Maryland Hospital Association Mental and Behavioral Health Data Collection Pilot Protocol

August 2018

AMHERST H WILDER FOUNDATION
Here for good.
Wilder Research

Introductions

- Erin Dorrien, Director of Policy and Data Analytics, Maryland Hospital Association
- Dr. Stephanie Knight, Chief of Psychiatry, University of Maryland Medical Center
- Darcie Thomsen, MSW, Research Scientist, Wilder Research
- Kristin Dillon, PhD., Research Scientist, Wilder Research

Agenda

- Purpose of the pilot
- Data collection process
  - Eligibility criteria
  - Technical assistance
  - Online tool preview
- Data collection definitions
  - Case studies to review definitions
- Analysis and reporting

Overview of the pilot

- Led by the Maryland Hospital Association
- 3 month pilot study (8/8/18 through 11/16/18)
- Based on a similar study in Minnesota

Purpose of the pilot

- Focus on quantifying need in state operated facilities and community based resources
- To measure the number, percent, and reasons for discharge delays
- To inform policy and practice within the mental health infrastructure in Maryland

Tool creation

- Started with Minnesota tool created by Wilder Research
- Revised by MHA design team
- Gathered input from:
  - MHA Behavioral Health Task Force
  - Several hospitals with inpatient psychiatric units
  - Community behavioral health providers

Data Collection Process

Technical assistance

If you have questions about the pilot, contact:

Kristin Dillon

Kristin.dillon@wilder.org

651-280-2656

Eligibility criteria

Inpatient behavioral health patients:

Those admitted to inpatient psychiatry units

OR

All behavioral health patients

Eligible to be discharged to a different care setting, but continue to stay in your facility

What is tracked

Admission characteristics

Patient characteristics

Preferred discharge setting

Reason for potentially avoidable days

Discharge information

Form completion

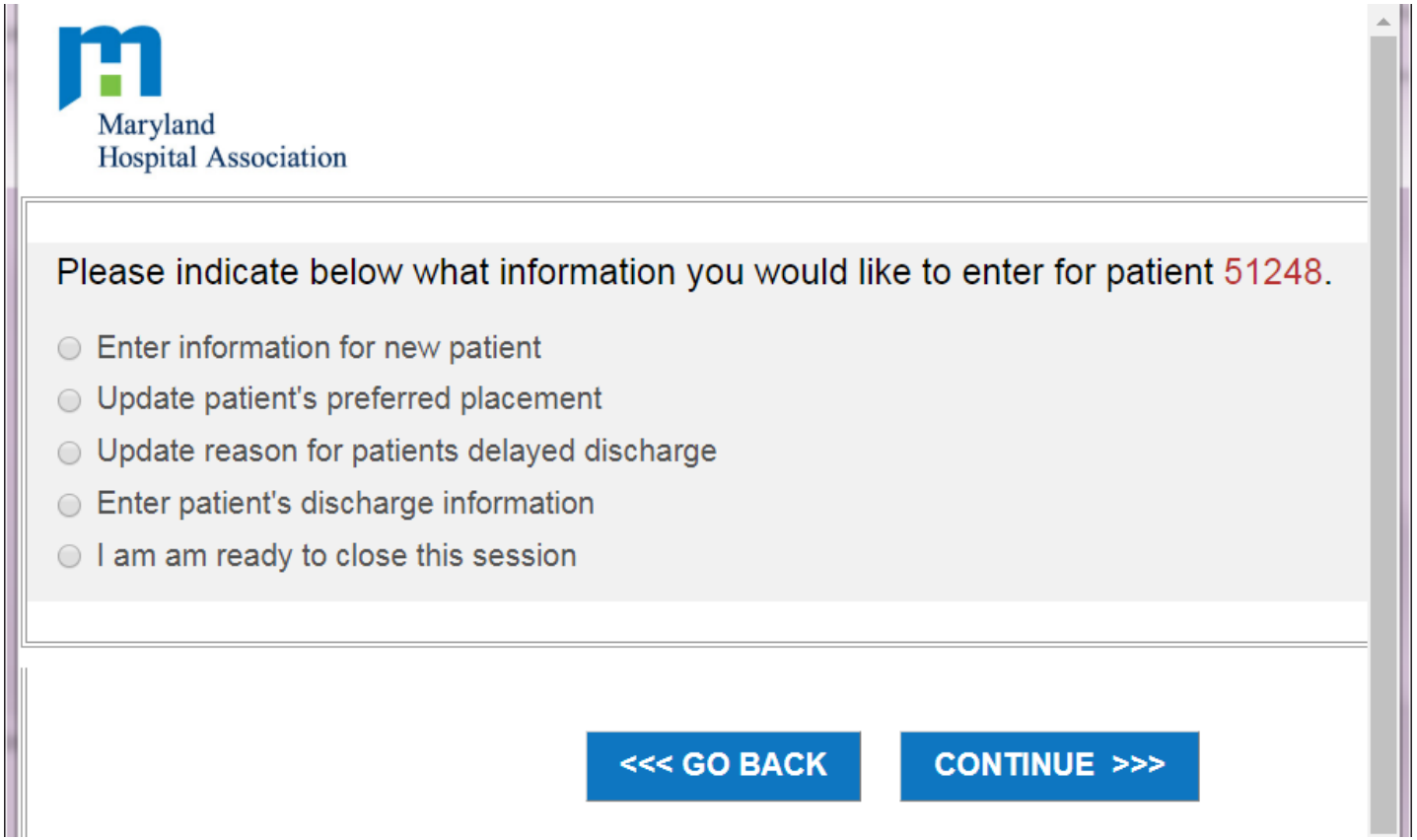
New patient who meets eligibility criteria

Preferred or pursued placement setting changes

Reason for discharge delay changes

Discharge

Online Tool preview



https://na2se.voxco.com/SE/1145/maryland/

Tips

- Be sure to document the ID number somewhere safe
- Find ways to work the data entry into your daily workflow
- If you need to exit before you finished entering information:
  - Click “continue” to save your data
  - To re-enter, choose the section in which you left off

Privacy and confidentiality

- Names and other identifying information are NOT to be included
- Identification numbers will be used only for tracking forms within this pilot
- Store ID numbers separate from other patient information

Questions

about the data collection process?

Data Collection Definitions

Internal hospital delays

- Delay in creating or implementing care plan/execution of orders
- Delay of social work/discharge planner execution of referral

Delays in referral process

- Waiting for CSA inside county of responsibility to identify and make referral
- Waiting for CSA outside county of responsibility to identify and make referral
- Waiting for agency to accept, process, or deny referral

Delays due to authorization or government systems

- Awaiting insurance or financial benefit activation
- Awaiting insurance authorization
- Awaiting waiver approval
- Medicaid transportation delay

Delays within placement setting

- Preferred setting refuses or denies patient admission
- Lack of bed space in preferred setting
- Lack of access to outpatient services
- Off hours (nights/weekends) when coordination not available

Patient or family delays

- Delay due to patient legal involvement, including civil commitment or guardianship
- Lack of housing/housing instability
- Patient non-adherence to plan of care/refusal of placement
- Family inability to pick patient up

Case Studies

Case study 1

Erica is a 32 year old female admitted voluntarily to inpatient psychiatry after an accidental overdose on heroin. A friend called EMS when Erica became unresponsive after using and Erica was given narcan in the field by EMS. On arrival to the ED, Erica was agitated, combative, and expressed suicidal ideation. On evaluation by the psychiatric crisis team in the ED, Erica was more calm, but continued to endorse suicidal ideation and reported a history of depressive symptoms “my whole life”, 2 prior suicide attempts (one at 16yo, one at 28yo), and intermittent polysubstance abuse (“I mean, I tried it all once or twice or ten times. But mostly heroin now.”) that started at age 12 but has been increasing in intensity for the past 18 months. Erica has had housing instability for the past year, staying place to place with family, friends, and acquaintances, but her behavior when using has burned many bridges with people who cared about her. She has a long, complex history of childhood trauma and is in contact only with her great aunt, who is 81yo and recently moved to a nursing home.

Case study 1, continued

On the unit, Erica is stabilized on sertraline, prazosin, and suboxone. Her suicidal ideation begins to subside and she is able to engage in safety and discharge planning discussions on day 6. On day 6, Erica is interested in residential dual diagnosis treatment and consents to referrals to two facilities, which are sent the same day. Day 6 is a Friday, so the facilities don't review her referrals until Monday, day 9. Facility 1 clinically accepts Erica on day 9, but does not anticipate an open bed until day 11. Facility 2 requests more clinical information/updates on day 9, which are submitted, but not reviewed by the program until day 10. On day 10, Facility 2 declines Erica due to "the severity of her psych issues" despite the program being self-described as dual diagnosis. On day 11, Facility 1 does not have an open bed and anticipates an opening on day 12. On day 12, Erica expresses ambivalence about residential treatment and has new complaints and concerns about aspects of Facility 1's program rules and location. On day 12, Erica is given resources for additional programs to consider, but cannot make a decision about which facilities she would agree to be referred to. On day 13, another Friday, Erica selects 2 additional SUD residential treatment facilities and is referred. On days 16 and 17, both programs are reviewing her referral. On day 18, one program advises they will not accept Erica on suboxone, but will accept her if she is willing to come to the program without it. Erica wants to stay on suboxone, so declines the bed. On day 19, there is no open bed. On day 20, she is accepted by a program and is discharged directly to that program.

Case study 2

James is a 44 year old male with a long history of schizophrenia admitted involuntarily after leaving threatening notes for his group home/assisted living care provider and found to have hidden a kitchen knife under his bed. On admission to the unit, James initially engages well with the treatment team, is pleasant and cooperative, and admits to having hidden the knife and leaving threatening notes for his care provider, offering an explanation full of delusional, paranoid ideas about the care provider's involvement with the Illuminati, the NSA, and the CIA. The care provider has already advised the team that James is not welcome to return to the home. James also refuses to return, but is agreeable to medication adjustments, re-engagement with outpatient treatment, and referral to a new group home care provider. James agrees to a postponement of his IVA hearing on day 6 of his admission and is converted to voluntary on day 13. During this time, he is restarted first on oral paliperidone, titrated to a therapeutic dose, then agrees to transition to the long-acting injection formulation, and is given his first Invega Sustenna injection and then given his second loading dose. He is referred to an assisted living/group home placement agency to assist in locating a new home on day 13 as well as an ACT team that serves the same area where placements are being sought.

Case study 2, continued

The placement agency identifies 3 potential group homes on day 15, but the care providers can't come to interview James until days 17, 18, and 19. The provider who visits James on day 17 declines him after James asks the provider questions about her possible involvement in secret societies. The provider on day 18 declines James after James admits he threatened his past care provider, even though this information was shared in the original referral and James shares that he did not intend to hurt the care provider, "just scare her enough to admit what she's doing". James declines the provider who visits on day 19 due to the location of the home. The placement agency has no additional providers to recommend for several days. On day 25, the team determines James may need a higher level of support than assisted living/group homes are willing/able to provide and the team refers James to RRP. James is deemed appropriate for RRP, but there are no openings in his home jurisdiction and he is placed on the waitlist. On day 32, assisted living/group home placement agency refers a licensed provider who has other clients with chronic mental illness in his home and accepts James; James also agrees to placement. James is discharged to the program on day 33.

Questions

about the reasons for discharge delays?

Analysis and Reporting

Reporting plan

- Wilder Research will:
  - Analyze results
  - Develop aggregate report
  - Explore data by groups of hospitals with shared characteristics
- MHA will determine if the final report will be made public

Questions?