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

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

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Boarding of Persons in Emergency Departments (EDs)

Each day individuals 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 psychiatric bed, if there is not a plan in place for them by 24 hours in the ED, there needs to be additional steps to facilitate their admission.

The Executive Office of Health and Human Services (EOHHS), its Department of Mental Health (DMH), Department of Public Health (DPH), and 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 support this Protocol that identifies and resolves barriers to psychiatric admission.

This Protocol is the product of an Expedited Admissions Task Force, charged by former EOHHS Secretary Marylou Sudders in 2017 to establish clear steps and responsibility for escalating cases, where an admission has not been achieved in a reasonable period of time, to senior clinical leadership at Insurance Carriers, Inpatient Psychiatric Providers, 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 the Commissioners of DOI, DPH, and DMH. This collaboration continues, and members of the Task Force worked closely together to decrease the length of time behavioral health patients board in EDs until 2022 when the Task Force was subsumed by the legislature's creation of the EPIA Advisory Council in An Act Addressing Barriers to Care for Mental Health (Chapter 177 of the Acts of 2022). This effort relies on early and continuous communication by all parties involved. **To that end, EOHHS procured a vendor to build a Behavioral Health Treatment and Referral Platform (BH TRP) to automate referrals in support of rapid, reliable, and timely communication between EDs, inpatient psychiatric facilities, Insurance Carriers, state agencies, and EPIA.**

Expedited Psychiatric Inpatient Admissions Protocol Principles

- **Emergency Departments (EDs) and the ED Clinicians (hereafter referred to as the "ED Evaluation Team"), Inpatient Psychiatric Providers, Insurance Carriers (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 those persons boarding within the Commonwealth in need of inpatient psychiatric hospitalization have access to services in a timely and geographically reasonable manner.**
- ED Evaluation Teams 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 throughout the escalation process, particularly in assuring that clinical information is current and communicated, as described in the Protocol.
- When a patient is in a medical/surgical bed for any reason and requires inpatient psychiatric hospital level of care once medically stabilized for transfer, the clinical team or whatever system is in place for ongoing evaluation, management, and bed searching will have the primary responsibility for identifying and securing inpatient psychiatric hospitalization for such patients. This hospital staff must continue active and assertive efforts throughout the escalation process, particularly in assuring that clinical information is current and communicated as described in the Protocol. All guidance for "ED Evaluation Teams" is applicable to this inpatient clinical team or system.
- There is an expectation that Inpatient Psychiatric Providers 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.
- 24 hours from the time a patient is evaluated and determined to need inpatient Level of Care (at which time a referral is created in the TRP) is the maximum threshold for a patient boarding in an ED to initiate escalation steps to obtain admission.
- At the 60-hour (or 48 hours if the individual is under 18 years of age) duration time of an ED Boarding episode, DMH will receive escalation referrals and take geographic considerations, family preference, etc. into account but without further delay in procuring a bed.
- Individuals under the age of 18 years will automatically be escalated to DMH at 48 hours of boarding.
- Any necessary authorization (for inpatient hospital level of care, 1:1 staffing, or other

specific needs associated with medical comorbidity such as high-cost medications and special equipment or resources) 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 (special services needed beyond generic per diem rate) is expected to be incorporated into contracts between Inpatient Psychiatric Providers and Insurance Carriers.** If an Inpatient Psychiatric Provider identifies a need for such special services and the Insurance Carrier authorizes coverage, the facility is expected to admit the patient

  - At the time of verbal authorization, Insurance Carriers 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 Inpatient Psychiatric Provider is able to reference that specialing was authorized.
  - Insurance Carriers' billing and payment policies should be updated to reflect how an Insurance Carrier's specialing process works, how payment will be made to Inpatient Psychiatric Providers, and includes the specialing codes established in the coding grid that are required by the plan.
  - Insurance Carriers must provide authorization of specialing as soon as the need is identified in order to reduce admissions wait time.

- Early and continuous communication between the ED Evaluation Team 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 bed search work.
  - This communication must be reciprocal; Insurance Carriers and ED Evaluation Teams are expected to communicate as to the status of their efforts to secure admission, as needed and made possible using the TRP.
  - To ensure timely communication needed for the EPIA Protocol's success, it is expected that **ED Evaluation Teams and Insurance Carriers have an identified point person to manage the TRP waitlist and process as the required electronic means of communication during the referral process.**.
  - 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 a successful admission.
- Inpatient Psychiatric Providers, Insurance Carriers, ED Evaluation Teams, and DMH (along with other stakeholders) are expected to use the standardized Bed Search Protocol that was developed with state agency and stakeholder consensus and is provided through the TRP.
- If the constraint to finding a hospital bed is an individual or family preference, this protocol will be activated, and the ED Evaluation Team will continue to work on acceptance at those preferred placements.

    - The ED Evaluation Team will also try to understand and alleviate any barriers that are limiting the scope of Inpatient Psychiatric Provider possibilities with the family.
- No later than 24 hours after the time at which 1) the decision is made that an individual requires hospital level of care and 2) the referral is entered into the BH TRP, the Insurance Carrier will be notified by the automated system for assistance.
    - When it is clear that a placement will not be identified by 60 hours (or 48 for youth) of boarding duration, DMH may be consulted by the ED Evaluation Team or Insurance Carrier on a case-by-case basis for acceleration of the Protocol.
- If the request for inpatient placement is withdrawn or a level of care change or the patient is placed after escalating the case, these Protocols no longer apply.

Guiding Principles for Bed Search Efforts

- The hospital where a patient is boarding should make every effort to prioritize and procure a bed within their hospital system's network.

- The ACO/MCO for the boarding member should make every effort to prioritize and procure a bed within their hospital system's network.

- Patients should be re-hospitalized by the same Inpatient Psychiatric Provider where they were most recently hospitalized for continuity of care.

- The Insurance Carrier and/or EPIA should establish a working partnership with the ED Evaluation Team through the designated point person and the TRP.

- A standardized admission packet will be used for bed searches and admission decision-making by all Inpatient Psychiatric Providers – please refer to *Appendix 1.*

- Utilizing secure electronic transfer of clinical information within the Treatment and Referral Platform (TRP) is expected.

- Inpatient Psychiatric Providers have 2 hours at maximum (one hour for routine admissions and two hours for more complicated admissions) after they open and initially view the complete admission packet in the TRP to respond to an ED Evaluation Team, Insurance Carrier, or EPIA with their decision whether to admit a boarding patient.

EPIA Protocol Escalation Steps

1. **First 24 hours after evaluation determined the need for Inpatient Level of Care (LOC) and a patient referral is created in the TRP.**
   a. Once a patient is determined to require Inpatient LOC and a referral is created in the TRP (at which time waitlist duration begins), the ED Evaluation Team may notify the appropriate person at the Insurance Carrier who will also be alerted by the TRP.
   b. The Insurance Carrier will use its internal care management processes to determine if it has access to additional useful information for the ED Evaluation Team to assist with finding an appropriate placement.
   c. At any time after the decision is made to admit the individual to an Inpatient Psychiatric Provider and a referral is created in the TRP, the ED Evaluation Team may request assistance from the Insurance Carrier via the TRP or other applicable methods of communication. An automated notification will be sent to the Insurance Carrier at 24 hours after a patient who meets IP LOC and unloaded to the TRP.

2. **If an admission bed has not been procured by 24 hours after clinical decision for Hospital LOC**
   a. The ED Evaluation Team must make a formal Request for Assistance to the Insurance Carrier, if this has not already been done through the TRP or other applicable methods of communication.
   b. Within two hours of the submission to the TRP or other applicable methods of communication by an ED Evaluation Team 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.
      i. When a TRP referral notification or request via other methods of communication is made outside of normal business hours (e.g., after hours and on weekends or holidays), the Insurance Carrier shall acknowledge receipt of the Request no later than the morning of the next calendar day after the request is made, and shall proactively provide assistance.
   c. The TRP referral waitlist or request via other methods of communication must provide the Insurance Carrier with clinical information about the individual, updated clinical information, barriers to admission, evidence of the bed searches to date, and a summary of responses from hospitals who have denied admission to the individual.
   d. <u>The Insurance Carrier</u> must work closely with the ED Evaluation Team point person to avoid redundancy in bed searches and to determine which hospital(s) is most appropriate to meet the needs of its member. Insurance Carriers must engage senior

clinical and administrative officials at potential Inpatient Psychiatric Providers continuously until an admission bed is identified and agreed upon.

i. The Insurance Carrier, in discussion with Inpatient Psychiatric Providers, proactively offers, determines, and authorizes payment for required supports or resources (i.e., single room, extra staffing, high-cost medications for complex comorbid medical conditions etc.) when such supports or resources are determined to be needed by the Inpatient Psychiatric Provider who also has the capability to provide such specialized resources to allow for admission. All authorizations are documented and provided to the ED Evaluation Team and to the Inpatient Psychiatric Provider. A clear mechanism of how payment will be provided by the Insurance Carrier is included when making these specialing arrangements. When an Insurance Carrier authorizes these resources, the Inpatient Psychiatric Provider is expected to accept the patient.
ii. The Insurance Carrier must mitigate any authorization issues that are presenting barriers to a successful admission acceptance and shall provide documentation of such authorization to the Inpatient Psychiatric Provider in a timely manner.
iii. If a specific Inpatient Psychiatric Provider 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 Inpatient Psychiatric Provider agree to prioritize the admission of the individual against the next discharge. However, the patient status in the TRP should be updated with a status of “Accept Pending Bed”; if another Inpatient Psychiatric Provider is found to have a bed prior to the preferred Inpatient Psychiatric Provider’s availability, that readily available bed should be secured for the patient, should all parties agree.
iv. If an in-network bed is unavailable, the Insurance Carrier should seek placement in appropriate out-of-network facilities (considering services required by the individual, geography, etc.).
v. The Insurance Carrier actively seeks to obtain admission of the individual until an inpatient bed has been secured. This includes a review of the updated clinical referral packets and ongoing discussion with senior leaders of the Inpatient Psychiatric Providers to break down barriers to admission.
vi. If at any time after the decision is made that an individual with co-occurring complexity requires psychiatric hospital LOC and it is clear that a placement will not be identified within 60 hours (or 48 hours if the individual is under 18 years of age), the Insurance Carrier (or, in the absence of an engaged Insurance Carrier, the ED Evaluation Team), may consult with DMH on a case-by-case basis for acceleration of the Protocol.

3. If an admission bed has not been identified by 60 hours (or 48 hours if the individual is under 18 years of age) from a patient's evaluation that determined the need for inpatient LOC and referral creation in the TRP:

a. DMH involvement will include the following:
   i. The Deputy Commissioner of Clinical & Professional Services or designee oversees the DMH team that facilitates placement.
   ii. The Insurance Carrier or ED Evaluation Team designates a senior clinical administrator to communicate with DMH.
   iii. The internal DMH EPIA team will work with Insurance Carriers, ED Evaluation Teams, and Inpatient Psychiatric Providers to determine next steps to ensure that psychiatric admission for the individual is accomplished.

b. DMH works with ED Evaluation Teams, Insurance Carriers, and Inpatient Psychiatric Providers to ensure up-to-date information and clinical assessment is provided in a timely and effective manner until a bed becomes available.

c. All parties involved agree to use the Guiding Principles for Bed Search Efforts (see page 6) developed by the EPIA Multi-Stakeholder Implementation Workgroup.

d. DMH engages senior clinicians and administrators of Inpatient Psychiatric Providers, Insurance Carriers and ED Evaluation Teams, as indicated, to understand and resolve any barriers to admission.

e. If State Agencies' involvement is required to resolve barriers to admission, DMH will convene a conference call with the appropriate State Agency representatives, ED Evaluation Teams, Inpatient Psychiatric Providers, Insurance Carriers, and others as needed to resolve such barriers.

f. When network adequacy and payment issues create barriers to admission, DMH facilitates a discussion with the Insurance Carrier, MassHealth, and DOI, as appropriate.

g. Data collected from this process is reviewed on a regular basis by EOHHS (and posted on mass.gov), DMH Licensing for use during regulated surveys for continuing licensure, and the EPIA Advisory Council to report to the Legislature.

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

The above protocol, including but not limited to timeframes and the creation of a referral in the TRP, will be followed for 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 Evaluation Team will continue its efforts to locate an appropriate placement and to engage the identified payer (if there is one) for assistance as outlined above. A referral should be created in the TRP at the time that the evaluation is conducted and psychiatric inpatient LOC is determined. If at any time it becomes clear that an inpatient bed will not be identified within 60 hours (or 48 hours if the individual is under 18 years of age), the ED Evaluation Team may consult with DMH on a case-by-case basis for acceleration of the Protocol.

5. Active Role of the ED Evaluation Team for those without Insurance Carrier Support

It is expected that the ED Evaluation Team's clinical and administrative leadership play an active role during the daily (or more frequent) bed searches in the 60-hour (or 48-hour if the individual is under 18 years of age) period prior to DMH involvement.

a. The ED Evaluation Teams must have an Internal Escalation Protocol in place for any long-stay ED Boarding individual that involves ED Evaluation Team clinical and administrative leaders who will then escalate their search efforts to clinical and administrative leaders at the Inpatient Psychiatric Providers 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 Guiding Principles for Bed Search Efforts (page 6) is expected.
e. Full escalation prior to DMH involvement at 60 hours (or 48 hours if the individual is under 18 years of age) 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's network to optimize these relationships on behalf of the boarding individual.
g. The Boarding Hospital's senior administrators will contact similar senior leadership at Inpatient Psychiatric Providers with available psychiatric beds to advocate for their boarding patient's admission.
h. This Internal Escalation Protocol applies to all individuals without an Insurance Carrier advocate.

6. Active Role of the Inpatient Psychiatric Providers licensed by DMH

a. It is expected that all licensed Inpatient Psychiatric Providers maintain Admission Denial Logs signed by Medical Directors or designee serving as the medical director who are consulted on all admission denials when there is a bed available.
b. All inpatient units and facilities are expected to maintain a daily Unit Conditions log for review by DMH Licensing teams during scheduled and unannounced survey visits.
c. The daily emails from EPIA listing those currently expedited to DMH must be reviewed and taken into account when considering admissions for the day as well as planning against next discharges.
d. There must be an Inpatient Psychiatric Provider point person who is readily available to engage in timely discussions with ED Evaluation Teams, Insurance Carriers, and the EPIA team concerning expedited ED Boarders.
e. Adherence to the Bed Search Protocol (page 13-14) developed by the EPIA Multistakeholder Implementation Workgroup is expected:
    - Use of the standardized admission packet (appendix #1).
    - Decision whether to admit or not within 1-2 hours (one hour for routine admissions and two hours for more complicated admissions) of viewing a referral in the TRP.
    - Assurance that all denials were reviewed by the Medical Director or designee serving as the Medical Director prior to the decision to deny.
    - Work to admit those patients deemed appropriate by the Inpatient Psychiatric Provider against next discharge.
f. Regular admission of long-waiting (14+ days) ED Boarding patients from the EPIA list should be prioritized and planned for by hospital leadership.
g. Electronic communication through the TRP of clinical information from ED Evaluation Teams, Carriers, and EPIA is expected.

Summary for Insurance Carriers

Member Insurance	Proposed Process
MassHealth Involved	
MassHealth managed care	• TRP notification to Insurance Carrier before or by 24 hours after evaluation and referral creation in the TRP • Senior administrative & clinical leaders are actively involved with bed-finding • TRP notification to DMH at 60 hours for adults (48 hours for those under 18 years of age)
MassHealth non-managed care (FFS, HSN, duals)	• ED Evaluation Team activates their Internal Escalation Protocol by 24 hours • TRP notification to DMH at 60 hours for adults (48 hours for those under 18 years of age)
Commercial Coverage	
Insurance Carrier regulated by DOI	• TRP notification to Insurance Carrier before or by 24 hours after evaluation and referral creation in the TRP • Senior administrative & clinical leaders are actively involved with bed finding • TRP notification to DMH at 60 hours for adults (48 hours for those under 18 years of age) if individual is still boarding
Administrator for self-funded ERISA Plans not regulated by DOI Out of state insurance carrier	• ED Evaluation Team Request for Assistance to appropriate Plan Administrator or Insurance Carrier by 24 hours after evaluation and referral creation in the TRP • If Insurance Carrier will not engage in this protocol, the ED Evaluation Team continues to search for a bed and activates their Internal Escalation Protocol and • TRP notification to DMH at 60 hours for adults (48 hours for those under 18 years of age) if the individual is still boarding
Other	
Medicare Only Uninsured	• The ED Evaluation Team makes active efforts to assist patients with application for MassHealth coverage starting at 24 hours after evaluation and referral creation in the TRP; and/or, • Continues to search for a bed and activates their Internal Escalation Protocol; • TRP notification to DMH at 60 hours for adults (48 hours for those under 18 years of age) if still unplaced

Insurance in BOLD represents those in the standard protocol outlined.

Summary for Bed Search

	Proposed Process
Use of the TRP will be part of the Bed Search activities and will trigger health plan and state agency involvement at 24 hours and EPIA involvement at 48 or 60 hours after evaluation and referral creation in the TRP.	**General search for bed availability** - Meaningful Waitlist for Child/Adolescent and specialty units by Inpatient Psychiatric Providers is encouraged
	Patient specific bed search - Get DCF/DMH/DDS involvement as soon as possible, if applicable - **Insurance Carriers** advocate at senior administrative/clinical levels and work to decrease any perceived barrier to admission by Inpatient Psychiatric Providers - Prioritize hospital network/system where the patient is boarding and/or the system where the patient receives their outpatient care (ACO/MCO) - For boarding individuals with lapsed Medicaid, or those who are uninsured and applying for MassHealth, ED Evaluation Teams are expected to work with MassHealth to expedite this re-insurance process - If there is a family preference, the boarding hospital should clearly note in the TRP the name(s) of the preferred facility(s) and prioritize the preferred inpatient facility if the preferred facility "accepts" in the case multiple beds are offered. Evaluation team providers should continue to work with the patient or family to enlarge the number of preferred Inpatient Psychiatric Providers.
Check TRP frequently to view the responses of Provider Facilities to the individual patients in the TRP waitlist.	**Yes, there is a Bed Available ("Accept")** - Once a complete Admission Packet is viewed, the Inpatient Provider reviews and provides a clear Yes (Accept)/No (Decline) within two hours (one hour for routine admissions and two hours for more complicated admissions) - If Inpatient Psychiatric Provider determines that the case is complicated and requires internal escalation, a final determination about admission is made within two hours - If the initial clinical presentation and/or unit conditions do not permit admission, change the patient status to "Decline" in the TRP, and document in the Medical Director Admission Denial Log (per DMH regulations)
	Maybe ("Need More Info"), Bed Available or opening up later in the day ("Accept Pending Bed") - Identify the clinical barrier, acuity, or staffing issues that need to be addressed by the Inpatient Psychiatric Provider to overcome hesitancy to accept, and submit via the TRP - May require telephonic or other communication with the ED Evaluation Team or others involved in the escalation (Insurance Carrier and/or EPIA) and the necessary transparency to resolve barriers - Decision from the Inpatient Psychiatric Provider is received within two hours (one hour for routine admissions and two hours for more complicated admissions)
	No, Bed Not Available ("Decline"), however: - Based on initial clinical presentation, would this Inpatient Psychiatric Provider

	consider accepting the patient pending a discharge? *Yes* – Mark member "Accept Pending Bed" and put on waitlist (only for C/A or Geriatric units) and provide more clinical information about potential bed availability, i.e., potential wait time, etc. *No* – Provide a clear "No" from Inpatient Psychiatric Provider to ED Evaluation Team
	-
Acceptance for transfer to the Inpatient Psychiatric Provider	- Any Insurance Authorization needed, including authorization for any special services that are required to facilitate admission, are completed prior to transfer - Planned arrival time agreed upon with appropriate doctor-to-doctor and nurse-to-nurse communication before transfer - Availability of parent or guardian to sign the Conditional Voluntary Admission legal status within 24 hours for patients under 18 years of age - Notification of other participating stakeholders, as applicable - Close the loop with all stakeholder advocates involved

Appendix 1: Standardized Admission Packet (the Packet)

1. Demographic Information (minimally includes full name, date of birth, insurance numbers, and guardianship)
2. Comprehensive Evaluation (3-5 Pages)
    a. Initial Evaluation
        i. Diagnosis/Presenting Problems
        ii. Clinical assessment and need for inpatient Level of Care
    b. Medical Clearance
    c. Current updated clinical information
        i. Summary ED Course & any treatment provided
        ii. Medications administered in the ED
        iii. Behavioral response to medication administered
        iv. High risk behaviors (substance use, etc.)
        v. Court involvement
        vi. Family or other therapeutic interventions in ED
        vii. Patient's baseline
    d. Current assessment and mental status exam (same day as bed search)
        i. Requirement of any special services including but not limited to single room, 1:1, medical accommodation
        ii. Disposition expected at the end of acute hospitalization (if applicable)
        iii. Parent/guardian preferences (if applicable)
        iv. Guardianship/Rogers (if applicable)
        v. Agency involvement (if applicable)
        vi. Collateral contacts (if applicable)
3. 24 Hour ED Course Summary/Update for each day in the ED since arrival