carrier before or by 24 hours • Senior administrative & clinical leaders are actively involved with bed finding • Insurance Carrier outreaches to DMH at 60 (48 for youth) hours if individual is still boarding
Administrator for self-funded ERISA Plans not regulated by DOI Out of state insurance carrier	• ED Evaluation Team Request for Assistance to appropriate Plan Administrator or Insurance Carrier by 24 hours • If Insurance Carrier will not engage in this protocol, the ED Evaluation Team continues to search for a bed and activates their Internal Escalation Protocol and • Escalates to DMH at 60 (48 for youth) hours if the individual is still boarding
Other	
Medicare Only Uninsured	• The ED Evaluation Team makes active efforts to assist patients with application for MassHealth coverage starting at 24 hours; and/or, • Continues to search for a bed and activates their Internal Escalation Protocol; • Requests help from DMH at 60 (48 for youth) hours if still unplaced

Insurance in BOLD represents those in the standard protocol outlined.

Summary for Bed Search

	Proposed Process
Bed searches are initiated with a phone call by ED Evaluation Team clinicians or their designee	**General search for bed availability** - Meaningful Waitlist for Child/Adolescent and specialty units by Inpatient Psychiatric Providers is encouraged
	Patient specific bed search - Get DCF/DMH/DDS involvement as soon as possible if applicable - **Insurance Carriers** advocate at senior administrative/clinical levels and work to decrease any perceived barrier to admission by Inpatient Psychiatric Providers - Prioritize hospital network/system where the patient is boarding and/or the system where the patient receives their outpatient care (ACO/MCO) - For boarding individuals with lapsed Medicaid, or are uninsured and applying for MassHealth, ED Evaluation Teams are expected to work with MassHealth to expedite this re-insurance process - If there is a family preference, only the packet and updated one page worksheets are sent to the preferred Inpatient Psychiatric Providers while continuing to work with family to enlarge the number of preferred Inpatient Psychiatric Providers
Begin Calling Inpatient Psychiatric Providers – outcome of calls:	**Yes, there is a Bed Available** - Send complete Admission Packet for review (secure email or eFAX, if possible) - Once a complete Admission Packet is received, the Inpatient Provider reviews and provides a clear Yes/No within one hour - If Inpatient Psychiatric Provider determines that the case is complicated and requires internal escalation, a final determination about admission is made within an additional hour - If the initial clinical presentation and/or unit conditions do not permit admission, provide a clear 'No" and document in the Medical Director Log (per DMH regulations)
	Maybe, Bed Available or opening up later in the day - Identify the clinical barrier, acuity, or staffing issues that need addressed by the Inpatient Psychiatric Provider to overcome hesitancy to accept - May require communication with the ED Evaluation Team or others involved in the escalation (Insurance Carrier and/or EPIA) and the necessary transparency to resolve barriers - Decision from the Inpatient Psychiatric Provider is received by COB; if patient presented after 3pm, by COB the next day
	No, Bed Not Available, however: - Based on initial clinical presentation, would this Inpatient Psychiatric Provider consider accepting the patient pending a discharge? *Yes* – put on waitlist (only for C/A or Geriatric units) and provide more clinical information *No* – Provide a clear "No" from Inpatient Psychiatric Provider to ED Evaluation Team

Transmission of the Admission Packet only when requested by the Inpatient Psychiatric Provider based on phone call above	- Exceptions: any EPIA involved youth is expected to have their Admission Packet sent to all the child and adolescent Inpatient Psychiatric Providers and the daily one-page update until admission bed is procured
Acceptance for transfer to the Inpatient Psychiatric Provider	- Any Insurance Authorization needed, including authorization for any special services that are required to facilitate admission are completed prior to transfer - Planned arrival time agreed upon with appropriate doctor to doctor and nurse to nurse communication before transfer - Availability of parent or guardian to sign the Conditional Voluntary Admission legal status within 24 hours for youth under 18 years of age - Notification of other participating stakeholders, as applicable - Close the loop with all stakeholder advocates involved

Appendix 1: Standardized Admission Packet (the Packet)

The following demographics and clinical information do not need to be presented on the initial cold call but should be collected and provided to the Insurance Carrier and Inpatient Psychiatric Providers (and to DMH if requested) pursuant to the escalation process:

1. Administrative Face Sheet (minimally includes full name, date of birth, insurance numbers and guardianship)
2. Comprehensive Evaluation (3-5 Pages)
    a. Initial Evaluation
        i. Diagnosis/Presenting Problems
        ii. Clinical assessment and need for inpatient level of care
    b. Medical Clearance
    c. Current updated clinical information
        i. Summary ED Course & any treatment provided
        ii. Medications administered in the ED
        iii. Behavioral response to medication administered
        iv. High risk behaviors (substance use, etc)
        v. Court involvement
        vi. Family or other therapeutic interventions in ED
        vii. Patient's baseline
    d. Current assessment and mental status exam (same day as bed search)
        i. Requirement of any special services including but not limited to single room, 1:1, medical accommodation
        ii. Disposition expected at the end of acute hospitalization (if applicable)
        iii. Parent/guardian preferences (if applicable)
        iv. Guardianship/Rogers (if applicable)
        v. Agency involvement (if applicable)
        vi. Collateral contacts (if applicable)
3. 24 Hour ED Course Summary/Update for each day in the ED since arrival (one page per day)

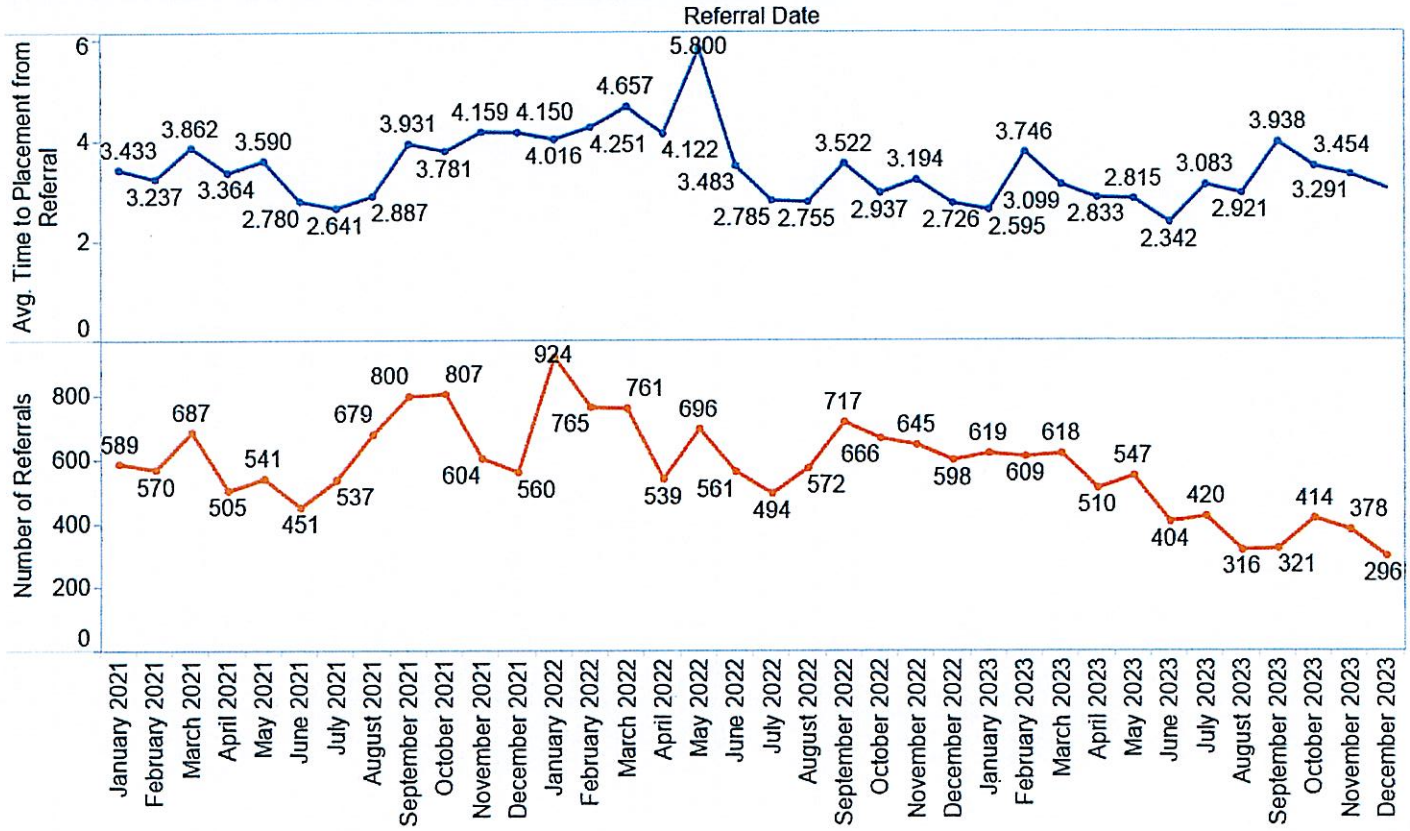
Appendix 4

EPIA TREND DATA 2021-2023

Average Time to Placement and Number of Referrals

Age Range
All Ages

Month of Referral Date
January 2021 to December 2023
and Null values

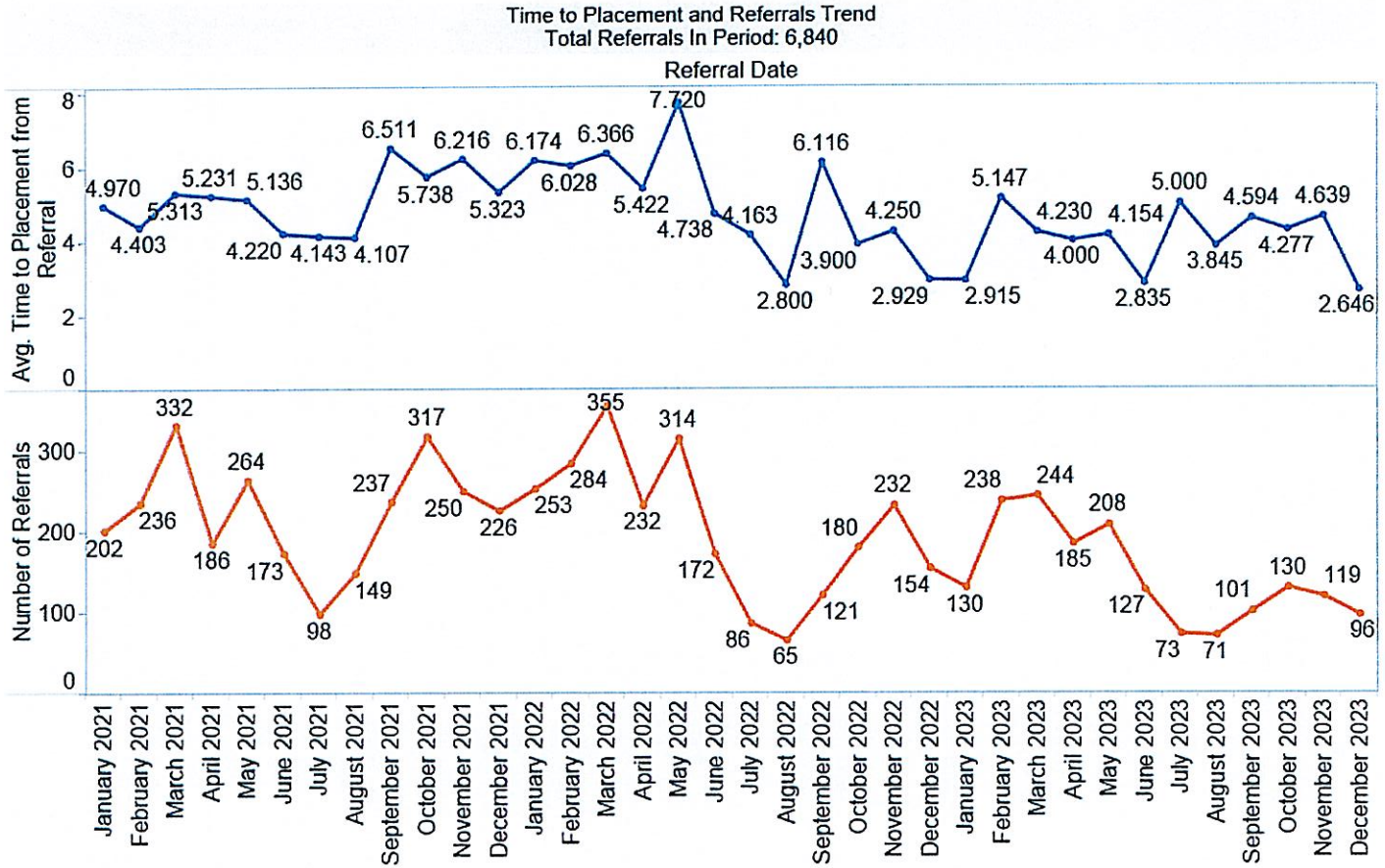


Exclusions Based on Time to Placement inlcudes outliers placed before referral and over 300 days after referral. Only includes Dispositioned referrals

Average Time to Placement and Number of Referrals

Age Range
Ages 0 - 17

Month of Referral Date
January 2021 to December 2023
and Null values

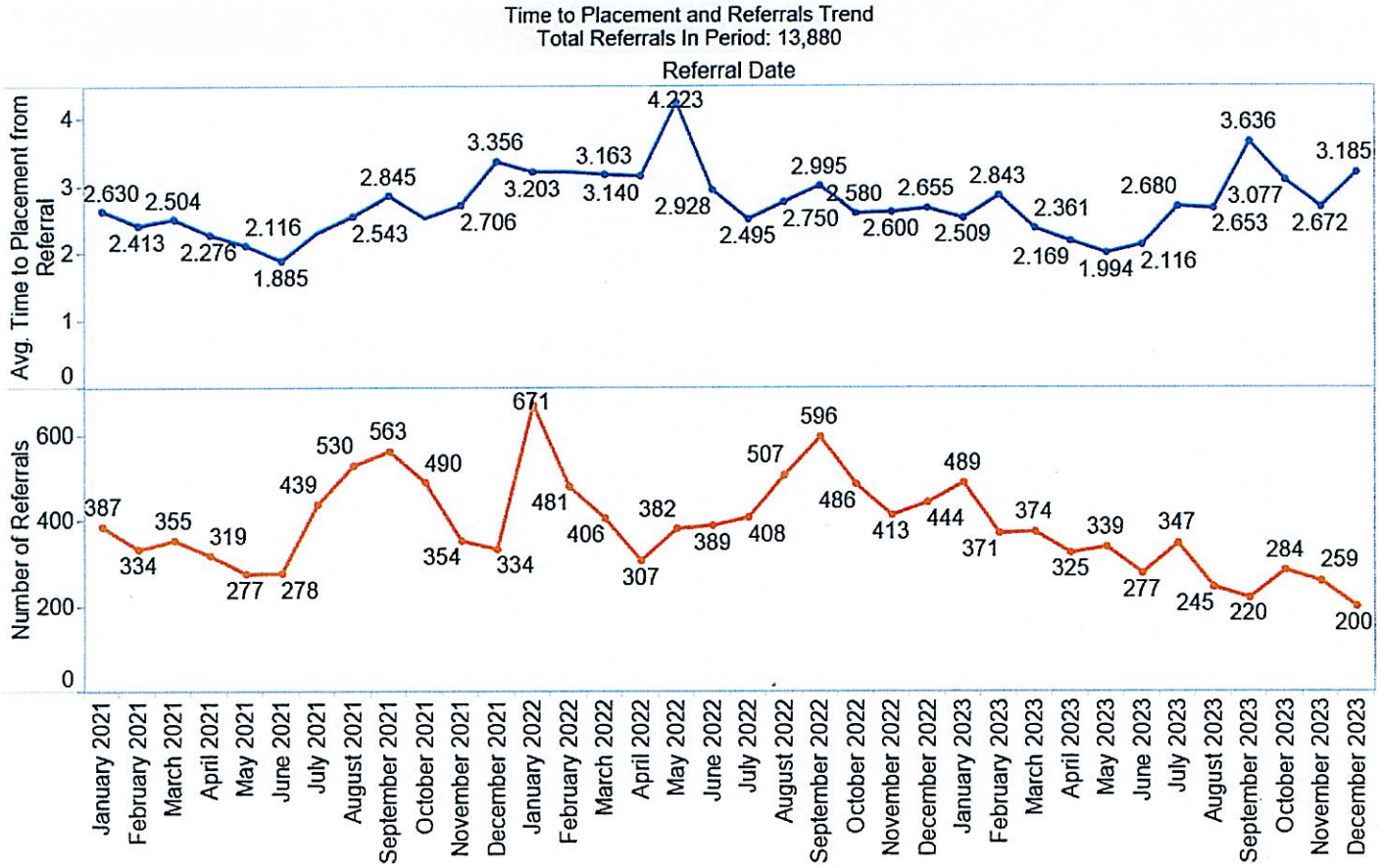


Exclusions Based on Time to Placement inlcudes outliers placed before referral and over 300 days after referral. Only includes Dispositioned referrals

Average Time to Placement and Number of Referrals

Age Range
Ages 18+

Month of Referral Date
January 2021 to December 2023
and Null values



Exclusions Based on Time to Placement inlcudes outliers placed before referral and over 300 days after referral. Only includes Dispositioned referrals