**Task Force on Behavioral Health Data Policies and Long Term Stays**

**ED Boarding Recommendations for Discussion at 1-27-15 Meeting**

Numbers in parentheses at the end of each recommendation correspond to the numbering in the “ED Boarding Recommendations complete list” document and are available here for your reference.

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|  |  | **Support** **(Y or N)** | **Notes****(Optional)** |
| **Bedfinder** | Accept the December 2014 report from the Special Commission to Investigate the Expansion and Enhancement of the MABHA Website.  |  |  |
| Add information regarding CSS. (1) |  |  |
| Including bedfinder reporting requirements into licensure /regulation. (8) |  |  |
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| **ED Processes / ESP Services** | Reassess the need for medical clearance processes, especially for well-known individuals. (30) |  |  |
| For EDs with no / little psych support at a minimum have telepsych consultations, contract with an ESP or psych consultation service. (55) |  |  |
| Eliminating the requirement that ESPs participate in the authorization process. (TFM) |  |  |
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| **Payment** | Develop pilots for alternative payment models that incentivize reduced lengths of stay for inpatient psychiatric and ED. (TFM)[[1]](#footnote-1) |  |  |
| Increased participation by insurers in bed search and placement and increased reimbursement to the provider who must board the patient in their facility. (22) |  |  |
| Increase reimbursement for psychiatric inpatient admissions to allow for staffing and coordination of individuals with complex needs. (37) |  |  |
| Support legislation (e.g., House Bill 1788 (2013-2014)) which would provide licensure of beds designated for “difficult to manage” patients or medically complex patients. (17)  |  |  |
| Prohibit prior authorization requirement in health plans contracts. (44) |  |  |
| Legislation to supersede out of network restrictions for ED boarders. (11) |  |  |
| Use bed finder to find appropriate out of network beds, when in-network beds are not available. (21) |  |  |
|  |  |  |  |
| **ED Alternatives** | Consideration of Taunton State hospital or other sites for pilot programs that divert high acuity and dual diagnosis patients away from EDs. (18) |  |  |
| Increase use of separate but adjacent psychiatric EDs within the hospital. (38) |  |  |
| Create post-ED crisis pod that would serve to care for patients needing emergent mental health care pre-inpatient stay or in lieu of inpatient stay. (TFM) |  |  |
|  |  |  |  |
| **Inpatient Service Availability / Capacity** | DOI to develop standards to ensure plans have adequate BH networks. (14) |  |  |
| Establish single authority to make determinations for placement for patients who have extended boarding, been refused admission or whose course of treatment is in dispute. (15) |  |  |
| Regulation to provide appropriate staffing levels in all care facilities on the weekend. (19) |  |  |
| *Recommendations concerning difficult to place patients:* |  |  |
| * + Enforce no reject provisions in hospital contracts. (31)
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| * + New licensing requirements where psych hospitals/units can’t deny admission b/c of history of medical condition. (52)
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| * + Assess whether units with more single rooms / higher staff ratio can help patients with aggressive behavior recover. (55)
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|  |  |  |  |
| **Community Service Availability / Capacity** | Increase use of peer support services, including peers attached to ESPs to provide early diversion services, reduce stress and advocate for the needs of individuals awaiting hospital admission. (32) |  |  |
| Increase the capacity of mobile crisis teams and their ability to bill for stabilization services. (36) |  |  |
|  |  |  |  |
| **Other** | Are there other recommendations that you would like to discuss? If so, please indicate the recommendation and whether it was recommended by a prior group (if known.) |  |  |

1. Task Force Member [↑](#footnote-ref-1)