Expedited Psychiatric Inpatient Admission

96-Hour Notice to DMH:

*DMH REFERRAL TOOL*

Survey Definitions

Date Created: 1/31/2018

Information provided on this survey shall be submitted to the Department of Mental Health via the secured website at <https://eohhs.ehs.state.ma.us/ReviewSurvey/ReviewSurvey.aspx?id=442> to request assistance with placement after 96 hours.

All Fields with an (\*) are mandatory.

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| Question#: | Field Name: | Definition: |
| \*1 | Referring Entity/Organization | Select the type of organization that is seeking help with assistance to place a member/patient |
| \*2 | Name of referring Entity/Organization | Insert the name of the organization that is seeking help with assistance to place a member/patient |
| **Provide senior leadership information at the referring entity below that DMH should contact:**  |
| 3 | First Name | Insert the First Name of the person DMH should contact related to this request |
| 4 | Last Name | Insert the Last Name of the person DMH should contact related to this request |
| 5 | Title of the person above  | Insert the Title of the person listed in field 3 and field 4  |
| 6 | Contact telephone number of the person above | Insert the phone number of the person listed in field 3 and field 4  |
| 7 | Contact email of the person above. Please use all lowercase letters- NO CAPITAL letters/ No blank spaces- Please select the checkbox to send an email confirmation of this submission to the above contact person. | Insert the email address of the person listed in field 3 and field 4 and check the box to have an email confirmation of the submission sent to the contact person listed above |
| **Please provide member demographic Information below:** |
| \*8 | First Name | Insert the First Name of the member/patient |
| 9 | Middle Name | Insert the Middle Name of the member/patient |
| \*10 | Last Name | Insert the Last Name of the member/patient |
| 11 | DOB (mm/dd/yyyy) | Insert the Date of Birth of the member/patient |
| 12 | Gender | Select the Gender the member/patient classifies as |
| 13 | Guardian/Custody | Insert the name of the Guardian or primary custodial authority of the member/patient |

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| Question#: | Field Name: | Definition: |
| 14 | Insurance Carrier  | Insert the name of the Insurance Company covering the member/patient  |
| 15 | Insurance Plan Type (Check all those that apply) | Select the type of coverage of which the member/patient is enrolled |
| 16 | Insurance ID#/MassHealth ID# (If applicable) | Insert the Insurance ID number or MassHealth ID number |
| 17 | State agency involvement (Check all those that apply) | Select any state agency or agencies that is involved with the member/patient |
| Please provide boarding details below: |
| 18 | Where is the Member boarding? | Insert the name of the place where the member/patient is currently located. (example: Hospital Name, ER name, Home) |
| 19 | Which ESP is involved (if applicable)? | Insert the name of the ESP involved with the member/patient |
| 20 | Date of initial evaluation(mm/dd/yyyy) | Insert the initial evaluation date performed by the ED |
| 21 | Time of evaluation (Please use military format e.g. 2300 is 11PM) | Insert the time of the evaluation performed by the ED |
| 22 | Date of request for assistance to insurance carrier (mm/dd/yyyy) | Insert the date of which the facility contacted the Insurance Company with a request for assistance |
| 23 | Time of request to the insurance carrier (Please use military format e.g. 2300 is 11PM) | Insert the time of when the facility contacted the Insurance Company with a request for assistance |
| 24 | Diagnosis | Select the primary diagnosis of the member/patient |
| 25 | Diagnosis option "Other" description | Insert additional diagnosis descriptions, if other was selected in field 24 |
| 26 | Secondary Diagnosis | Insert the secondary diagnosis of the member/patient that was not provided in field 24 and/or field 25 above |
| \*27 | Is there a personal and/or family preference for placement? | Select whether or not the patient, family, guardian and/or primary custodial authority has a personal preference for placement |
| 28 | Identify the primary barrier to placement other than personal/family preference. (If applicable) | Select the primary barrier of placement that has been identified. Do not include personal or family preference in this field |
| 29 | Please describe "other" barriers here | Insert additional barriers not identified in field 28 |

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| Question#: | Field Name: | Definition: |
| 30 | Provide presenting concerns & precipitating events (clinical formulation- if available) | Insert any additional concerns, events, and/or clinical formulation that has been identified |
| 31 | Please describe any services authorized by Carrier to support admission (e.g., 1:1, single room, enhanced medical supports etc...) | Insert all services authorized by the Insurance Company to support admission |
| 32 | Out of network facilities considered (if any) | Insert all out of network providers considered by the Insurance Company |
| **------------------------------ FACILITIES TO TARGET FOR DMH INTERVENTION -----------------** |
| **Facilities where senior leadership and/or CMO were contacted by insurance carrier to have follow-up discussions, doc-to-doc, etc...to advocate for admission and escalation results** |
| -------- FACILITIES I -------- |
| 33 | Contacted facility name | Insert the name of the facility that was contacted by the Insurance Company, ED or ESP |
| 34 | Facility contact information | Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP |
| 35 | Facility response | Insert the facility’s final response or disposition received by the Insurance Company, ED or ESP |
| -------- FACILITIES II -------- |
| 36 | Contacted facility name | Insert the name of the facility that was contacted by the Insurance Company, ED or ESP |
| 37 | Facility contact information | Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP |
| 38 | Facility response | Insert the facility’s final response or disposition received by the Insurance Company, ED or ESP |
| -------- FACILITIES III -------- |
| 39 | Contacted facility name | Insert the name of the facility that was contacted by the Insurance Company, ED or ESP |
| 40 | Facility contact information | Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP |
| 41 | Facility response | Insert the facility’s final response or disposition received by the Insurance Company, ED or ESP |

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| Question#: | Field Name: | Definition: |
| -------- FACILITIES IV -------- |
| 42 | Contacted facility name | Insert the name of the facility that was contacted by the Insurance Company, ED or ESP |
| 43 | Facility contact information | Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP |
| 44 | Facility response | Insert the facility’s final response or disposition received by the Insurance Company, ED or ESP |
| **PLEASE NOTE: The secure email account (expedited.admission@massmail.state.ma.us) is limited to receiving ONLY clinical and/or administrative summaries.** |
| \*45 | Is clinical and/or administrative document(s) being submitted to the secure email account? (expedited.admission@state.ma.us) | Select yes or no to confirm whether or not the referring organization will be sending additional content related to this request via email |
| 46 | Contact email of the person submitting this form. Please use all lowercase letters- NO CAPITAL letters/ No blank spaces. REMINDER: select the checkbox to receive an email confirmation of this submission. | Insert the name of the person that is submitting this request and then check the box if the person would like to receive a copy of the submitted survey |
| **IMPORTANT NOTE: To confirm this referral is a valid request requiring immediate DMH assistance, please copy the email exactly "as is" from below-no CAPITAL letters- and paste in the text field. Remember the checkbox next to the email MUST be selected for a prompt response.**  |
| \*47 | Copy and paste email- NO CAPITAL LETTERS- exclude quotation marks- "expedited.admission@state.ma.us" PLEASE REMEMBER TO SELECT THE CHECKBOX | Copy and paste the below email address expedited.admission@state.ma.us inthe box and check the box to receive a copy of the submitted survey.\*Note: When you click send at the bottom of the survey, the survey will be sent to the email address listed in this field |