Psychiatric Health Facility Medical Care Evaluation Study:

ADMINISTRATIVE DAYS
JANUARY 2018 – (ONGOING)

Purpose of MCE Studies

The purpose of medical care evaluation (MCE) studies is to promote the most effective and efficient use of Psychiatric Health Facilities (PHF) and their services, consistent with patient needs and professionally recognized standards of health care. MCE studies focus on a particular subject area or goal, with the hope of making tangible improvements over the course of the study.

PHFs are inpatient psychiatry units that serve and stabilize patients that have been identified by either law enforcement or medical professionals as a danger to themselves, to others, or as gravely disabled (i.e., as a result of a mental health disorder is unable to provide for their own food, clothing, and/or shelter). Patients are evaluated and placed in PHFs based on the level of acuity or severity of their mental health concerns. It is common for initial admission to be the result of a 5150, an involuntary hospitalization due to serious mental health concerns, which typically lasts a minimum of 72 hours. In the County of Santa Barbara, there is only one PHF with just sixteen (16) beds – limited resources to treat patients needing the highest level of care.

After this initial 72-hour period, patient mental health acuity is reassessed and placement is evaluated. The level of patient care is determined by a number of regulations and considerations. For example, patients who continue to meet medical necessity may remain under acute care within the PHF. Those not meeting standards for acute care stays can remain on the PHF with an "administrative" stay designation. Numerous regulations and guidelines are provided by Medi-Cal to determine whether patients are eligible for administrative days. Additional regulations limit the number of administrative days that are eligible for billing to Medi-Cal. Thus, there are both billable and non-billable administrative days.

The aims of this specific study are to (1) identify and describe the current trends in acute, billable administrative days, and non-billable administrative days (2) implement strategies to improve appropriate categorization and billing (acute, billable administrative days, and non-billable administrative days) and (3) reduce the amount of non-billable administrative days.

Description

Initial baseline data were analyzed using 2017 data for acute, billable administrative days, and non-billable administrative days. IST and Jail Days were excluded from this baseline data analysis.

During 2017, 51.6 % were acute days and 48.4% were administrative days.
Of all administrative days in 2017, 58.4% were billable (hence, 41.6 % were non-billable).

Hypothesis

The hypothesis of the current study is that by implementing trainings on administrative day regulations and guidelines and providing tools for staff to determine appropriate classification, non-billable administrative days will decrease over time.

Rationale

Patients with high acuity who are in need of inpatient services are often identified as high-risk patients. However, there are limited inpatient resources available to serve some of the most at-risk patients in the system. In order to ensure that these services are being utilized most efficiently, a thorough study of the current implementation of administrative days is needed.

Underlying Concerns

1. Access to care
2. Timeliness of transition to lower-level of care
3. Maximize limited inpatient resources

Usefulness of the study

To date, the implementation of acute and administrative days has been understudied. If effective, the current study will be useful in that it will result in more efficient use of limited resources (i.e., 16 inpatient beds for acute care).

Theoretical framework

The theoretical framework chosen to guide the current study is grounded in implementation science, defined by the CDC as "the systematic study of how a specific set of activities and designated strategies are used to successfully integrate an evidence-based public health intervention within specific settings" (RFA-CD-07-005). Aarons, Hurlburt, & Horwitz (2011) proposed a multi-level, four-phase model of implementation processes including exploration, adoption/preparation, implementation, and sustainment which includes inner and outer contextual factors that impact implementation of practices in public sector service settings.

In the context of the current study, the exploration stage included an identified concern from organizational leadership regarding the maximal utilization of limited inpatient resources (i.e., 16 beds). The adoption/preparation phase consisted of training preparation and communication between leadership and staff regarding the use of said resources. Particular emphasis has been placed on increasing access to care for patients who are in the greatest amount of need. This MCE is considered to be between the implementation and sustainment phase in which trainings have been developed as a means of intervention. Ongoing data collection and monitoring will indicate the relative success of the training intervention and will help to suggest whether further intervention is needed.

Identify Components of Quality that are Assessed by this Evaluation

1. Efficiency of limited inpatient resources
2. Appropriate patient classification

Data Sources

Data from the electronic billing system (ShareCare) were pulled in order to analyze the baseline and ongoing number of acute and administrative days for each, beginning with calendar year 2017. For each quarter, the total number of acute, billable administrative days, and non-billable administrative days was compiled.

Analysis

Data are aggregated and analyzed by quarter, as can be seen below.

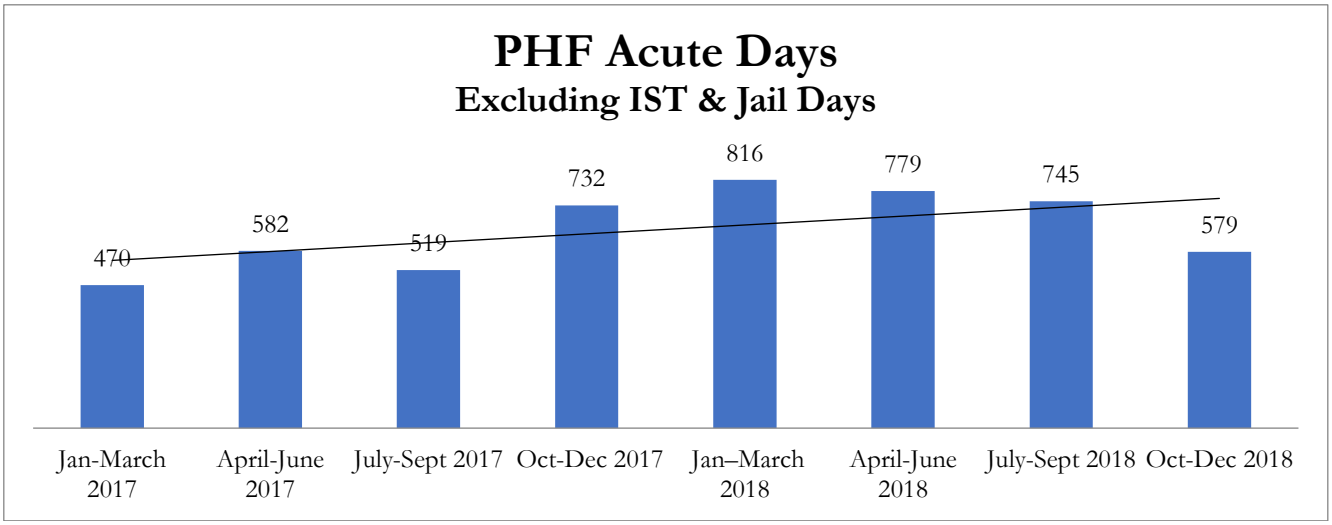
Results

Table 1 includes only clients who are not under court orders or in jail custody.

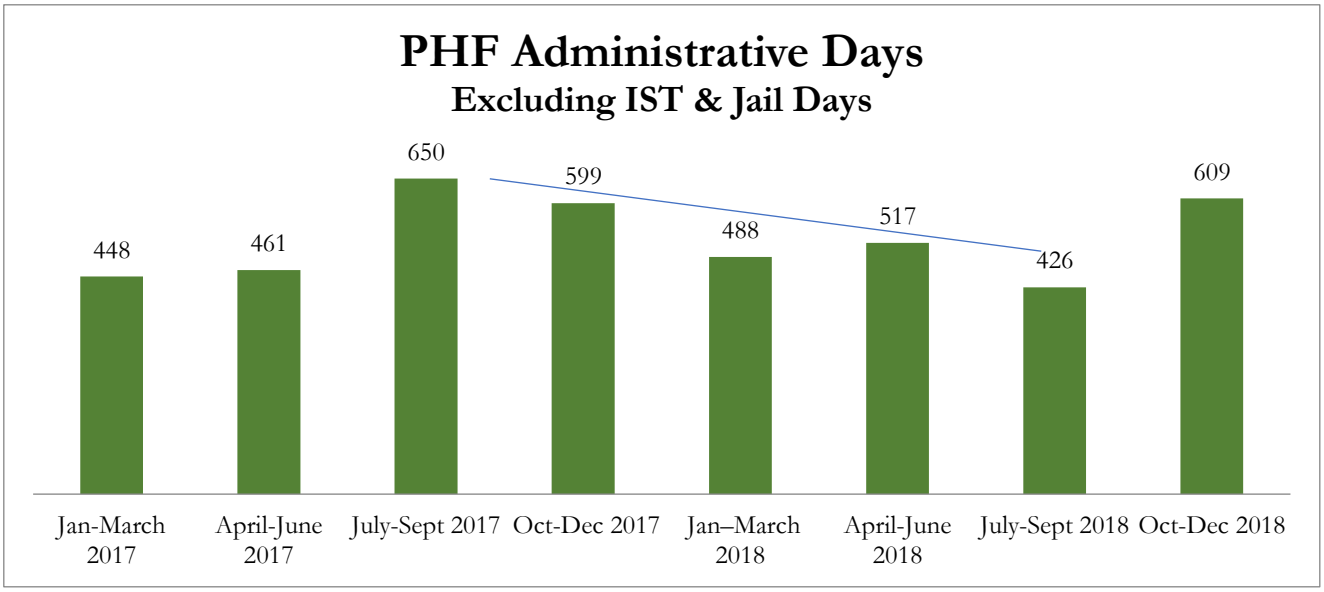
Table 1

	Acute Day			Admin Day		
Service Quarter	**PHF General Acute Day - Bill**	**PHF General Acute Day -Non Bill**	**Acute Day Total**	**PHF Admin Day - Bill**	**PHF Admin Day -Non Bill**	**Admin Day Total**
Jan-March 2017	387	83	470	399	49	448
April-June 2017	465	117	582	350	111	461
July-September 2017	489	30	519	229	421	650
October-December 2017	692	40	732	199	400	599
January to March 2018	703	113	816	240	208	448
April-June 2018	763	16	779	245	272	517
July-September 2018	729	16	745	194	232	426
October -December 2018	494	85	579	293	316	609

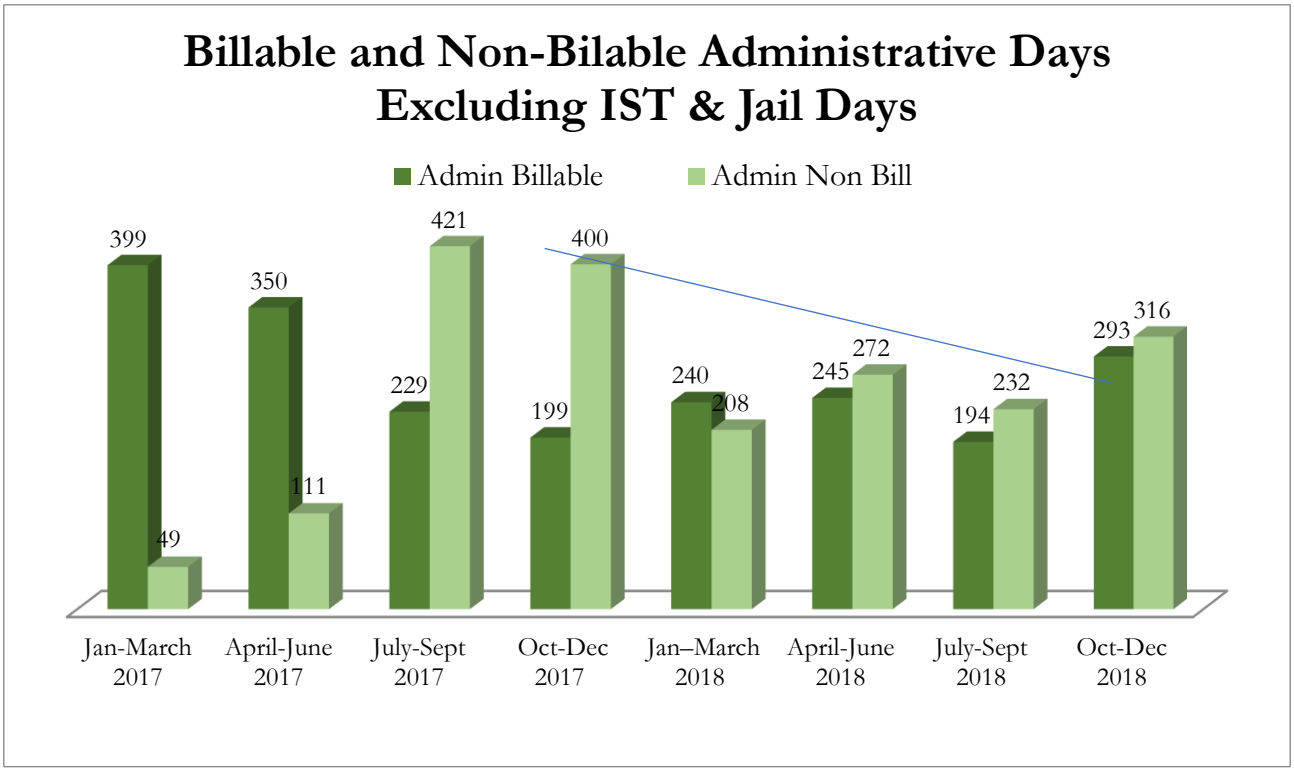
The total number of PHF acute days, both billable and non-billable, (excluding IST and jail days) has generally been increasing over time, but decreased in the most recent quarter.



The total number of PHF administrative days, both billable and non-billable, (excluding IST and jail days) had generally been decreasing since July 2017, with the exception of the most recent quarter.



Among all administrative days, both billable and non-billable, (excluding IST and jail days), there was a steep increase in non-billable administrative days in July-September 2017; non-billable administrative days have since been declining, with the exception of the most recent quarter.



A change in staffing likely explains why there was such a sharp increase in administrative non-billable days in July-September 2017. Prior to May 2017, the PHF had 1.5 FTE Psychiatrists: a 1.0 Medical Director and another .50 FTE – essentially, 12 hours of available MD time Monday through Friday. On evenings and weekends, a contracted Psychiatrist was on call. Other programs in the crisis system of care, such as the Crisis Stabilization Unit (CSU), accessed MD services, as needed, through Tele-psychiatry.

As of May 2017, the MHP restructured the working hours and scope of psychiatrists. PHF psychiatrists, as of May 4th, began working 16-hour shifts, with the expectation that they serve and support not only PHF clients, but also clients throughout the crisis system of care. Hence, during any given 16-hour shift, a MD would certainly be on the PHF, but would also be expected to see crisis clients at the Crisis Stabilization Unit and Crisis Residential Treatment facility. During the first few months of this restructuring there were nearly ten (10) different and new to the PHF MD's, all of whom had varying levels of comfort with discharging and familiarity with resources related to discharge. Over time, the number of MD's stabilized (at about 4), they were trained and had more experience, the administrative non- billable days steadily decreased.

Note that the number of conserved patients has an impact on the number non-billable administrative days, because they must stay at the PHF until an appropriate level placement is available (over which the PHF has no control).

Questions:

What might explain October-December results?

IST and conserved; increase to 6 IST patients

Program Impact

Recommendations for the Future

Resources and References

July to December 2017	January 2018 -	
Baseline	**Intervention Period**	**Post- Intervention**
	3/21/18 Training 1 4/27/18 Training 2 01/15/19 Training 3	

Improving Documentation for Acute Services Training:

- Medical Necessity Criteria for Admission
- Medical Necessity Criteria for Continued Stay Services
- Administrative Day Services
- Examples of Documentation Deficiencies and Recommendations

The documentation trainings were provided by Dr Leslie Lundt and Denys Medel, QCM and was focused on medical necessity criteria, with specific examples of notes that did and not meet the standards.