Bed Search/Admission Protocol

Guiding Principles to support this Protocol

a. The MABHA website is the basis for all bed searches associated with ED Boarding. Inpatient Psychiatric Providers are expected to update the website three times a day. DMH and EHS monitor this site daily.

b. The use of MABHA to track and monitor ED Boarders is required. All Emergency Departments (EDs) and the ED Clinicians including emergency service providers and mobile crisis intervention providers (hereafter referred to as the "ED Evaluation Team") are expected to enter all ED Boarders with managed/unmanaged public insurance coverage (Medicaid, Medicare, Duals, Medicaid FFS, Medicaid, MCO/ACO, Health Safety Net).

c. For those individuals with lapsed Medicaid or who are uninsured and applying for MassHealth, it is expected that ED Evaluation teams work with MassHealth to expedite this re-insurance process.

d. Clear communication lines and relationships are established among ED Evaluation Teams, Inpatient Psychiatric Providers, Insurance Carriers, and other involved entities throughout the process that includes a feedback loop to ensure that all participants are updated on the status of the bed search (**point persons identified daily for timely updates**).

e. Bed finding includes the hospital network/system where the patient is boarding and/or the system where the patient receives their outpatient care (ACO/MCO).

f. Generally, the patient should return to the Inpatient Psychiatric Provider where the patient was most recently admitted (e.g. within the last 3 months).

g. Meaningful Waitlist for Child/Adolescent and specialty units by Inpatient Psychiatric Providers is encouraged.

h. Close collaboration and communication between clinical teams and the parent/guardian during boarding episode is basic to a smooth and non-wasteful bed search especially with regard to preferences or other barriers to admission.

i. Insurance Carrier and Inpatient Psychiatric Provider Senior Leadership and Medical Directors or designees serving as medical director must be involved in clinical discussions to resolve any barriers to admissions and to arrange special services when clinically appropriate.

j. Get DCF/DMH/DDS involvement as early as possible in the process.

k. Electronic transfer of clinical information is preferred and is a best practice that the system is working towards.

The Protocol

1. Bed searches are initiated with a phone call by the ED Evaluation Team
    a. General search for bed availability
    b. Patient specific bed search

2. Outcome of the Call
    a. **Yes, Bed Available**
        i. Send Admission Packet for review (secure email or eFAX, if possible)
            1. Once a complete Admission Packet is received, the Inpatient Psychiatric Provider reviews and provides a clear Yes or No **within one hour.**
            2. If Inpatient Psychiatric Provider determines that the case is complicated and requires escalation to Medical Director, Program Director etc, a **final** determination about admission is made **within one more hour**.
        ii. Bed is held pending further information requested by Medical Director and until final decision can be made.
        iii. If the initial clinical presentation and/or unit conditions do not permit admission, **provide a clear 'No"** and document in the Medical Director Log (per DMH regulations)
    b. **Maybe, Bed Available or opening up later today**
        i. Often used when there is a complex case that requires more time and internal discussion within the Inpatient Psychiatric Provider to decide on admission
        ii. Key is to identify the clinical barrier, acuity, or staffing issues that need addressed by the facility to overcome hesitancy to accept
        iii. May require some back and forth with the ED Evaluation Team or others involved in the escalation (Insurance Carrier and/or EPIA) and the necessary transparency to resolve barriers
            1. Decision from the Inpatient Psychiatric Provider is received by COB; if patient presented after 3pm, by COB the next day
        iv. Escalation within Inpatient Psychiatric Provider, ED Evaluation Team, or Insurance Carrier as needed to facilitate resolution for a final admission decision
        v. Transparency between involved parties around the likelihood of "getting to yes" for admission
    c. **No, Bed not Available**
        i. Based on initial clinical presentation, would this Inpatient Psychiatric Provider consider accepting the patient pending a discharge?

1. **Yes** – put on waitlist (only for C/A or Geriatric units) and provide more clinical information
2. Provide a **clear "No"** from Inpatient Psychiatric Provider to ED Evaluation Team

2. **Standardized Admission Packet** (the Packet). The following demographic and clinical information does not need to be presented on the initial cold call but should be collected and provided to the Insurance Carrier and to DMH, as well as the Inpatient Psychiatric Provider pursuant to the escalation process:
    a. Administrative Face Sheet (minimally includes full name, date of birth, insurance number and guardianship)
    b. Comprehensive Evaluation (3-5 Pages)
        i. Initial Evaluation
            1) Diagnosis/Presenting Problems
            2) Clinical assessment and need for inpatient level of care
        ii. Medical Clearance
        iii. Current updated clinical information
            1) Summary ED Course & any treatment provided
            2) Medications administered in the ED
            3) Behavioral response to medication administered
            4) High risk behaviors (substance use, etc)
            5) Court involvement
            6) Family or other therapeutic interventions in ED
            7) Patient's baseline
            8) Current assessment and mental status exam (same day as bed search)
        iv. Requirement of any special services including but not limited to single room, 1:1, medical accommodation
        v. Disposition expected at the end of acute hospitalization (if applicable)
        vi. Parent/guardian preferences (if applicable)
        vii. Guardianship/Rogers (if applicable)
        viii. Agency involvement (if applicable)
        ix. Collateral contacts (if applicable)
    c. 24 Hour ED Course Summary/Update for each day in the ED since arrival (one page per day)

3. **ED Evaluation Team** will document the call and its outcome in a standardized bed search worksheet.

4. **Inpatient Psychiatric Providers** will document calls and outcome per the DMH regulations concerning clinical denials when there is a bed available (Medical Director's denial log). These logs must be maintained for DMH licensing review.

5. **Transmission of the Admission Packet only when requested by the Inpatient Psychiatric Provider based on phone call above.**
    a. The only exceptions are referrals for youth in which any EPIA involved youth is expected to have their Admission Packet sent to all the child and adolescent Inpatient Psychiatric Providers and the daily one page update until placed.
        i. If there is a family preference, only the packet and updated one page worksheets are sent to the preferred Inpatient Psychiatric Providers while continuing to work with family to enlarge the number of C/A units preferred.

6. **Insurance Carriers** will advocate at senior administrative and clinical levels wherever the ED Evaluation Team sends Admission Packets and work to decrease any perceived barrier to admission by the Inpatient Psychiatric Providers.

7. **Acceptance for transfer** to the Inpatient Psychiatric Provider l
    a. Any Insurance Authorization needed, including authorization for any special services that are required to facilitate admission are completed prior to transfer
    b. Planned arrival time agreed upon with appropriate doctor to doctor and nurse to nurse communication before transfer
    c. Availability of parent or guardian to sign the Conditional Voluntary Admission legal status within 24 hours for youth under 18 years of age
    d. Notification of other participating stakeholders, as applicable
    e. Close the loop with all stakeholder advocates involved