Patients with Behavioral & Mental Health (BMH) Needs Presenting to a Children's Emergency Department (ED)

Challenges to Transitioning Patient to a Higher Level of Care

November 19, 2020

Snapshot: BMH Visits to a Children's ED

Since July 2015, BMH visits to a Children's ED have **increased by 116%**.

30% of BMH visits are 5-12y
66% of BMH visits are 13-18y
3% of BMH visits are 18y+

A patient with BMH support needs stays **3.5 times longer** in a Children's ED than a patient with only medical needs.

Top 5 BMH Diagnoses

1. Suicidal ideation
2. Conduct disorder
3. Depression
4. ADHD
5. Anxiety

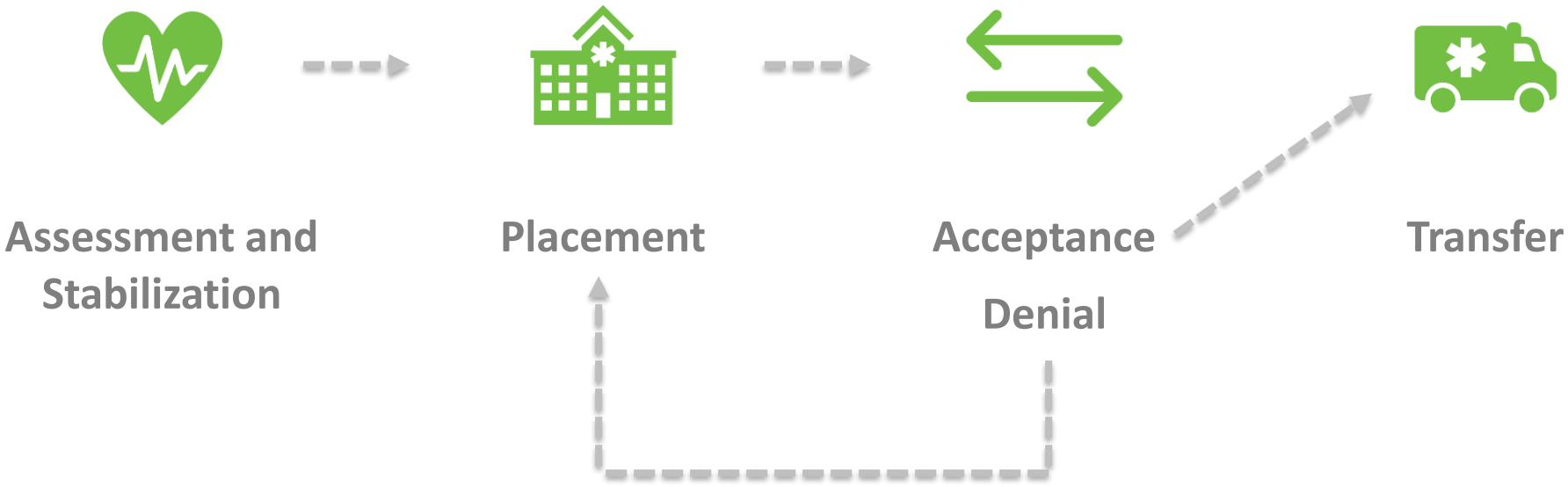
Payor Sources

1. CMO (51%)
2. Private/Commercial (21%)
3. Traditional Medicaid (20%)
4. Self-pay (6%)
5. Medicare (1%)

53% of BMH visits to a Children's ED **require transfer** to a psychiatric facility.

12.5% of patients who transfer from Children's ED to a psychiatric facility **return to Children's within 30-days** with a BMH complaint.

Process to Transition to Higher Level of Care



Several factors create challenges during this transition, including:

- •Payor Source
- Exclusionary Criteria
- Lab Work
- Consent Forms

Payor Source is a Challenge

Least Challenging

- Commercial/Private (21%)
- CMO (51%)
- Traditional Medicaid (20%)
- Self-Pay (6%)

Most Challenging

Exclusionary Criteria is a Challenge

Department of Behavioral Health and Developmental Disabilities
Medical Clearance and Exclusionary Criteria for admission to State Hospitals & Crisis Stabilization Units
Effective 1.15.2020

	Exclusionary Criteria
1.	Angina
2.	Burns (severe) requiring acute care or physical therapy; if the burn could be cared for at home without nursing care, it is not an exclusion.
3.	Chronic Pain Coverage that includes IV opioid analgesia. All other chronic pain syndrome requires a Physician to Physician discussion
4.	Delirium
5.	Dementia: Crisis Stabilization Units (CSU) and State Hospitals (SH) are not equipped to treat individuals with dementia as primary diagnosis. These individuals are also at risk of victimization and are better treated at a geriatric facility that specializes in memory care
6.	Dialysis
7.	Unstable fractures, open or closed
8.	GI bleed, active
9.	Infectious disease requiring isolation and/or treatment by IV antibiotic
10.	Intravenous fluids or IV medications
11.	Joint dislocations, acute, until reduced
12.	Draining wound, open, requiring daily deep would care
13.	Oxygen dependent (must be off all supplemental 02 and O2 saturation greater than 90% with normal activity for CSU admission)
14.	TB, Active
15.	Traumatic Brain Injury (TBI) in the absence of mental illness (if the individual was diagnosed with a mental illness prior to the TBI, the facility will evaluate.) *Georgia Code - 37-3-1.16.1 - "Traumatic brain injury" means a traumatic insult to the brain and its related parts resulting in organic damage thereto which may cause physical, intellectual, emotional, social, or vocational changes in a person. It shall also be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but for the purposes of this chapter, traumatic brain injury shall not be considered mental illness.*
16.	Tubes or drains, chest or abdominal, including ostomies
17.	Individuals must be able to complete their ADLS independently to be admitted to a facility.
18.	Durable medical equipment that is not readily available or is required to be plugged in.

- Exclusionary criteria excludes placement for patients who:
  - Cannot complete Activities of Daily Living (ADL)
  - Are aggressive and cannot be safely managed at a CSU.
  - Are of a certain age
  - Are COVID +

Patients with BMH support needs and an **Autism diagnosis** wait in ED for placement **15 hours longer** than patients without Autism.

Patient Example

10-year-old female with **significant developmental delay** with a history of **Autism**, **Aggression**, and Major Depressive Disorder presents to the Emergency Department after expressing thoughts of harming herself to her mother. Patient injured two employees within an hour of arrival and was placed in restraints. Patient receives a 1013 and requires placement at a psychiatric facility for further care. Patient has **traditional Medicaid** for insurance.

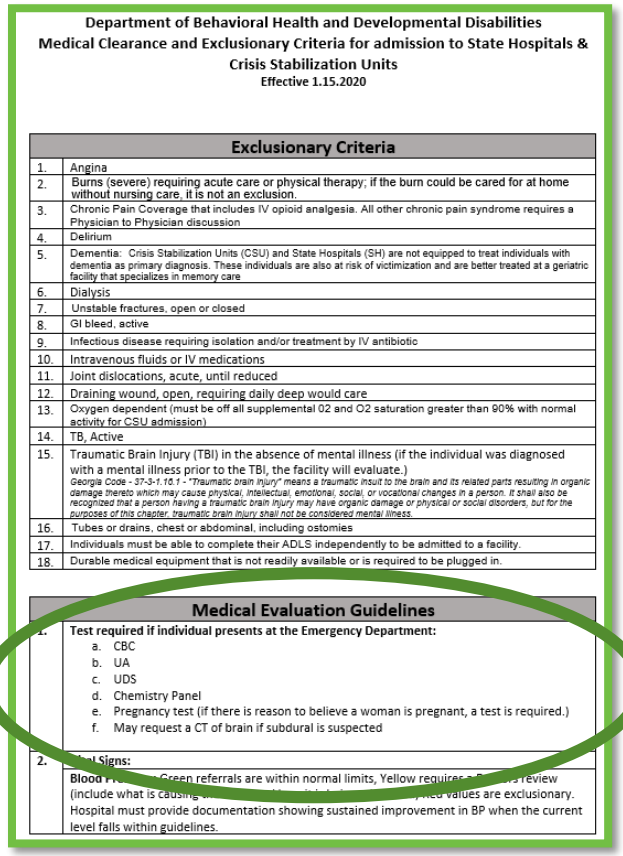
Challenge: Payor Source/Insurance

- There are a limited number of facilities that can accept patients with **traditional Medicaid**.
- There are even further limitations because Autism is an exclusionary criteria.
- None of the facilities that can accept traditional Medicaid can accept patients with an Autism diagnosis.

Required Lab Work is a Challenge

Regardless of whether the psychiatric condition warrants lab work, we are required to obtain labs on each patient needing placement.

- Acceptable lab ranges are not based on pediatric values.
- Patients are flagged as "**yellow**" or "**red**" on the **GCAL bed board** if lab work is outside acceptable ranges.
- Patients are flagged even if a lab is *only 0.05* outside the acceptable range.
- There can be delays in decisions regarding patient placement if flagged after-hours because there is not a physician available to review the labs.



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Medical Evaluation Guidelines	
1.	**Test required if individual presents at the Emergency Department:** a. CBC b. UA c. UDS d. Chemistry Panel e. Pregnancy test (if there is reason to believe a woman is pregnant, a test is required.) f. May request a CT of brain if subdural is suspected
2.	**Vital Signs:** **Blood Pressure:** Green referrals are within normal limits, Yellow requires review (include what is causing elevated values are exclusionary. Hospital must provide documentation showing sustained improvement in BP when the current level falls within guidelines.

Patient Example

16-year-old male with a history of Bipolar disorder presents to the ED **at 10pm** with suicidal ideation. Patient has **no other medical history**. Patient receives a 1013 and requires placement at a psychiatric facility for further care. Because patient **does not have insurance**, he will be placed on the GCAL Board. Lab work is required before patient can be accepted.

DBHDD/GCAL's Acceptable Lab Values for WBC

<1.8K **<3K** **3K - 10K** **10.1K - 17K** **>17K**

- Patient's WBC is **10.15K** which flags this patient as "**yellow**" for review by a Medical Director at one of the GCAL facilities.
- Because it is 10pm at night, there is not a Medical Director to review this patient; therefore, he will remain in ED until the next morning.

Consent Forms are a Challenge

Large (some are >30 pages)	Not all are available in Spanish	Forms differ by facility
Forms are frequently lost	Parent is not always present to sign forms	DFCS not present to sign forms

Medical vs BMH Transfer – Placement

	Medical Transfer	BMH Transfer
Placement	• Smaller number of patients	• Larger number of patients
	• Facilities are chosen based on the specialty (medical) required.	• Facilities are chosen based on specialty (psych) and by payor source.
	• Placement is initiated through the receiving hospital's Transfer Center.	• Depending on payor source, placement can be initiated in a variety of different ways.
	• Very little exclusionary criteria exists.	• Exclusionary criteria exists and can cause placement challenges.
	• An MD-MD conversation occurs with every transfer.	• An MD-MD conversation may only occur if facility requests more clinical information.

Medical vs BMH Transfer – Acceptance/Denial

Acceptance or Denial

Medical Transfer	BMH Transfer
• Patients are accepted quickly.	• Acceptance takes longer.
• Very few denials per patient.	• More denials per patient.
• Medical conditions requiring medical transport (i.e. burns, OB) have higher reimbursement rates.	• Psychiatric conditions requiring a BMH transfer are reimbursed at lower rates.
• Insurance prior authorization is not required prior to transfer.	• Insurance prior authorization is not required prior to transfer.

In Summary

- Streamline the admission and transfer process
- Develop a pediatric-specific required lab set and criteria
- Develop a process for facilities to accept and safely care for patient who are:
  - Aggressive
  - Developmentally delayed
  - COVID +

Questions?

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Appendix

Recommendations to the Sub-Committee

 **Aggression**	• Consider implementing a reimbursement leveling system that would allow for additional staffing so that aggressive patients can be safely monitored while receiving the intensive treatments they need. • Create an interim level community program to support these patients with aggression.
 **Required Lab Work**	• Provide funding for the CSUs to support an on-call physician after-hours to review flagged patients so that acceptance is not delayed. • Provide additional resources to DBHDD to make IT upgrades to the GCAL system to include pediatric-specific vital sign and lab value ranges.
 **Consent Forms**	• Create a universal Consent form, in English and Spanish. • Develop an electronic process for sending/receiving consent forms via the electronic GCAL bed board or another electronic platform. • Provide resources to DBHDD to support IT upgrades that would support universal electronic consents.

Recommendations to the Sub-Committee

 **Care Coordination**	• Develop a partnership with leaders from Children's, DPH, DBHDD, Georgia Collaborative ASO, private insurers, CMOs, acute psychiatric hospitals and CSUs to discuss children who are high utilizers of crisis care and how we can best support the needs of the child.
 **Reimbursement**	• Further explore the reimbursement landscape.
 **Behavioral health Workforce**	• Require a minimum data set surveys for licensed behavioral health providers to better understand the behavioral health workforce. Data set could include who is actively practicing and where, types of insurance accepted, certifications specialties, telehealth offered, etc.
 **Autism**	• Increase bed capacity across the crisis care continuum to ensure that there is improved access resulting in the child needs appropriately matched.