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# Report to the Joint Conference Committee of the San Francisco Health Commission November 25, 2014

## April 2014 Initial visit and Baseline Assessment

- **Purpose:**
  - a. To confirm the findings of the most recent State audit of the inpatient psychiatric unit at SFGH. (Note: This was the third such audit over a nine year period with no substantial positive changes in findings.)
  - b. To make recommendations for moving forward to address State identified and MTA identified deficiencies
- **Results of Review of State Audit Findings**
  - a. Confirmed all medical necessity findings of the audit
    - i. Primary Medical Necessity Problems:
      - 1. Diagnoses do not meet eligible diagnoses as required by State regulation
        - a. Substance abuse diagnoses
        - b. Rule outs
      - 2. Patients do not meet inpatient admission criteria
      - 3. Patients do not meet continued stay criteria
      - 4. Patients do not have complete or comprehensive treatment plans signed by the physician.
    - ii. Prior to our coming on site, UM responsibility had been shifted to the hospital's UM Department and was no longer the responsibility of UCSF which has a contract for staffing and managing the inpatient unit.
  - b. Confirmed problems with billing for administrative days
    - i. The required calls to determine if placement beds available were not being made in sufficient numbers and properly documented.
    - ii. This was addressed before we came on site with social work reassigned to UM and UM assigned responsibility for ensuring required calls completed. They developed a system with multiple redundancies that ensures this billing is supported.
  - c. Findings related to the UR Plan

- i. Were addressed by internal hospital UM. Changes to the UR Plan were approved by the state prior to our coming on-site.
- Additional Issues:
    - a. Very little in the way of structure or internal controls to manage regulatory compliance
    - b. No unifying clinical philosophy to guide staff decision-making; program development; treatment planning
    - c. Need to improve medical leadership in both administrative and clinical areas so it is more appropriate for an acute unit of care.
    - d. Lack of treatment. Mentioned also in the debriefing report given by state. Primary treatment modalities: medication, milieu management, and OT skill building group/individual. No individual, group, family therapy/counseling being provided.
      - i. Social workers primarily engaged in discharge planning.
      - ii. No addictions specialist. Significant lack of co-occurring/substance use treatment (also affecting discharge planning)
    - e. Broken relationship with Transitions staff resulting in some prolonged stays in either behavioral or custodial status. MDs need to move to a lowest level of care philosophy to reduce numbers of individuals discharged to facilities, particularly locked facilities.
    - f. UM new to psych inpatient authorizations for billing with no depth of experience or robust processes as was available on the medical side.
    - g. Poor documentation practices.
      - i. Insufficient focus by all disciplines on supporting medical necessity
      - ii. Treatment plans deficient and not supporting intensive treatment in an acute setting.
      - iii. No internal processes for assuring all documents present
      - iv. Much duplication in initial assessment including multiple credentials diagnosing, determining goals and objectives
    - h. Only formal team-based communication structures were team meetings in morning with focus on reporting on status of individual, not for strategizing, treatment planning.
    - i. Compliance program focused only on billing. Program not robust. Unclear lines of responsibility between compliance, regulatory affairs, QI and risk.

## Structure of Consultation

### 3 Person Team

- Mary Thornton, BSRN, MBA, CHC, CHPC: project manager with focus on medical staff, compliance
- Lesa Yawn, PhD, JD: focus on treatment scheduling, utilization management, forms development and documentation
- Virginia Knight, PhD Nursing: focus on nursing, treatment schedule development

Monthly Meetings: with schedule distributed prior to the scheduled on-site.

- Staff at SFGH were available and fully participating at meetings, particularly clinical leadership
- Work assigned and staff expected to implement during month and report out at next on-site visit.

#### Workgroups:

Initially set up 3 staff workgroups:

- Clinical philosophy and clinical leadership: focus on developing and training all staff on clinical philosophy; developing a more hierarchical leadership approach to accommodate needs of acute patients; developing role definitions and responsibilities.
- Assessment and treatment planning: develop new forms that avoided duplication; met regulatory requirements; and provided necessary support for medical necessity.
- Treatment: assigned to design a robust and intensive treatment schedule that covered 7 days per week at same level of intensity and provided opportunities for treatment in the evenings as well. The schedule would assign group and individual interventions for nursing, social work and OT.

Consultants also assigned to work with staff groups based on their area of focus described above.

### **Major Accomplishments in Relation to Key Findings**

All of the accomplishments listed below came about because of joint efforts on the part of the consulting team and the inpatient unit staff along with Utilization Management Department and Corporate Compliance.

#### **Documentation of Medical Necessity**

1. Assisted a very able and experienced UM staff who were just recently given responsibility for inpatient psychiatric UM to develop their role in authorizing the billing of acute and behavioral inpatient psychiatric services. This included the development of a tool for assessing medical necessity using State and CMS regulations, a process for communicating UM findings to the medical staff, and the on-going development of inter-rater reliability among UM staff, a process now used throughout UM in the hospital for the on-going development and assessment of inter-rater reliability among all UM staff.
2. Designed and assisted in the implementation of a UM process using the tool described above to prevent SFGH from billing any inpatient days that did not meet medical necessity for admission or continued stay
3. Developed the corrective action plan required by the State based on the results of the 2013 audit findings and assisted in the implementation of the monthly corrective action record reviews SFGH committed to in the CAP. This process includes the continuous testing of the UM tool described above to ensure it remains a robust and reliable internal control on improper billing. This process also tests the internal controls developed by UM to ensure that the required documentation to bill administrative days is also working appropriately.

4. Provided multiple trainings to medical and other staff on the components of and the documentation of medical necessity.
5. Worked with UM and Medical leadership to develop a documentation system that allowed UM to more easily determine medical necessity during the very early days of the inpatient stay including the development of a new admission note, initial psychiatric assessment, and the integrated plan of care.
6. Developed a temporary and now in process of developing a final version of a new psychiatric assessment to address State and UM concerns about content to address medical necessity and to allow billing during the initial period post admission.
7. Expanded nursing responsibilities in daily "huddles" with the MDs, in treatment team meetings, and in their own documentation, including new forms, to assist in communicating medical necessity or lack thereof to other members of the team but in particular the MDs.
8. Worked with both OT and Social Work staff on developing new assessments forms and changes to both group and individual progress notes to focus on medical necessity issues.

### **Inter-Disciplinary Treatment Planning**

1. Developed and helped to implement a process for treatment planning to take place in an integrated, interdisciplinary manner for both new admissions and those in continued stay including those patients in behavioral and custodial status on the units. These meetings encourage interdisciplinary strategizing for positive patient outcomes and are moving towards a more person-centered approach.
2. Developed multiple training and other tools including a detailed script that includes roles, time frames and content of the development of the treatment plan including inclusion of the patient, where clinically appropriate, in planning and in development of their individual treatment schedule.
3. Assisted in bringing back to inpatient psych the "Lower Level of Care" meetings with the Transitions staff. These meetings are intended to coordinate the discharge efforts for those patients who are among the most difficult to place. These meetings among other efforts by the consulting team and inpatient and UM staff are an attempt to make discharge planning more focused, consensus-based with the patient, community and hospital agreeing on discharge placement, and to increase efficient and early planning. There is general agreement that patients need to move more quickly from the unit to their community based setting, that the MDs need to apply recovery principles including risk taking to discharge planning, and that active discharge planning needs to take place earlier in the inpatient stay.
4. Developed a new Inter-Disciplinary Treatment Plan form (still in beta testing) that meets all regulatory requirements for content, encourages a recovery focus and person-centered planning including rehabilitation and health and wellness goals in addition to psychiatric.

### **Inter-Disciplinary, Intensive Treatment Schedule**

1. Developed with inpatient staff a very intensive treatment schedule that covers both day and evening hours and both days of the weekend. All agreed that given the level of acuity and the short

stays that reducing efforts on weekends was not appropriate. The schedule delineates time and content of the treatment, e.g. medication education, coping skills, etc and then the treatment team determines based on the acuity of the patient and their individual needs whether staff will provide this treatment either in a group or individual format. Groups are assigned to all disciplines except medical who will fill in for staff shortages. In this way, staff will assure individualized care whose intensity and content is based on patient acuity and patient choice.

2. Nursing's role under the new treatment schedule is greatly expanded role including regular patient engagement rounds and group and individual interventions with patients using evidence-based practices for motivational interviewing, medication education, and the development of coping skills.
3. Worked with OT to help them better understand their role and to transition their interventions and documentation to more of a focus on medical necessity. The OT staff have provided a stable, energetic, diligent structure for the treatment team. They have filled in where needed, taken on additional responsibility without complaint.

## **Other Findings**

### **Internal Controls and Regulatory Compliance**

1. Worked with compliance to design and implement the Corrective Action Plan required by the state.
2. Continue to have discussions about how to more clearly delineate the lines between compliance, regulatory affairs, QI, and Risk Management.
3. Continue to add to the list of new Policies and Procedures or modifications to current P&P to reflect current practice.
4. Recently the unit added an audit function to ensure that every required document is actually in the medical record and is complete and accurately signed. This step was added after a recent review by the consulting team showed multiple documents incomplete or unsigned.

### **Medical Leadership**

1. Assisted clinical leadership in the development of a clinical philosophy that mirrors the outpatient system in its focus on recovery and on person-centered approaches to care. All staff were trained by clinical leadership on the new philosophy and how it applied to their everyday work.
2. Continue to discuss with the medical leaders the importance of their role as "captains" and need for them to provide continuous direction and to ensure that decisions made by the team and committed to are carried out .
3. Working with DPH, Mental Health Plan, to develop better communication between the community and the hospital on discharge planning alternatives. See also 3 under Interdisciplinary Treatment Planning for a description of work with the Transitions staff and role of MDs in practicing recovery based principals.

### **Documentation**

1. Multiple trainings with staff and individual consultations on documentation carried out. This continues to be an area of weakness for MDs as they adjust their documentation to better reflect medical necessity on a daily basis. Also additional work needs to be done to ensure that the treatment plans are comprehensive, accurate and timely. Nursing appears to have settled on a format that is useful and thorough. They continue to be assisted by nursing leadership.
2. SW staff is going through a substantial transition and their documentation will need to reflect their new roles, discussed below.
3. OT has transitioned easily to a new format for documentation that brings their observations and interventions into the medical record. Prior to this their documentation was contained in a separate folder on the unit but not easily accessible.
4. Trained MDs on new documentation methodology, Evaluation and Management, that was required of psychiatrists with changes to the CPT coding manual in 2013.

### **Social Work**

1. Worked with UM who recently took over responsibility for social workers to develop an implementation plan for the division of the social work team into clinical social workers and discharge social workers. The former group would be responsible for providing individual, group and family therapy/counseling. (The state was very concerned about the over-reliance on OT for treatment interventions on the unit.) The discharge social workers were intended to become experts in the levels of care available to the patients on the unit and to help ensure that discharges were successful for the patient. This has been a very difficult transition discussed further below under outstanding issues.

### **Major Outstanding Issues**

1. Medical leadership: problem solving and sustainability of change will need to be evaluated over time; demanding and getting the best from the medical team as well as other disciplines is essential; understanding and operationalizing medical necessity for the benefit of their patients which will likely lead to more acute days and less days in administrative or custodial care; leading in discharge planning and allowing the community to partner along with the individual in decisions about placement with the goal of decreasing those discharged to facility based care, especially locked facilities; continuing to operationalize recovery and person-centered planning approaches.
2. Treatment team meetings and the integrated plan of care: IPOCs need a great deal of attention and MDs need to model for the remaining staff the need for plans to be well thought out, implemented as designed and of value to the team not just an exercise required by regulators. Strategizing needs to result in changes to the plan in writing whenever notable changes are made to how care will be delivered even if these conversations take place outside of the treatment team meetings. Documentation needs to be individualized and focused. The individuals needs to be more involved in designing their own care and needs to be informed about any changes.

3. UM: implementation of InterQual UM standards for determining authorizations of admission and continued stay may create problems with current documentation practices.
4. Clinical schedule: needs to be implemented; needs to not be pre-empted even for staff vacancies; needs to be managed.
5. Discharge planning: more expertise; more coordination; more status; development of a discharge packet and instructions to ensure more successful placements and community stays.
6. Policy and procedures: needs to catch up with the work we have done.
7. Compliance and QI: Compliance needs to do claims audits and needs to be a bigger presence in the hospital overall; QI needs to focus on the changes that have been implemented that are intended to improve outcomes. Lines between regulatory and compliance need to be clearer than they are right now.
8. Documentation: there remain issues both with ensuring all documentation is in the record and is complete and with the content of the documentation. The former is now being addressed with a new staff person who will audit each chart for required documents and assure that they are all signed and complete.

## Next Steps

This has been a very rigorous process with lots of change implemented or continuing to be implemented. We believe it is time for us to get out of the way for a while and to let the inpatient team along with UM continue to problem solve and operationalize. Per our original proposal we would finish our work on-site and then leave for at least 3-4 months coming back to review that the changes made were sustained and are producing positive results with respect to the major state audit findings.

Because of the difficulty of implementing some of the changes to practice we have had to extend our on-site work through December 2014. During this last on-site we will be compiling the various documents and instructions we have prepared, will develop a final list of policies and procedures that need development or modification, continue to evaluate the implementation of the clinical schedule, and continue to work with staff on the content of the integrated plan of care and discharge practices.

Because of concerns about the sustainability of the changes made to date, we now believe now that rather than waiting 3-4 months to come back as originally planned, we will do the following:

1. January 2015: review one patient chart for each of the attending MDs and provide individual feedback. This will allow us to look at documentation, UM findings, implementation of the treatment schedule, and the discharge planning process.
2. February 2015: same as above
3. March 2015: on-site review similar to baseline conducted in April of 2014.

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