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2025 Annual Report
Expedited Psychiatric Inpatient
Admission (EPIA)
Advisory Council

January 2026

MASSACHUSETTS DEPARTMENT
OF MENTAL HEALTH

Annual Report to the Legislature from the
Expedited Psychiatric Inpatient Admission (EPIA)

Advisory Council

December 31, 2025

Introduction

Formation of the Advisory Council and Its Charge

This is the third 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 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. The protocol provides for active intervention and escalation of ED Boarding cases along prescribed time frames, with particularly difficult cases 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 for admission to an inpatient psychiatric hospital. This effort relies on early and continuous communication by all parties involved.

Since the last annual report of the EPIA Advisory Council, Phase 1 of the BH TRP (Behavioral Health Treatment Referral Platform) went live on February 26, 2025. Phase 1 automated referrals from emergency departments to inpatient psychiatric hospitals and connected 61 emergency departments, 57 inpatient psychiatric facilities, 24 payers and ACO's, and 3 state agencies. Point Click Care (Vendor) contracted by EHS built the BH TRP platform with diverse input from state and private stakeholders and guidance from the Council. As of writing this report, DCF (Department of Children & Families) also joined Phase 1 of the platform on November 6, 2025. Point Click Care is now working on Phase 2 of the BH TRP (expected to go live in late April 2026) which will automate referrals from emergency rooms to CBHC's (Community Behavioral Health Centers) and CBAT's (Community Based Acute Treatment). We are starting to work on maintaining and stabilizing Phase 1 automation of referrals from EDs to inpatient psychiatric facilities while we continue to work on Phase 2. As reported in 2024 annual report, we updated EPIA 2024 Protocol: <https://www.mass.gov/doc/expedited-psychiatric-inpatient-admissions-protocol-2024> that incorporates the use of this BH TRP by all EDs, Psychiatric Inpatient Providers, Insurance Carriers, and state agencies working to admit patients from the EDs (and medical surgical units of general hospitals) to inpatient psychiatric units. This annual report uses EPIA data entered in a REDCAP database, and data available through the BH TRP platform since Phase 1 launch for the FY25, has been analyzed by the Council, and provides recommendations for further action to address the ongoing phenomenon of Behavioral Health ED Boarding.

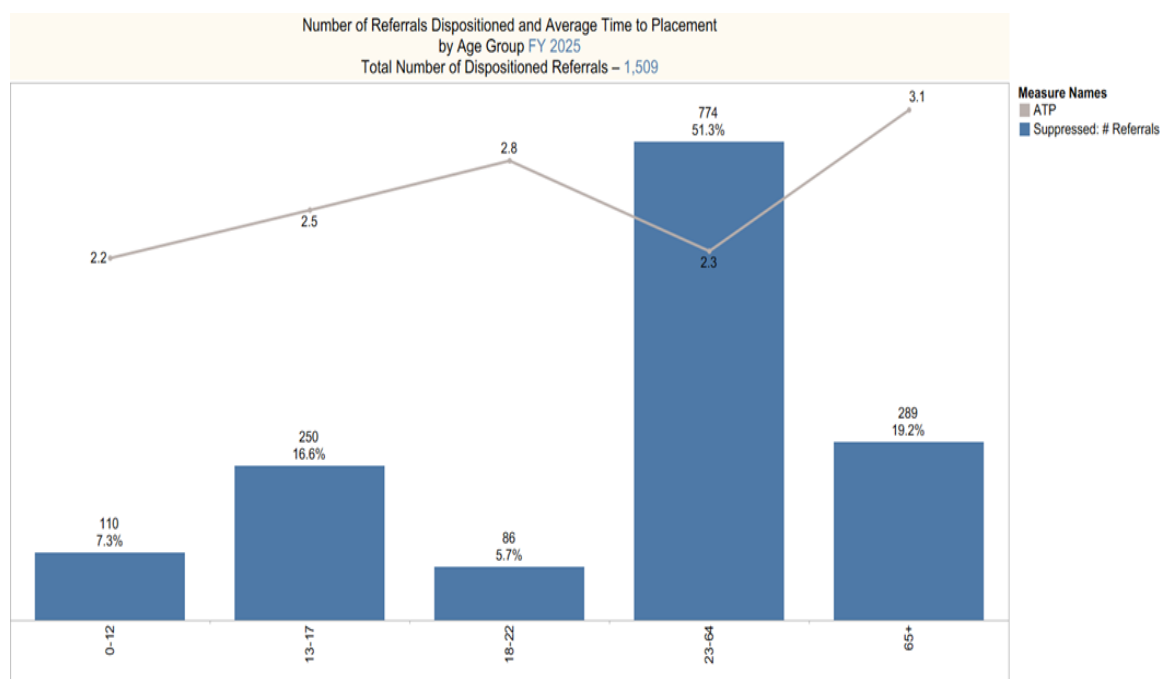
Data reported here has some limitations inherent in transitions from one dataset to another-specifically as we continue to build and expand BH TRP (Phase 2 build in progress) and continue to onboard new users. Since a new application was implemented in 2025, enhancements made during implementation may affect the data shown in this report and may limit direct comparison with data from prior periods.

Data Review

FY2025 Data

Data Summary

There was a total of 1509 referrals for EPIA assistance during FY25. Average Time to Placement for referrals escalated to EPIA assistance (60 hrs for 18 and older and 48 hrs for individual under 18) was 2.5 days, which is a reduction from 3 days from FY24 and a high of 4.9 days in FY19. Nearly twenty-four percent (23.9%) of the referrals were for youth under 18. The largest proportion of referrals are aged 23-64 (774 or 51.3%). As displayed below, the age group (0-12) had the shortest time to placement (2.2 days). Geriatric (65+) referrals had highest placement times (3.1 days) .

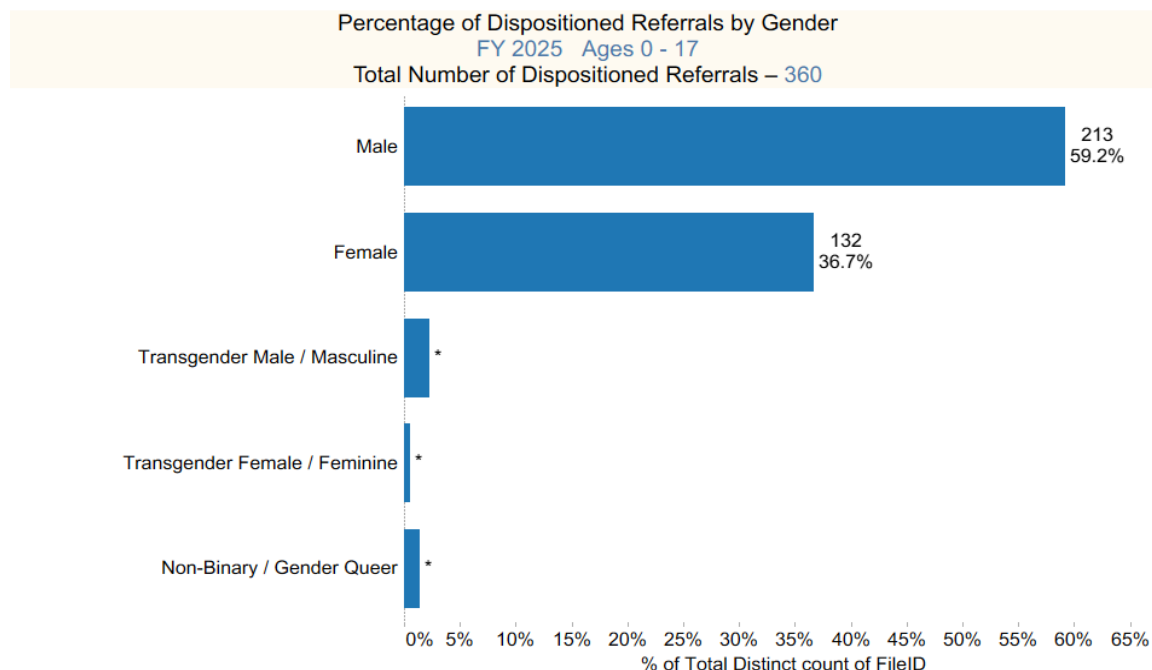


The data summary sections below describe the youth (0-17) and adult (18+) referrals by gender identity, race, ethnicity, insurance status, diagnosis, and the barriers to placement responsible for extended wait times. Further, the Average Time to Placement is examined by diagnosis and by barriers to placement separately for youth and adults.

EPIA Youth Referrals

Youth (ages 0-17) make up 23.9% (360 referrals out of 1509 total) of all referrals to EPIA during FY25.

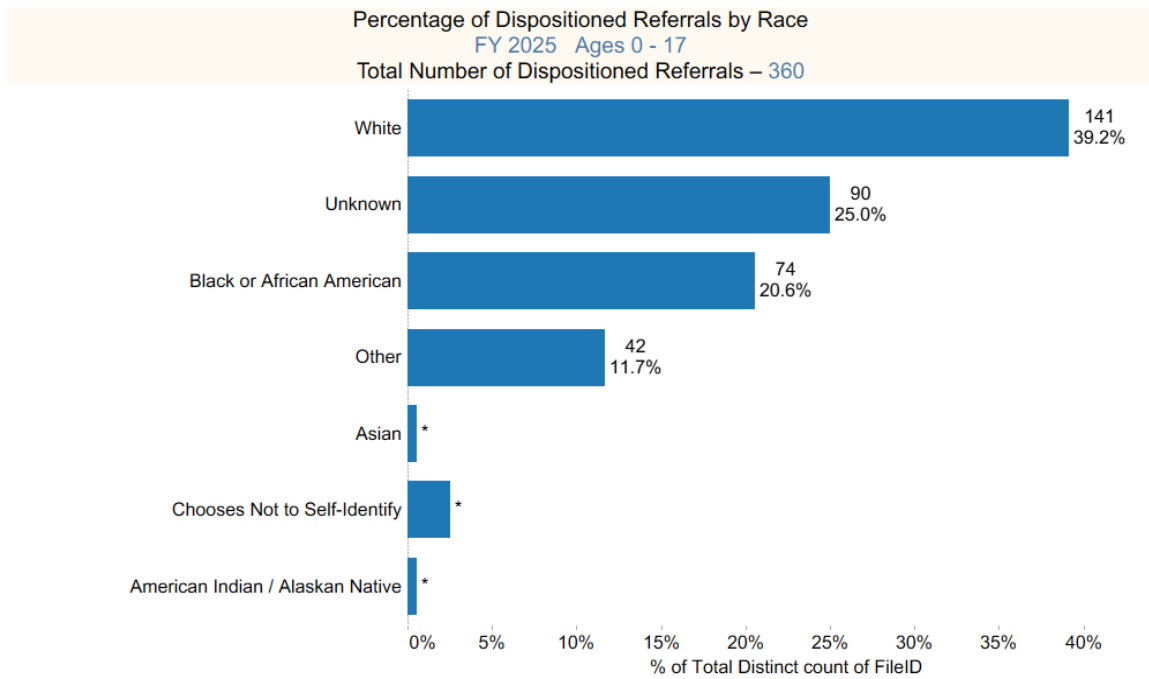
Gender Identity



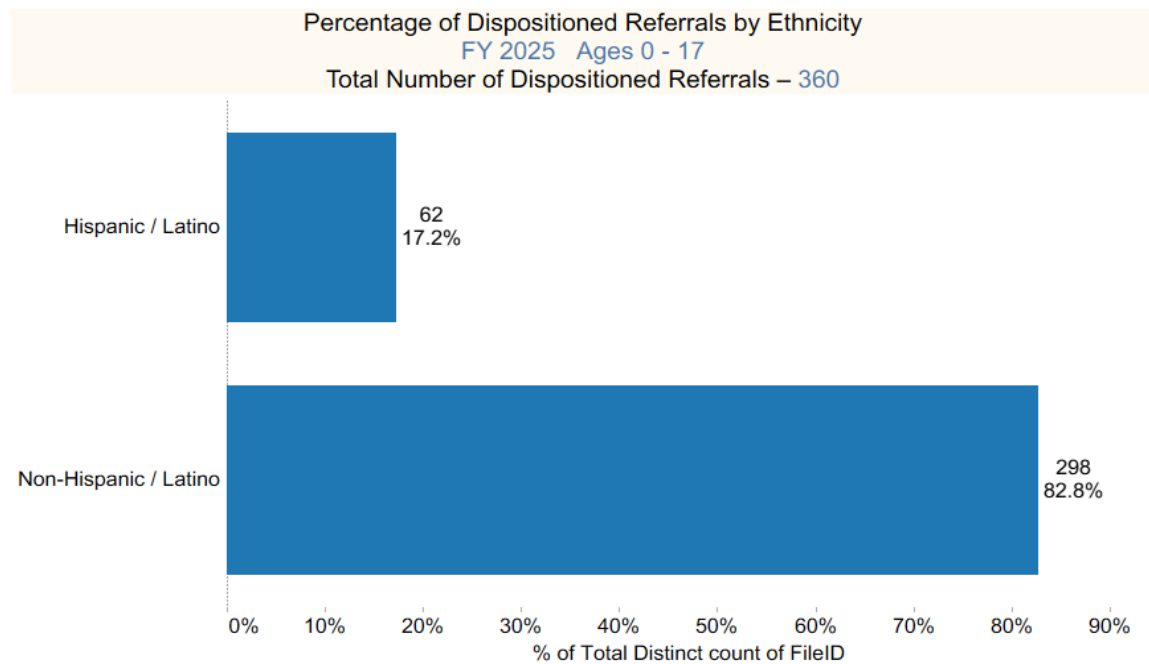
When disaggregating data by Gender Identity, referrals for youth under 18 have a preponderance of males (213 males and 132 females, 59.2% and 36.7%% respectively). Non-binary or gender queer youth make up a small proportion of referrals to EPIA (4.1%). Asterisk (*) in the figure above and throughout this report denotes less than 10 individuals (for privacy).

Race and Ethnicity

Youth whose cases were referred to EPIA, are predominantly White (39.2%). 20.6% are identified as African American, and less than 1% identified as Asian and American/Alaskan Native. These percentages can only be presented for those referrals whose racial identity was recorded. Unfortunately, approximately 37% of the EPIA referrals did not record race in the demographic questions-this has remained unchanged since FY24. Because of the high rate of non-reporting of race and we have difficulties in comparing this data to the Massachusetts population and thus advise EPIA health equity efforts.



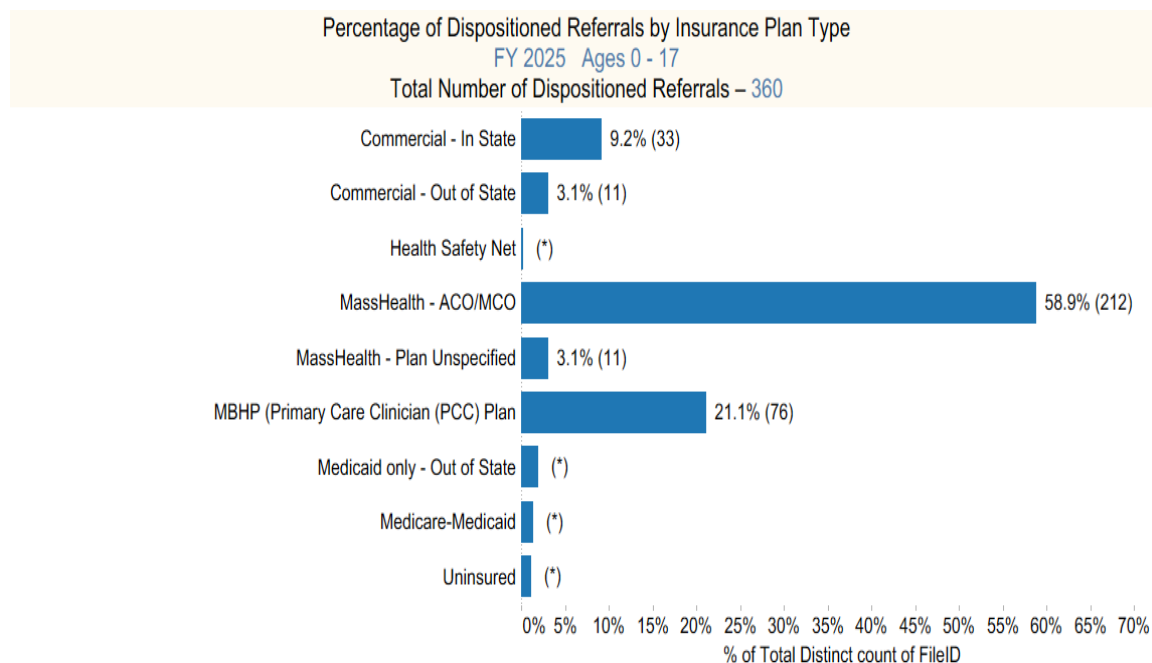
17.2% of youth referred to EPIA referrals identify as Hispanic or Latin



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-and this notification is now automated since we launched Phase 1 of BH TRP in February 2025. 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.

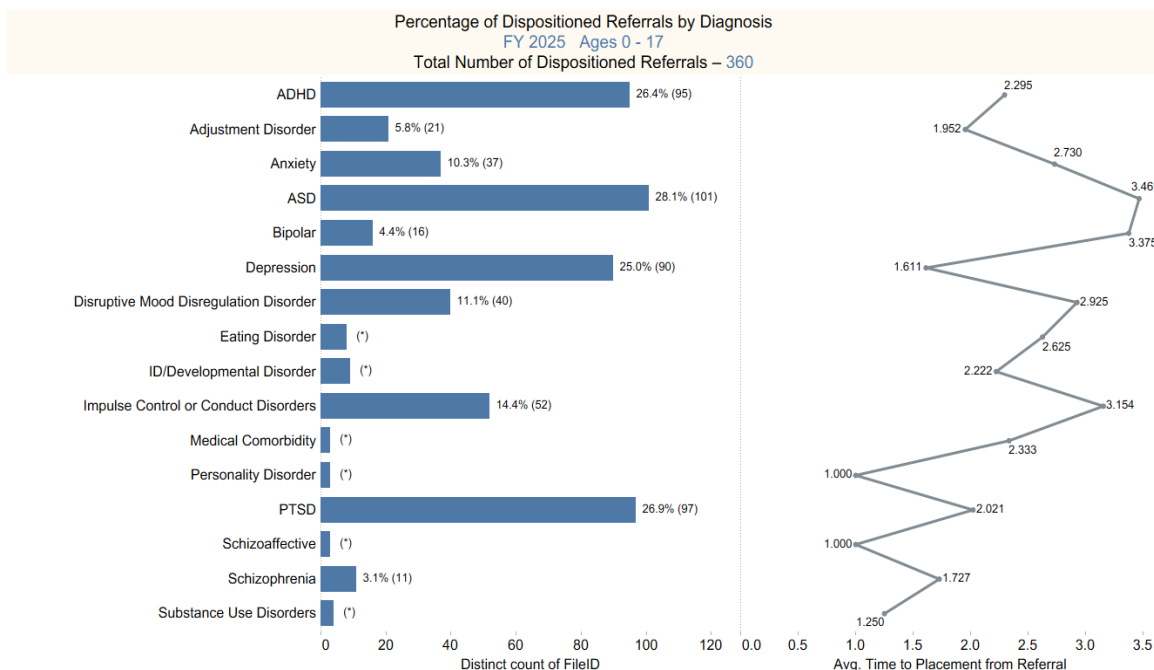


For the youth cases referred to EPIA and boarding in EDs for 48 hours or longer, a total approximating 83.1% were primarily covered by Managed Medicaid (MassHealth ACO/MCO, Unspecified MassHealth, and MBHP) while 12.3% were covered by Commercial Carriers (including both in-state and out-of-state commercial plans and self-funded employment-sponsored plans). This is disproportionate to the general population, and it is unclear what the insurance coverage is of all youth presenting to EDs for behavioral health help. The EPIA statistics capture the youth population that has been waiting in EDs for 48 hours or longer. We do not have full visibility into cohort that comes to EDs and are dispositioned prior to 48 hours-though since the launch of Phase 1 of BH TRP we have partial visibility for FY 25 and will have full visibility moving forward

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): Autism Spectrum Disorder or ASD (28.1%), PTSD (26.9%), ADHD (26.4%), Depression (25%), Impulse Control/Conduct Disorder (14.4%), Disruptive Mood Disorder (11.1%), and Anxiety (10.3%). Of note, Autism Spectrum Disorder now ranks as the most commonly recorded diagnoses compared to third most common in FY 24 (28.1% in FY25 compared to 18.3% in FY24), and Depression now ranks third most

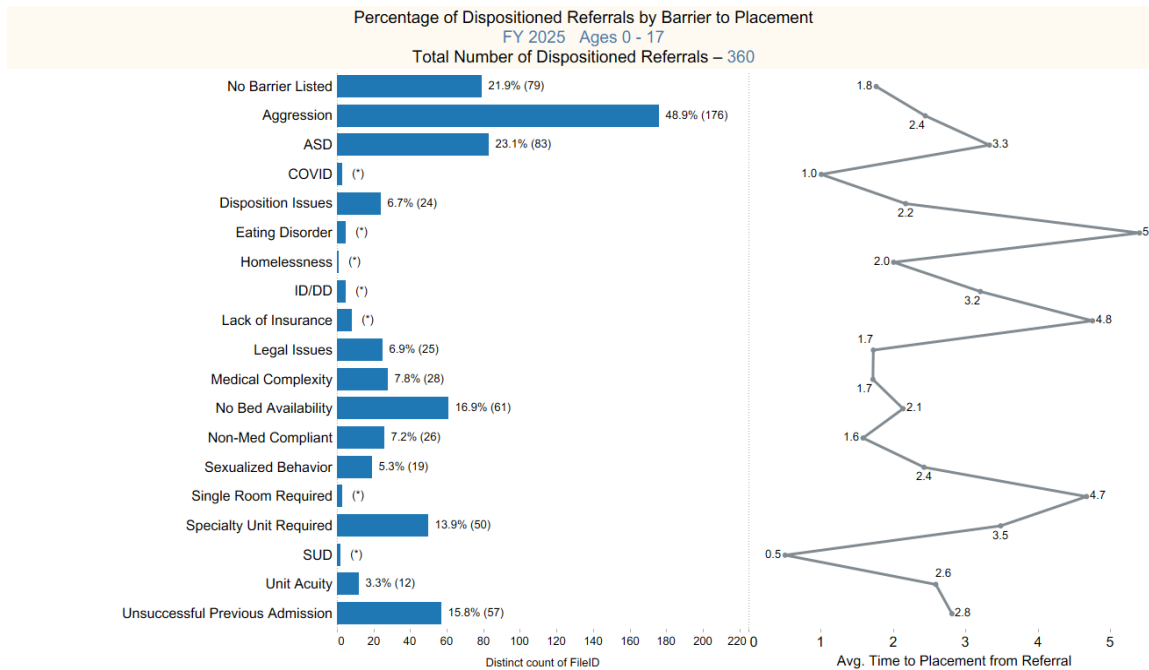
common compared to the most commonly recorded diagnosis in FY24 (25% in FY25 compared to 29.9% in FY24). Individuals diagnosed with Autism Spectrum Disorder took the longest time to place (3.46 days); with individuals diagnosed with Impulse Control or Conduct Disorder a close second (3.15 days) . We made significant strides in placing youth with medical comorbidities in FY25 (2.33 days) compared to FY24 (10.8 days).



Barriers to Placement (Reason for Delay in Admission)

For youth, barriers to placement in descending order of frequency include Aggression (48.9%), ASD (23.1%), No Barrier identified (21.9%), No bed Available (16.9%), Unsuccessful previous admission (15.8%), and Specialty unit required(13.9%). Aggression remained the top-most barrier to placement in continuation of FY24 trend. However, Autism Spectrum Disorder became the second most common barrier (from fifth most common in FY24). “No barrier” and “no bed available” though less frequent (38.8% combined total in FY25 compared to 41.3% combined total in FY24) continue to reflect a system’s problem and are not related to the individual youth’s need for acute services.

Significantly, the Average Time to Placement (ATP) for the barriers was highest for Individuals with Eating disorder (5.4 days), followed by those with lack of insurance (4.75 days), Single room required (4.66 days), and Specialty Unit Required (3.48 days). We made significant strides in reducing average time to placement for all the barriers from FY25. Lack of insurance is a rare event for youth, but when it happens, it prolongs the time to placement as noted. The most important task for EDs when trying to hospitalize an uninsured person (in this case a youth) is to use hospital resources to get the individual enrolled in MassHealth and once this happens, placement is rapid.

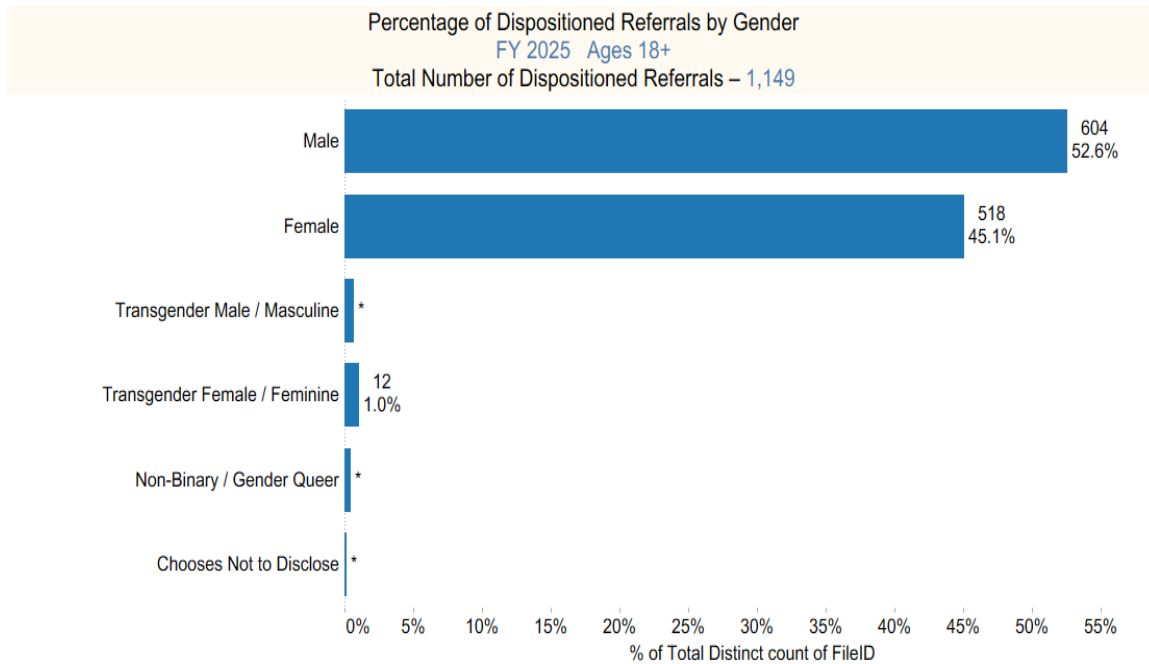


EPIA Adult Referrals

Adults comprise just over three quarters (76.2%) of EPIA referrals for a total of 1509 referrals. Most of the adults are in the 23-64 age group. Whereas youth under 18 are escalated to EPIA at 48 hours of ED boarding, adults are escalated to EPIA at 60 hours of ED boarding.

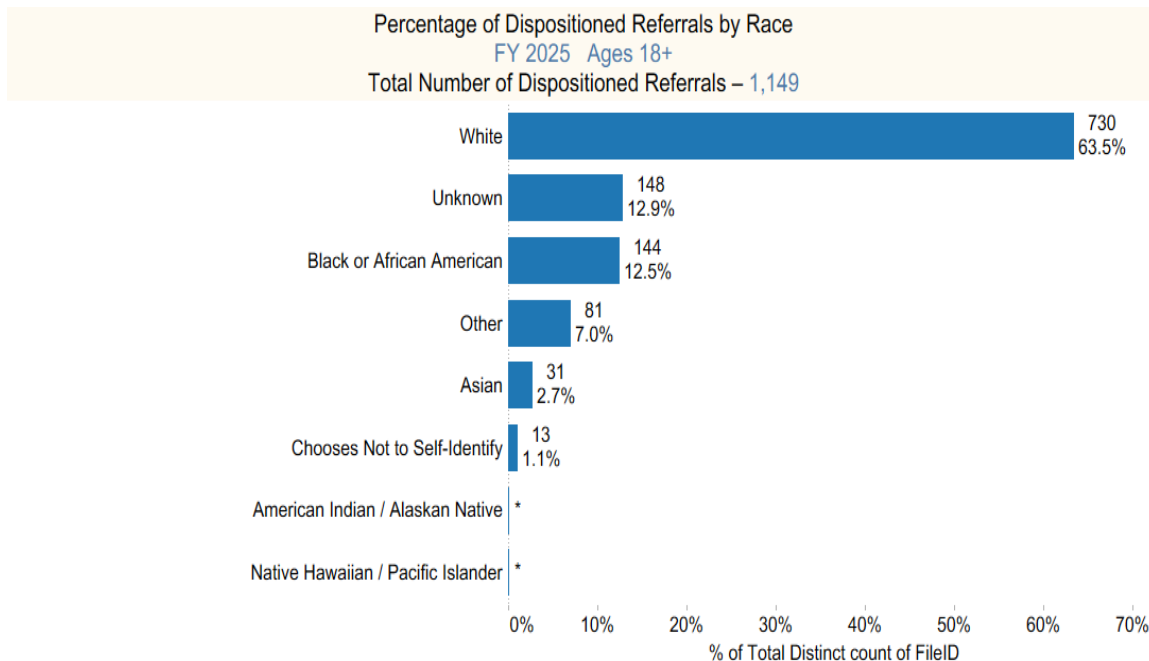
Gender

As compared with youth EPIA referrals (59.2%) a smaller proportion of adults referred to EPIA (52.6%) identify as Male. A larger proportion adults identify as Female (45.1%) compared to youth referrals (36.7%). Those who are non-binary or transgender reflect a combined 2.3% of the adults served (as compared to 4.1% in youth).

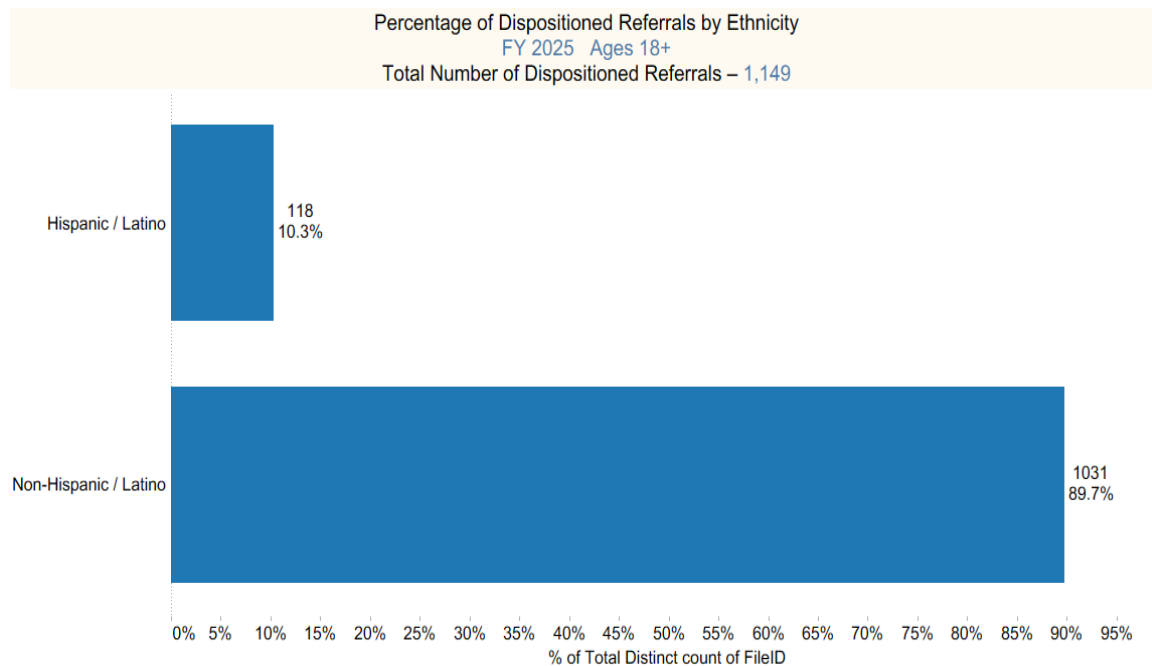


Race/Ethnicity

For adults whose cases were referred to EPIA, 63.5% were identified as white, 12.5% were identified as African American, and 2.7% were identified as Asian. As with Youth these figures represent those with a racial identity recorded. However, 19.9% do not have racial data recorded (12.9% Unknown and 7.0% Other), which limits the data to address health equity issues.

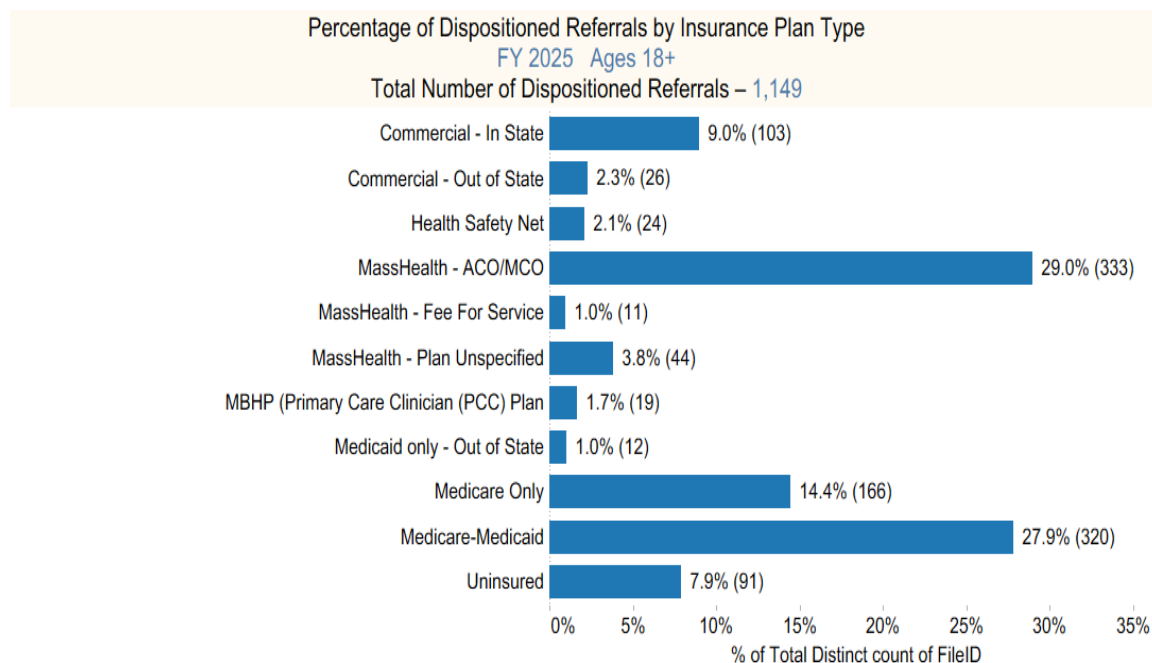


10.3% of adult EPIA referrals identify as Hispanic or Latino, a lower percentage than was seen with youth referred (17.2%).



Type of Insurance Coverage

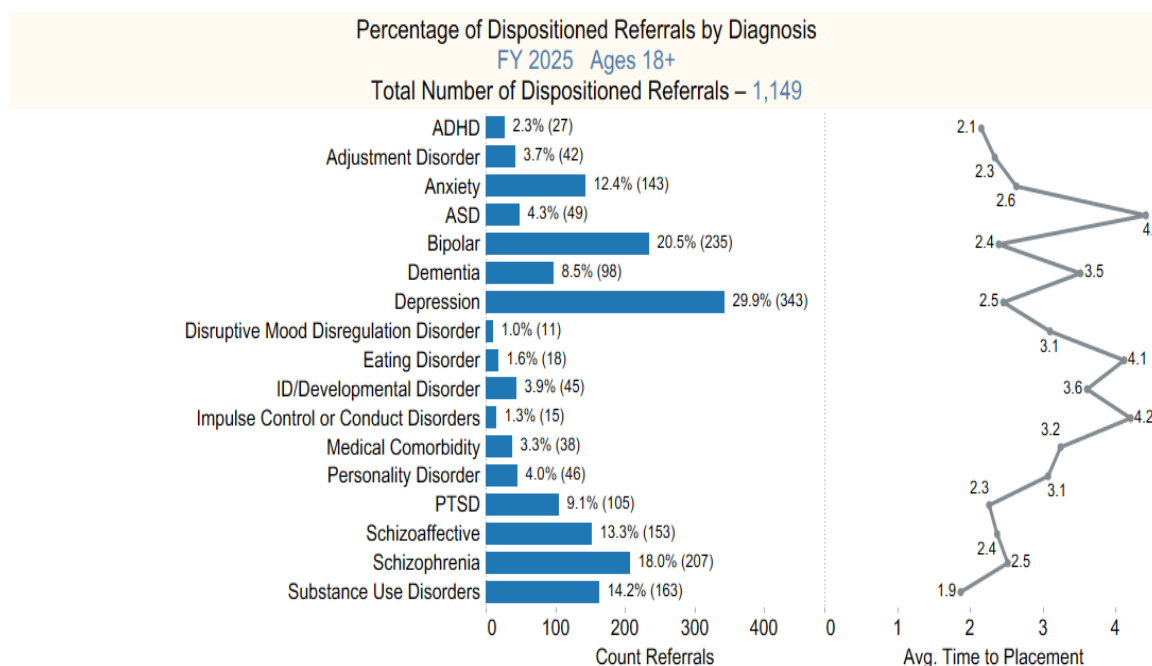
Of the adults referred to EPIA, who board in EDs longer than 60 hours, approximately 35.5% were primarily covered by Managed Medicaid, 43.2% were covered by Medicare (27.9% Medicare-Medicaid, 14.4% Medicare only, and 1.0% Out of state Medicare), 11.3% were covered by Commercial Carriers (including both insured health plans and self-funded employment-sponsored plans) and 7.9% were uninsured. A total of 78.7% of adults referred to EPIA were persons insured with 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 (29.9%), Bipolar Disorder (20.5%), Schizophrenia (18%), Substance Use Disorders (14.2%), Schizoaffective disorders (13.3%), and Anxiety (12.4%). The frequency of each diagnosis and the percentages remain relatively unchanged from FY24 for adults. As reported in FY24, diagnoses seen in higher percentages among adults were reported in much lower percentages for youth (bipolar disorder 4.4%, Schizophrenia 3.1%, and Substance Use Disorders and Schizoaffective disorders <1.0%). And diagnoses much higher in youth were much lower in adults (ASD 4.3%, ID/DD 3.9%, and ADHD 2.3%).

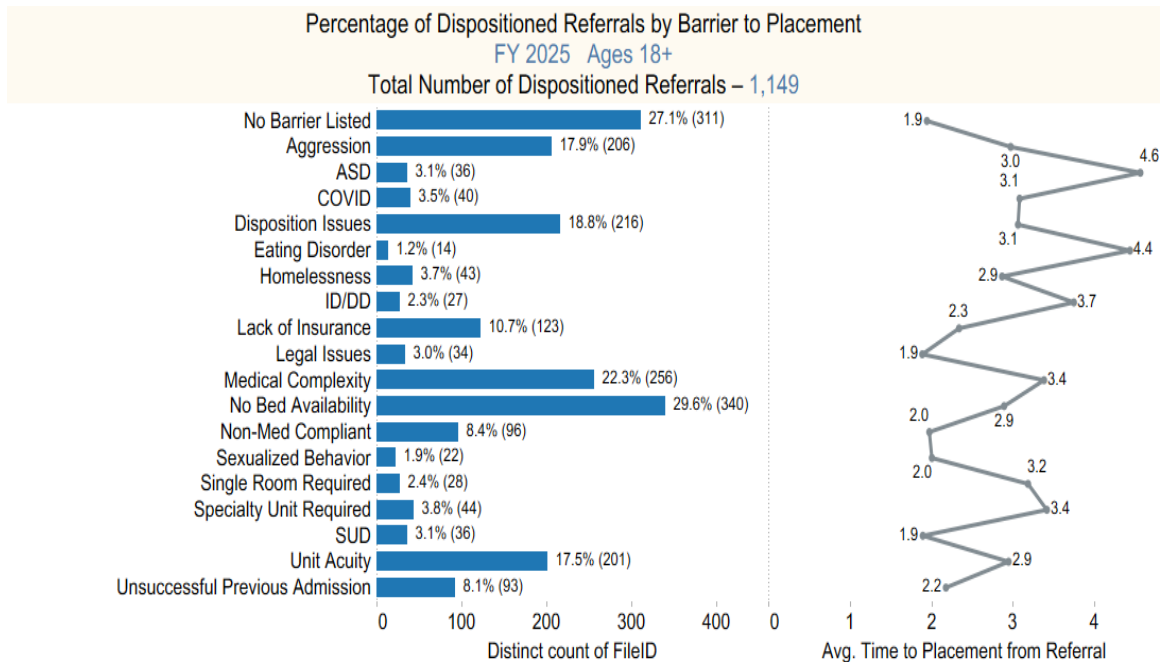
Adults have an average time to placement of 2.5 days after escalation to EPIA for assistance. Those diagnoses that have higher time to placement are usually small numbers of individuals with challenging placement issues like Autism Spectrum Disorder (4.4 days), Impulse Control Disorders (4.2 days), Eating disorder (4.1 days), Dementia (3.5 days), medical comorbidity (3.2 days), and personality disorders (3.1 days).



Barriers to Placement (Reasons for Delay in Admission)

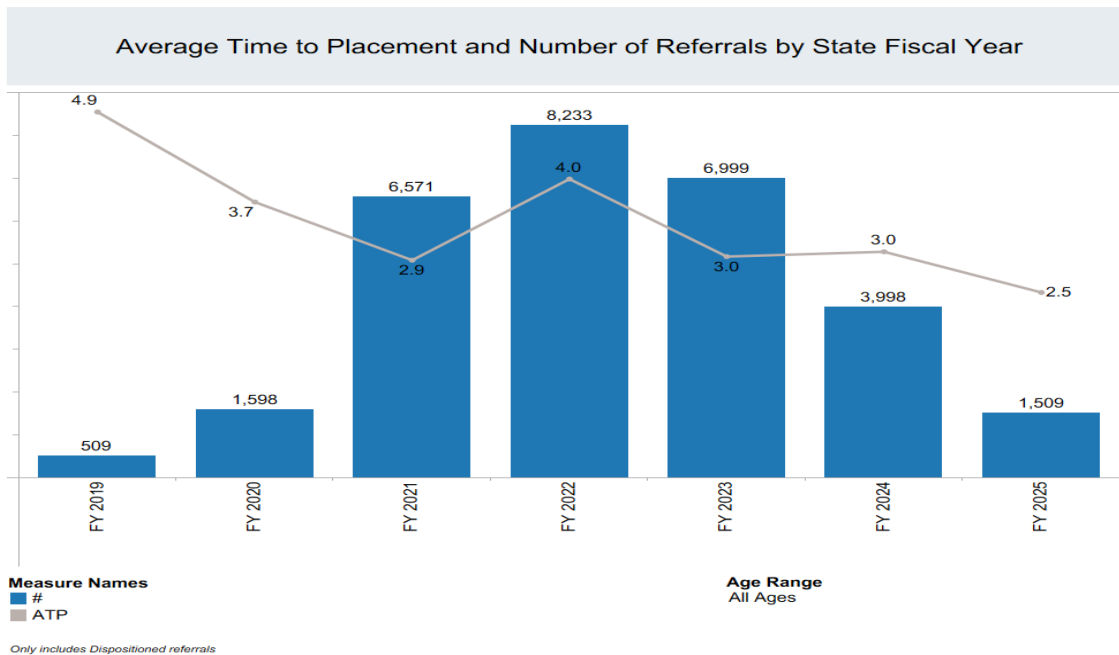
Some different barriers were noted for adults than for youth. First, “No Bed Availability” was most frequent barrier for adults (29.6%) quickly followed by no barrier listed at 27.1%. The other barriers in descending order of frequency include: Medical Complexity (22.3%), Disposition issues (18.8%), Aggression (17.9%), Unit Acuity (17.5%), and Lack of Insurance (10.1%). As with youth, barriers to admission are most frequently noted for adults also reflect system problems more than an individual’s particular clinical presentation. System problems can be seen in No Bed Available, and Unit Acuity. Aggression as a barrier was much less noted for adults than for youth (17.9% versus 48.9% respectively). Medical complexity was more frequent in adults than youth (22.3% versus 7.8% respectively).

When looking at the Average Time to Placement associated with each barrier, all barriers are not far off from the mean of 2.5 days. The highest ATP of 4.6 days correlated with aggression as a major behavioral presentation. Though small in volume, eating disorder as a presentation extends stays in an ER.



Trends

1. **Volume:** Trend data shows that during FY22, ED behavioral health long boarding volumes were at their highest; during FY23, FY24, and FY25 the volume leveled off and continues to display a persistent 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, 2024, and 2025. Even with the decrease in time to escalate an EPIA referral to DMH for youth from 60 hours to 48 hours that started in February 2023, volumes through FY 2023, 2024, and 2025 have only decreased. For example, the boarding numbers for youth under 18 were 360 during FY25 compared to 1206 in FY24. This reflects that behavioral health ED boarding continues to approach the boarding numbers pre-COVID.



2. **Average Time to Placement:** Trend data for ATP also shows a promising trend. Overall, ATP is 2.5 days now compared to a high of 4.9 days in FY19 and 4 days in FY22. 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 (2019-2025).

3. **Percentage of Boarders who have a Level of Care change and no longer need inpatient admission:** In this FY2025 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%). In part, this reflects the work EDs have done to stabilize and provide care to patients while they board, and additional community-based resources are explored.

4. **Medically Admitted patients who become psychiatric admissions:** EPIA includes medically admitted patients who require a psychiatric inpatient admission upon discharge from the medical hospital. The EPIA data shows that when disaggregated by age, all age groups (except for adolescents) require longer time to psychiatric admission than the ED cohort. This goes along with what EPIA data shows about barriers to admission that includes medical comorbidity.

Percentage of Dispositioned Referrals by Med Admit and Age

Age Group	No			Yes			Grand Total		
	#	% of Age	ATP	#	% of Age	ATP	#	% of Age	ATP
0-17	347	96.4%	2.4	13	3.6%	4.0	360	100.0%	2.4
18-22	73	84.9%	2.4	13	15.1%	5.3	86	100.0%	2.8
23-64	651	84.1%	2.0	123	15.9%	3.6	774	100.0%	2.3
65+	197	68.2%	2.5	92	31.8%	4.5	289	100.0%	3.1
Grand Total	1,268	84.0%	2.2	241	16.0%	4.1	1,509	100.0%	2.5

Council Review

The Council has met twice 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 and what factors continue the ongoing phenomenon of ED Boarding.

Initiatives Introduced and Continued to Address Acute Behavioral Health Needs

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 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.
- Contracting with CBHCs to provide mobile crisis intervention, community crisis stabilization services for youth and adults, and routine outpatient services.

Discussion/Findings

1. Behavioral Health ED Boarding for inpatient level of care, while still high, has continued to decrease since the significant increase in demand during the COVID Pandemic. Early signs of an ED Boarding volume decreased during 2023 and continued through 2024, and 2025. This downward trend, though promising, is still showing boarding numbers like pre-COVID pandemic numbers which were already considered a crisis. From the EPIA data, there are fewer ED Boarders who are waiting prolonged times prior to admission to a psychiatric inpatient unit. This can be attributed to the attention and effort of the EDs, Insurance Carriers, inpatient providers and the EPIA team to prioritize boarding individuals. Additionally, EDs report sustained behavioral health volume but much improved patient throughput.
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 no longer are overrepresented in the EPIA referrals. For example, the percentage of youth was 30.2% in FY24 compared to 23.9% of FY25.
 - b. Given the continued 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. This is expected to improve as automation of referrals since BH TRP's launch continues to advance.
 - c. Public funded insurance coverage is the primary coverage for those waiting in EDs for inpatient psychiatric care for longer than 2 days. Public insurance coverage for the EPIA population maintained the historical trend of over 75% and was very similar to FY24. Public coverage for youth under 18 was 83.1% and for adults 18+ was 78.7% for FY25.
 - d. Commercial Insurance carriers cover 10-15% of the EPIA ED Boarding population.
 - e. A significant percentage (32.11% for 18 and older and 28.61% for 0-17%) of patients see their level of care change and are able to be discharged to the community likely due to services provided in the ED and to the expansion of diversionary home and community-based services. We expect these numbers to improve further as BH TRP Phase 2 allows automation of referrals to CBHC's and CBAT's.
 - f. Youth have different diagnoses than adults. Of note, Autism Spectrum Disorder now ranks as the most commonly recorded diagnosis compared to third most common in FY24. It takes significantly longer time to place youth who are on the autism spectrum (longest amongst youth), have intellectual or developmental disabilities, schizoaffective, have medical comorbid conditions, or who are involved with state agencies. For adults, the diagnoses and the longest time to placement remain relatively unchanged. The diagnoses needing the longest time to place remained individuals with autism, dementia, and medical comorbidity. For both youth and adults with these diagnoses 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. New specialized hospital beds coming online in recent years have helped some of the needs though this remains a challenging issue and will likely require additional specialized beds.

Barriers noted seem to reflect as much a systems problem as the diagnosis of the individual boarding. When “no barrier” is selected 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.

Recommendations for the Legislature:

1. The Council restates its FY24 recommendation that the Division of Insurance (DOI), with regular periodic reports, oversee the full implementation of both the Mental Health ABC Act and the Cares Act (Chapter 177 of the Acts of 2022) provisions especially those on payment parity for behavioral health evaluation and management services, commercial coverage of annual behavioral health wellness examinations, psychiatric collaborative care models, and services provided to patients before or while they board in EDs which will address upstream prevention of crisis, thereby further reducing ED boarding.
2. Given that older adults increasingly require the longest time to place the Council recommends that the Council expand its membership to include representation of an older adult lay member.
3. 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. These resources should include peer services such as recovery coaches, family support/family partners, and peer specialists. Consideration should also be given to maintain and expand ED Diversion programs as well as creating additional services and ensuring adequate resources, including:
 - a. Specialty inpatient and outpatient programs for patients with autism spectrum disorders and/or intellectual and developmental disorders.
 - b. Resources for patients involved with state agencies, including children involved with DCF.
 - c. 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.
 - d. The Protocol should reinforce the provision of the ABC Act requiring timely notification of pediatricians and other treating clinicians whenever a patient, who is under 18, is discharged from an emergency department to ensure that the people who are most familiar with the patient are informed.

4. The Council recommends that DMH require all psychiatric inpatient units to admit and discharge patients 24 hours a day and 7 days a week. The Commonwealth and/or the Council should explore options for providing incentives to psychiatric facilities that accept cases during weekends (this may include but not limited to extra payments for weekend admissions similar to MassHealth payment incentives).
 - a. This Recommendation also includes addressing the incentives and community resources required to provide safe and clinically sound discharges 24/7, including virtual clinical programs on the weekend and access to insurer approval on the weekends if needed. Other recommendations in this report include specific resources that will be needed to accomplish such 24/7 discharges.
 - b. The discharge issues hospitals face is significant and exasperate ED Boarding; especially for DMH State Hospital placements; DCF child discharge placements; and Geriatric patient discharges to Nursing Homes. Patients can wait months to be discharged, thereby occupying a bed that may be needed for an EPIA admission who subsequently waits in the ED.
5. Continue to reinforce the ability of the system to have direct admissions from the community which is an important part of the Behavioral Health Roadmap to prevent unnecessary use of ED visits by those in behavioral health crisis. We have made significant strides in direct admissions utilizing pre-admission medical screening performed at community sites which were adopted and accepted by psychiatric hospitals as well as safe and timely transportation from CBHCs/community sites. As of writing this report, 859 individuals benefited from direct admissions. In addition, we are observing a wider acceptance of this practice change as evidenced by increasing number of direct admissions each year (43 in 2023, 406 in 2024 and 410 in 2025).

Recommendations for EOHHS and the Advisory Council to Pursue:

6. The Council recommends that we make necessary adjustments in data collection and analysis moving forward as automation of referrals through BH TRP allows referrals of persons not meeting EPIA thresholds (48 hours for youth and 60 hours for 18 and older).
7. 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 protocol for all acute care 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, and inpatient psychiatric units and facilities. This includes training new staff how to escalate cases to internal leaders, insurance carriers' EPIA dedicated staff, and the DMH's EPIA team to assist with bed searches and to share information about patients.
 - b. As recommended in FY24 report data collected and analyzed through the BH TRP process should guide further changes to the protocol and services needed. This data should be

shared with stakeholders in the EPIA process to facilitate quality improvement and policy considerations.

8. 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, patients with developmental disorders or autism spectrum disorders, and patients involved with state agencies, and ways to make these best practices available when and where needed including in community-based and residential settings. This could be accomplished through a subcommittee structure with invited subject matter experts (SMEs), stakeholders, and peer specialists. Such an approach may result in recommendations to the Legislature.
 - a. DMH should use data collected from inpatient units on reasons for denying an admission when the unit has an open bed and use that information for EHS and the Council to better understand the Needs of the Commonwealth, planning future capacity, and identifying issues such as “cherry picking” or other selective admission procedures, including but not limited to needed resources are available to providers to care for such patients and addressing disposition barriers.
 - b. Executive Office of Health and Human Services should establish an ongoing statewide planning process for behavioral health care services using BH TRP and EPIA data, MassHealth data, DOI data and reports, and CHIA and HPC data to determine resources needed and practices by the behavioral healthcare system that need changed to meet the needs of an accessible, equitable, efficient, and effective care system.
9. Based on the high rate of ED Boarding patients who have a change of level of care and no longer need an inpatient admission (more than 1/3), the Council recommends the Phase 2 automation of referrals to CBHCs and CBATs be implemented fully and in a timely manner. In addition, increased utilization of youth and adult crisis stabilization units, respite programs, and peer specialists and parent supports to better serve those in crisis who no longer meet hospital level of care. Data collected on the utilization and availability of these diversion services will support continued refinement of services to meet the needs of behavioral health patients in crisis.
10. The data continues to identify delays in admission due to medical complexities. DMH should continue to examine the DMH requirements for clinical competencies to ensure that facilities provide a minimum level of medical care and update the clinical competencies as needed to reflect the needs of the population who continue to experience prolonged boarding for medical reasons. Such an examination should include detail on the resources needed to meet these competencies, including staffing. DMH should also examine disposition challenges for patients being discharged from these units, in particular those in need of skilled nursing facility care and patients appropriate for group homes who have medical needs, and the consequent impact of throughput from the ED.
11. Continued focus on efforts to fully implement the Behavioral Health Roadmap by all parties including that commercial carriers continue to cover all community-based services provided by community behavioral health centers beyond all those already required to be covered by DOI. EDs

and insurance payors are encouraged to support, promote, and notify behavioral health patients of the behavioral health helpline and their local community behavioral health center.