Psychiatric Health Facility Medical Care Evaluation Study

ADMINISTRATIVE DAYS
JANUARY 2017 – DECEMBER 2020

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 target a specific 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 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 basic needs for 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 disorder, for a period of up to 72 hours. The County of Santa Barbara, operates one sixteen (16) bed PHF – with 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. While patients 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 patient are eligibility 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. Incompetent to Stand Trial (IST) and Jail Days were excluded from this baseline data analysis.

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

Hypothesis

The current study hypothesized that the implementation of staff trainings on administrative day regulations and guidelines, and by providing tools for staff to determine appropriate classification would lead to significant decreases in non-billable administrative days over time/ billable administrative days will increase.

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. To ensure that these services are utilized most efficiently, a 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 current study is grounded in implementation science, defined by the Centers for Disease (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, and 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 were analyzed and presented to the Psychiatric Health Facility Governing Board (PGB) and Quality Assessment Program Improvement (QAPI) on a quarterly basis.

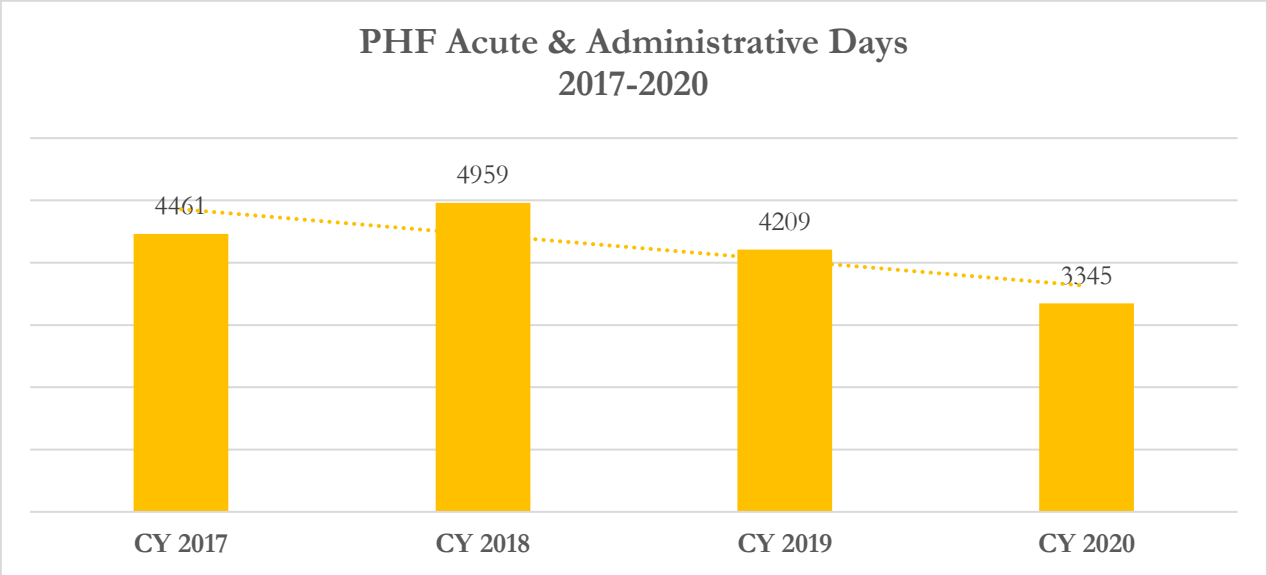
Results

Table 1 displays PHF acute and administrative days for patients who are not under court orders or in jail custody.

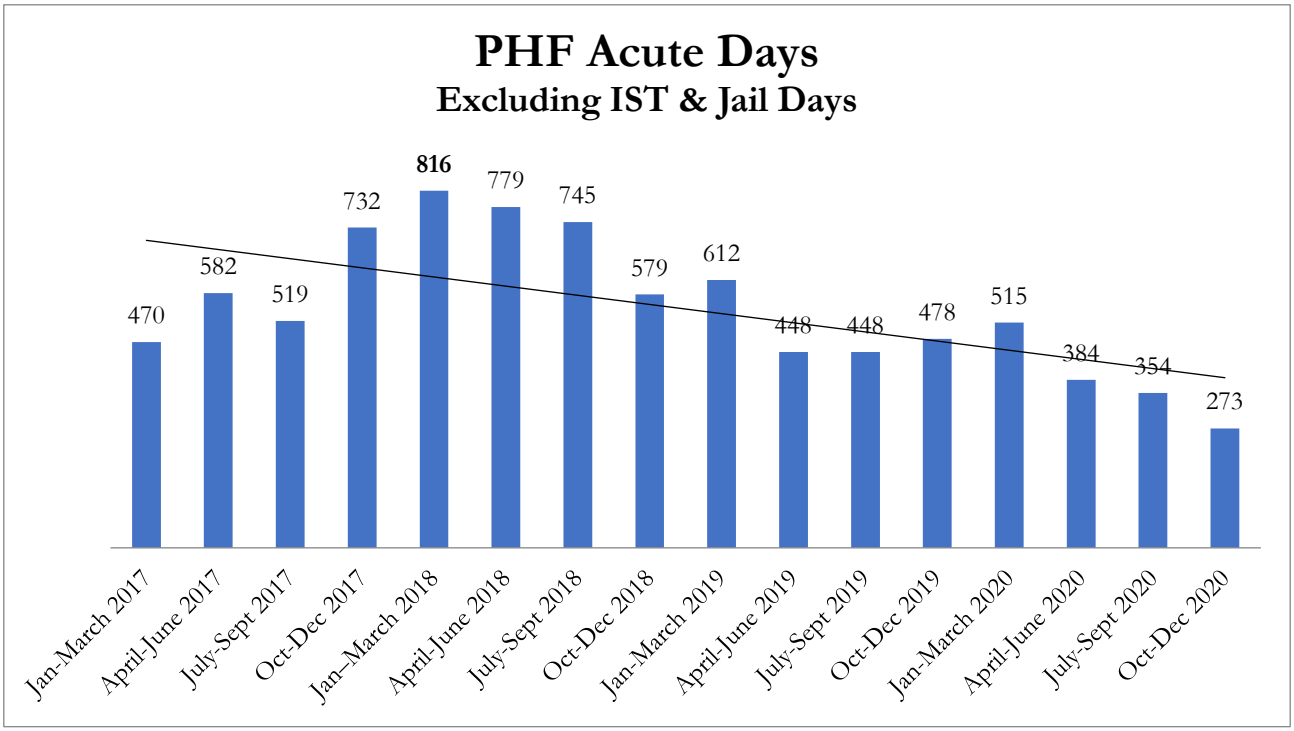
Table 1. PHF acute and administrative days between 2017-2020

	Acute Day				Administrative 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
January to March 2019	572	40	612		326	243	569
April to June 2019	374	74	448		303	279	582
July-September 2019	423	25	448		151	333	484
October -December 2019	434	44	478		276	312	588
January to March 2020	470	45	515		262	211	473
April to June 2020	348	36	384		268	141	409
July-September 2020	268	86	354		268	157	425
October -December 2020	233	40	273		312	200	512

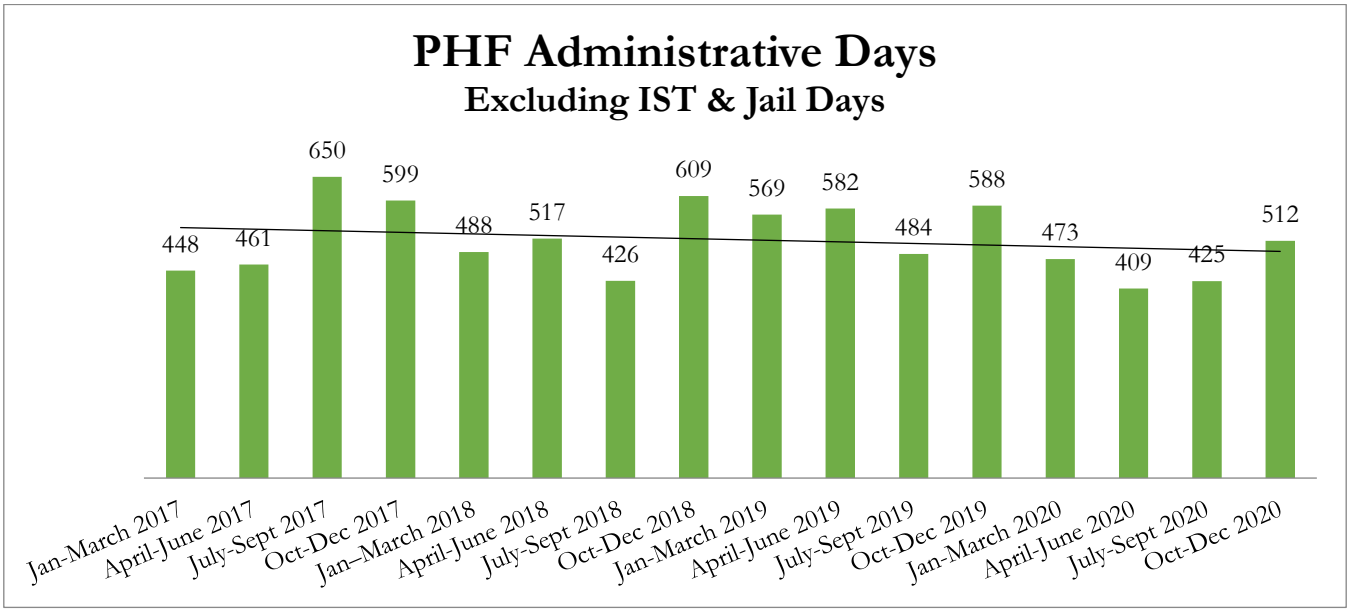
Overall, between 2017 and 2020, there was a decline in the total number of acute and administrative days.



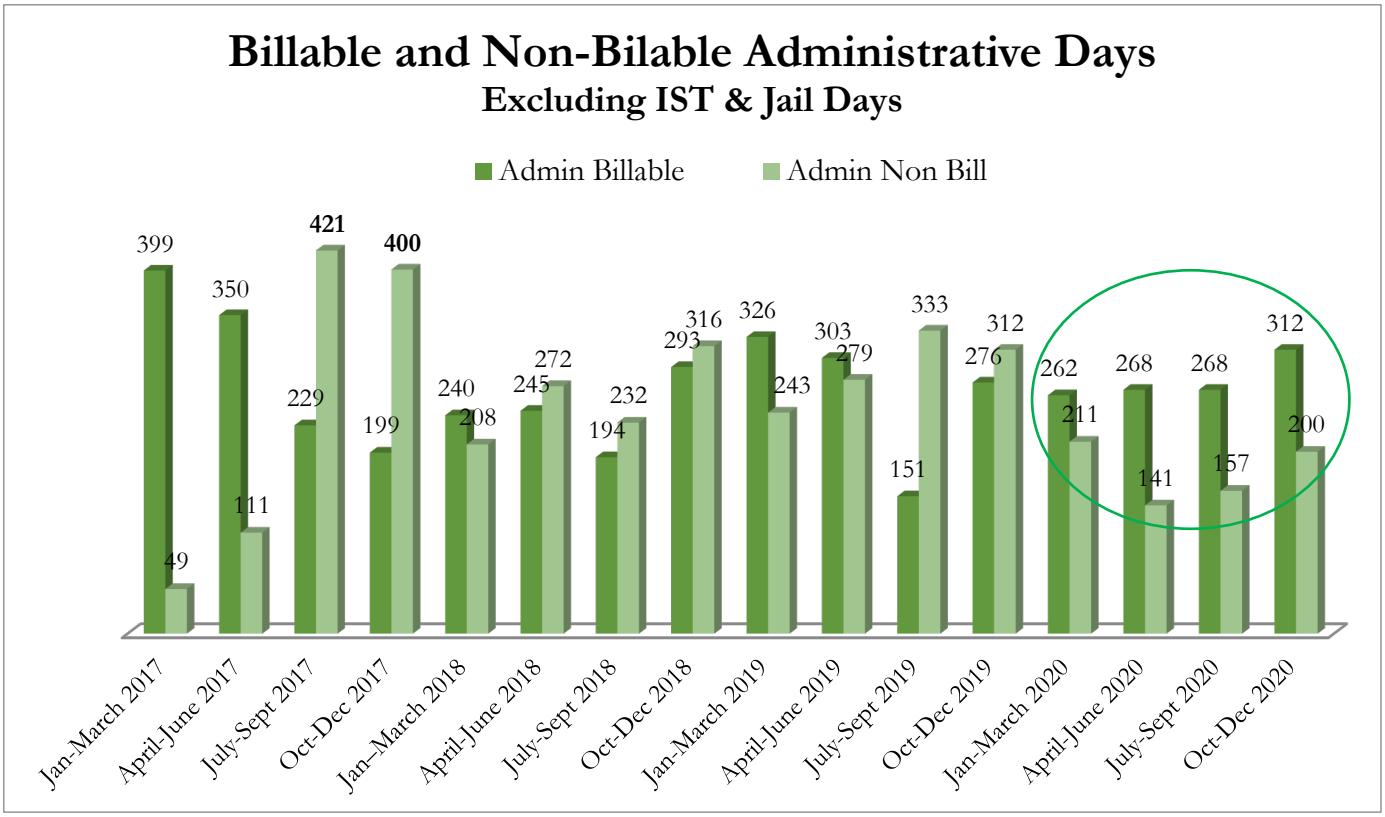
The total number of PHF acute days, both billable and non-billable, were generally increasing from January 2017 through March 2018; acute days have since been declining.



The total number of PHF administrative days, both billable and non-billable, (excluding IST and jail days) has varied some, but has, overall, had a fairly flat to slightly downward trend.

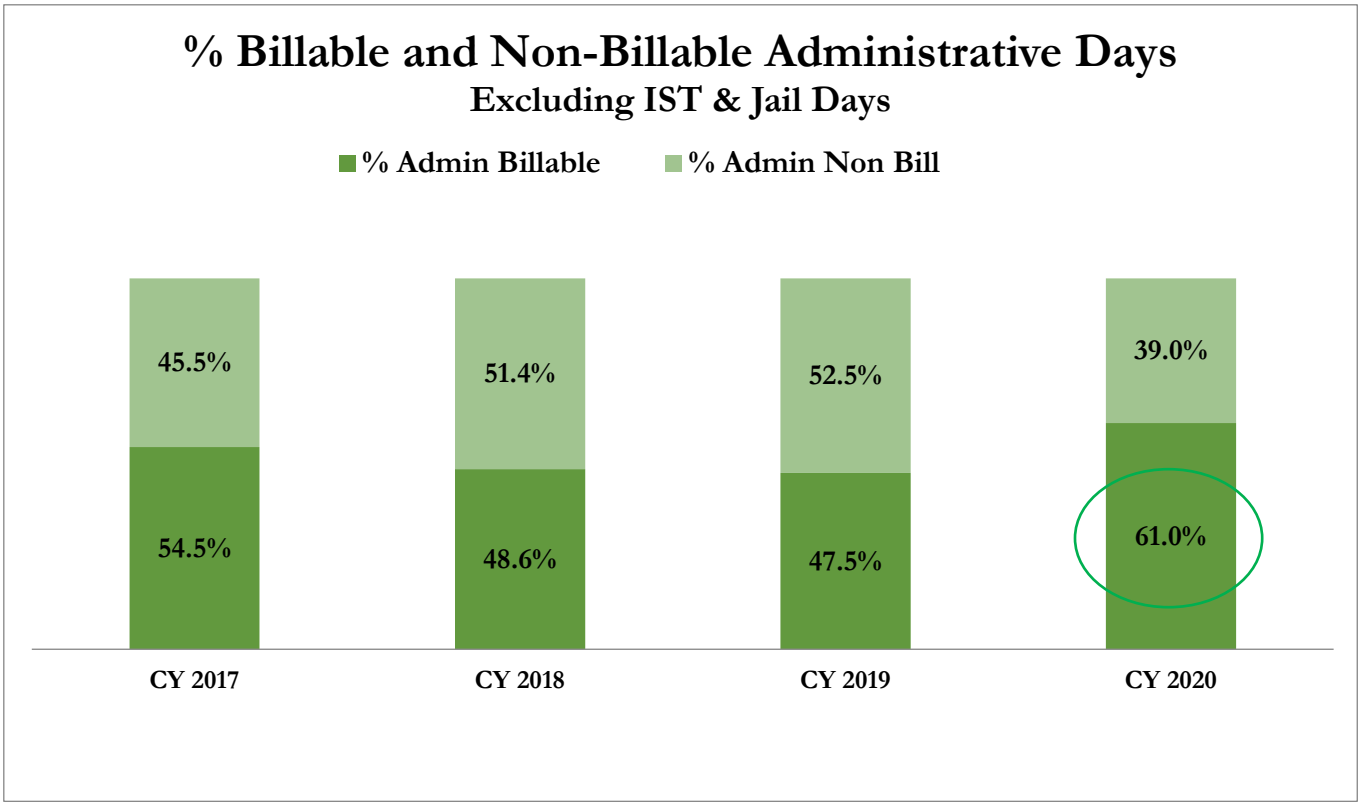


Non-billable administrative days were at their height in the latter part of 2017; since then, non-billable days have been lower, with variations by quarter. In CY 2020, billable days were consistently higher, in every quarter, than non-billable days (2020 annual quarterly average billable = 277, non-billable = 177).



A change in staffing may explain the 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 patients, 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). As they were trained and had more experience, the proportion of administrative non- billable days decreased, and the proportion of billable days increased, as can be seen below.



Conserved Patients: the number of conserved patients continues to have an impact on the number of non-billable administrative days because patients must stay at the PHF until an appropriate level of placement is available (over which the PHF has no control).

A patient requiring numerous hospital stays will trigger the treatment team to consider if conservatorship would be in the patient's best interest. It might take the team several days into the hold to make that determination. The process, thereafter, can be lengthy. It takes a few days to write the application, which is then delivered downtown to the Public Guardian's office. There is a 5 day service period followed by 30 days for investigation and writing the report/recommendation. The court hearing is typically a week thereafter. After a patient has been conserved, they remain in the PHF until they have been accepted at an appropriate placement.

As can be seen below, the number of conserved patients and conserved applications increased throughout FY 2018/19, was nearly the same (total quarterly average) in FY 2019/20, and was quite a bit lower in the first two quarters of FY 2020/21.

Patients	**Q1 July-Sept 2018**	**Q2 Oct–Dec 2018**	**Q3 Jan-March 2019**	**Q4 April-June 2019**	*Q Avg*
Already Conserved (at admission)	4	6	4	9	*5.75*
Applications for Conservatorship (during Q)	4	4	6	9	*5.75*
Overnight Stay: Court Hearing	0	4	3	2	*2.25*

TOTAL	*8*	*14*	*13*	*20*	*13.75*

Patients	**Q1 July-Sept 2019**	**Q2 Oct–Dec 2019**	**Q3 Jan-March 2020**	**Q4 April-June 2020**	*Q Avg*
Already Conserved (at admission)	11	9	8	6	*8.5*
Applications for Conservatorship (during Q)	4	1	6	2	*3.3*
Overnight Stay: Court Hearing	2	2	3	0	*1.8*
TOTAL	*17*	*12*	*17*	*8*	*13.5*

Patients	**Q1 July-Sept 2020**	**Q2 Oct–Dec 2020**	*Q Avg*
Already Conserved (at admission)	9	4	*6.5*
Applications for Conservatorship (during Q)	1	4	*2.5*
Overnight Stay: Court Hearing	0	0	*0*
TOTAL	*10*	*8*	*4.5*

Program Impact

As hypothesized, the MCE and implemented training interventions appear to have resulted in a positive impact.

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

While the administrative days, overall, were flat to slightly declining over the course of the study, billable days were increasing and accounted for 61% of all administrative days in CY 2020 – higher than any of the previous three years.

Recommendations for the Future

It is recommended that the following continue:

- Documentation training for all new PHF MDs

- Provision of training documents (electronic copies) and requirement of signed attestation (certifying receipt and review of training documents), and
- Ongoing support and technical assistance to individual PHF MDs

July to December 2017	January 2018 – December 2020	January 2021 -
Baseline	**Intervention Period**	**Post-Intervention**
	3/21/18 Training 1 4/27/18 Training 2 1/15/19 Training 3 5/07/19 Training 4 6/25/19 Training 5 (social workers) 10/28/19 Training 6 2/25/20 Training 7- Director of Social Services 6/9/20 Training 8 - e distribution	

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 were focused on medical necessity criteria, with specific examples of notes that did and not meet the standards. Dr. Lundt also provides peer review support and technical assistance to individual PHF MDs, as needed, on documentation of acute criteria. In FY 20/21, Dr Lundt continued to deliver orientation trainings with new doctors. Additionally, training documents were provided to all doctors and they were required to sign an attestation, certifying that they had reviewed the training documents.