

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

Expedited Psychiatric Inpatient Admission Protocol 2.0
EPIA 2.0
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Escalation Protocol for Securing Appropriate Placement for Individuals Boarding in Emergency Departments who require Inpatient Psychiatric Hospital Level of Care

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 hospital facilities, 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 placement.

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 to establish clear steps and responsibility for escalating cases, where placement has not been achieved in a reasonable period of time, to senior clinical leadership at Insurance Carriers, inpatient psychiatric units, 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 placement in an inpatient psychiatric hospital. It relies on early and continuous communication by all parties involved.

Expedited Psychiatric Inpatient Admissions Protocol Principles

The steps outlined in this Protocol are grounded in the following Principles:

- Hospital Emergency Departments (ED), Emergency Service Providers (ESP), inpatient psychiatric providers, 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.
- 24 hours is the maximum threshold for initiating escalation steps to obtain placement for a patient who is boarding in an ED.

- EDs and ESPs 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 to secure placement throughout the escalation process, particularly in assuring that clinical information is current and communicated for placement efforts, as described in the Protocol.
- There is an expectation that licensed facilities 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.
- Any necessary authorization (for inpatient hospital level of care, for 1:1 staffing or other specific needs) 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 facilities and carriers. If a facility identifies a need for such special services and the carrier authorizes coverage, the facility is expected to admit the patient.
 - At the time of verbal authorization, plans 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 provider is able to reference that specialing was authorized.
 - Plan billing and payment policies should be updated to reflect how the plan's specialing process works, and also to include the specialing codes established in the coding grid that are required by the plan.
 - Plans must provide authorization of specialing as soon as the need is identified as this will help reduce admissions wait time.
- Early and continuous communication between the ED/ESP 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 placement work. This communication must be reciprocal; Carriers and ESPs are expected to communicate with EDs as to the status of their efforts to secure placement and updated clinical information should flow back to ESPs and Carriers. To ensure timely communication needed for this Protocol's success, it is expected that EDs and ESPs have a point person specified on each shift.
- Inpatient Providers, Insurance Carriers, EDs, ESPs and DMH (along with other stakeholders) are expected to use a standardized Bed Search Protocol that is in development with state agency and stakeholder involvement. Once finalized, time for implementation will be provided.
- Carriers and Providers are committed to providing better continuity of care for inpatient treatment in order to improve patient outcomes. Patients should be rehospitalized at the same inpatient facility to the maximum extent possible
- 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 successful placement.
- If the constraint to finding a hospital bed is an individual or family preference, including due to parent/guardian lacking access to transportation to a distant hospital for a pediatric patient, this protocol will be activated, and the ED/ESP will continue to work on acceptance at those preferred placements. The ED/ESP will also try to understand and alleviate any barriers that are limiting the scope of placement possibilities with the family. At 96 hours, DMH will receive these referrals and take geographic considerations, family history, etc. into account. Priority will be given to placement as close to home as possible in order to facilitate family/guardian involvement with treatment but will not further delay placement.

- The time frames in this Protocol should not limit escalation of complex cases where it is clear that placement will not be readily identified.
- At any time after the decision is made to admit the individual to a psychiatric hospital, the Carrier should be notified immediately for assistance. If it becomes clear that a placement will not be identified by 96 hours, DMH may be consulted on a case by case basis for acceleration of the Protocol.
- All Carriers, EDs and ESPs must use [Adobe Acrobat Reader DC](#) for submitting a request for help to DMH through the secure email portal provided.
- If the request for inpatient placement is withdrawn, or the ED/ESP acquires a placement after escalating the case, these Protocols no longer apply and all relevant parties (Carriers, ED, Parent/guardian, DMH) are notified about this change.

Escalation Steps

1. First 24 hours after ED arrival

- a. Any time after a patient is admitted to the ED, the ED/ESP may notify the appropriate person at the Insurance Carrier or other party responsible for administering the patient's health coverage that one of their members is in the ED waiting for a psychiatric hospital admission. The Insurance Carrier will use its internal care management processes to determine if there is useful information that can be provided to the ED/ESP to assist in placement.
- b. At any time after the decision is made to admit the individual to a psychiatric hospital and it is clear that a placement will not be identified by 24 hours, the ED or ESP can reach out to the Insurance Carrier with a Request for Assistance.

2. If a placement has not been identified by 24 hours from a patient's arrival to an ED

- a. The ED/ESP must make a formal Request for Assistance to the Insurance Carrier.
- b. Within two hours of the submission of a Request for Assistance by an ED/ESP 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. When a Request for Assistance is made outside of normal business hours (e.g. after hours and on weekends or holidays), the Carrier shall acknowledge receipt of the Request no later than the morning of the next calendar day after the request is made, and shall initiate efforts to provide assistance..
- c. The Request for Assistance must provide the Insurance Carrier with clinical information about the individual, barriers to admission, updated clinical information, evidence of the bed searches to date, and a summary of responses from hospitals who have denied admission to the individual. For example:

Patient Demographics	Name DOB Health Plan Member ID Address/Contact Information
ED Presentation & BH Diagnosis	ED Facility Date/Time of Admission Length of Time Boarding Presenting problems/symptoms Diagnosis/co-morbid conditions

Placement/Boarding	Level of care needed Reason for Boarding
Contacts	ED contact person at the hospital (w/phone) ESP contact person (w/phone) State Agency Involvement (DDS, DCF, DMH, DYS)
If Information has changed since a previous contact was made to the health plan	Presenting problems & Symptoms Co-occurring complexity Additional Patient Needs Type of placement required
Facilities/units already contacted	Name of facility and reason, circumstance, or barrier provided as to why they are unable to accept patient for admission Other Resources needed to admit the patient if available to the ED/ESP; if barrier is lack of beds, when discharges are anticipated
Other Patient Information	Relevant patient history with a facility Patient, Parent, Family preference for Placement

- d. The Insurance Carrier must work closely with the ED/ESP point person to avoid redundancy in bed searches and to determine which hospital(s) is most appropriate to meet the needs of this member. Insurance Carriers must engage senior clinical and administrative officials at potential receiving facilities continuously until a placement is identified and agreed upon.
- i. The Insurance Carrier determines and authorizes payment for required supports or resources (i.e., single room, extra staffing etc.) when such supports or resources are determined to be needed by the Receiving Facility to allow for admission. All authorizations are documented and provided to the ED/ESP and to the receiving facility. When a Carrier authorizes these resources, the inpatient unit is expected to accept the patient.
 - ii. The Insurance Carrier must mitigate any authorization issues that are presenting barriers to a successful placement and shall provide documentation of such authorization requested by the receiving facility (See above Principles) in a timely manner.
 - iii. If the specific hospital(s) 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 hospital agree to prioritize the placement of the individual against the next discharge. However, the bed search continues and if another facility is found to have a bed prior to the preferred facility's availability, that readily available bed should be secured for the patient.
 - iv. If an in- network bed is unavailable, the Insurance Carrier should seek placement in appropriate out-of- network facilities (taking into account services required by the individual, geography, etc.).
 - v. The Insurance Carrier actively seeks to obtain admission of the individual until a placement has been secured. This includes a review of the updated clinical referral packets and ongoing discussion with senior leaders at the Receiving Facilities to break down barriers to admission.

- vi. Once the Insurance Carrier has exhausted its network and appropriate out-of-network options, and when 96 hours has elapsed and the individual still has not secured an inpatient placement, the Insurance Carrier must notify DMH for assistance.
- vii. If at any time after the decision is made to admit an individual with co-occurring complexity to a psychiatric hospital and it is clear that a placement will not be identified by 96 hours, Insurance Carrier (or, in the absence of an Insurance Carrier, the ED or ESP), may consult with DMH on a case-by-case basis for acceleration of the Protocol.
- viii. The Insurance Carrier is responsible for informing hospitals considered appropriate to admit the individual that the process is being escalated to DMH.

3. If a placement has not been identified by 96 hours from a patient's arrival to an ED

- a. The Insurance Carrier, or ED/ESP MUST request assistance from DMH at 96 hours.
- b. The Insurance Carrier or ED/ESP MUST contact DMH by submitting an online referral request using [Adobe Acrobat Reader DC](#), 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, ED, and ESP designate a senior clinical administrator to communicate with DMH.
 - iii. The internal DMH team works with Insurance Carriers/EDs/ESPs and Provider Hospitals to determine next steps to ensure that placement for the individual is accomplished.
- c. DMH works with ED/ESPs, Insurance Carriers and Provider Hospitals 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/Bed Finder Protocol developed by the EPIA Taskforce. This work is currently in progress.
- e. DMH engages senior clinicians and administrators at the Provider Hospitals, Insurance Carriers and ED/ESPs, 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, Hospital 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 Carriers, MassHealth and DOI as appropriate.
- h. Data collected from this process is reviewed on a regular basis by DMH Licensing for use during regulated surveys for continuing licensure and as indicated.

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

No individual boarding in an ED waiting placement in a psychiatric hospital will wait more than 96 hours 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/ESP 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/ESP MUST submit a Request for Assistance to DMH at 96 hours. If at any time it becomes clear that a placement will not be identified by 96 hours, the ED/ESP may consult with DMH on a case-by-case basis for acceleration of the Protocol.

1. Active Role of ED/ESPs for those without Insurance Carrier Support

It is expected that ED/ESP clinical and administrative leadership play an active role during the daily (or more frequent) bed searches in the 96 hour period prior to submitting a DMH request for assistance.

- a. ED/ESPs must have an Internal Escalation Protocol in place for any long stay ED Boarding individual that involves ED and/or ESP clinical and administrative leaders who will then escalate their search efforts to clinical and administrative leaders at the Provider Facilities 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/Bed Finding Protocol is expected, once developed.
- e. Full escalation prior to DMH involvement at 96 hours 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/network to optimize these relationships on behalf of the boarding individual.
- g. The Boarding Hospital's senior administrators will contact similar senior leadership at Provider Hospitals with available psychiatric beds to advocate for their boarding patient's admission.
- h. Escalation efforts will be documented and reported to DMH when seeking help from DMH.
- i. EDs and ESPs must submit request for help to DMH using [Adobe Acrobat Reader DC](#).
- j. This Internal Escalation Protocol applies to all individuals without an Insurance Carrier advocate.

Summary

Member Insurance	Proposed Process
MassHealth Involved	
MassHealth managed care	<ul style="list-style-type: none"> • ED/ESP 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 96 hours
MassHealth non-managed care (FFS, HSN, duals)	<ul style="list-style-type: none"> • ED/ESP activate their Internal Escalation Protocol by 24 hours • ED/ESP leader outreaches to DMH by 96 hours
Commercial Coverage	
Insurance carrier regulated by DOI	<ul style="list-style-type: none"> • ED/ESP Request for Assistance to Insurance Carrier by 24 hours • Senior administrative & clinical leaders are actively involved with bed finding • Insurance Carrier outreaches to DMH at 96 hours if individual is still boarding
Administrator for self-funded ERISA Plans not regulated by DOI	<ul style="list-style-type: none"> • ED/ESP Request for Assistance to appropriate Plan Administrator or Carrier by 24 hours
Out of state insurance carrier	<ul style="list-style-type: none"> • If Insurance Carrier will not engage, ED/ESP continues to search for a bed and activates their <u>Internal Escalation Protocol</u> • and escalates to DMH at 96 hours if the individual is still boarding
Other	
Medicare Only	<ul style="list-style-type: none"> • ED/ESP 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 <u>Internal Escalation Protocol</u>; • And requests help from DMH at 96 hours if still unplaced
Uninsured	

Insurance in BOLD represents those in the standard process outlined.