



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Alice Gleghorn, PhD
Director

Via Certified US Mail

May 3rd, 2019

Jason Murphy, Psy.D
Department of Health Care Services
Mental Health Division
Program Monitoring and Compliance Branch
1500 Capitol Avenue, Suite 72.420, MS 2703
Sacramento, CA 95814

RE: Santa Barbara County Psychiatric Health Facility (provider number 4285)
Triennial Review 2018-2019 Fiscal Year conducted 10/22/2018-10/26/2018
Plan of Correction

Dear Mr. Murphy:

Enclosed you will find Santa Barbara County Psychiatric Health Facility's timely submission of its plan of correction evidencing summary of actions and plan to address the above-referenced survey. Thank you for your support and responsivity in this process. Please contact me at 805-681-5220 if you have any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'Alice Gleghorn', written over a horizontal line.

Alice Gleghorn
PHF Chief Executive Officer

Enclosures: Plan of Correction with Supporting Documents

COUNTY: SANTA BARBARA
DATES OF REVIEW: 10/22/2018 through 10/26/2018

SPECIALTY MENTAL HEALTH SERVICES FISCAL YEAR 2018-2019
SANTA BARBARA COUNTY TRIENNIAL REVIEW
SANTA BARBARA COUNTY PSYCHIATRIC HEALTH FACILITY (PHF)
10/22/2018 through 10/26/2018

Plan of Correction

**ITEM 1, Section J: Chart Review – SD/MC Hospital Services, Part I:
MEDICAL NECESSITY, B(1-2):**

PLAN OF CORRECTION: To ensure admissions claimed for reimbursement documents that the beneficiary could not have been treated at a lower level of care, and, establishes presence of a qualifying impairment The Department of Behavioral Wellness (hereafter, The Department) will:

- 1) Create a required field in the PHF Admission Note template to describe why beneficiary cannot be treated at a lower level of care,
- 2) Create a required field in the PHF Admission Note template to describe the qualifying impairment(s) for admission, and,
- 3) Provide training for Medical Doctor (MD) staff on new required fields in Admission template.

Actions Taken:

The Department has calendared the template change requests to be reviewed at the May Data Meeting 5/6/19 with Information Systems management. The Department has submitted a JIRA Request for Modification of the note templates with the POC changes (see attached). JIRA is a project and issue tracking software solution designed to improve code quality and speed development for software development teams used by The Department.

The Department in coordination with Transitions Behavioral Health has scheduled MD training on documentation of medical necessity and improving inpatient documentation on 5/7/19 (see attached).

COUNTY: SANTA BARBARA
DATES OF REVIEW: 10/22/2018 through 10/26/2018

**ITEM 2, Section J: Chart Review – SD/MC Hospital Services, Part II:
CONTINUED STAY SERVICES, A(1-4):**

PLAN OF CORRECTION: To ensure continued stay services for days subsequent to the day of admission that are claimed to Medi-Cal document medical necessity criteria for acute psychiatric hospital services, The Department will:

- 1) Create two required fields in the PHF Physician Daily Note as follows:
 - a) explicit description of medical necessity criteria for the date of service
 - b) explicit description of why beneficiary cannot be treated at a lower level of care
- 2) Provide documentation training for MDs on completing required fields on medical necessity criteria for inpatient psychiatric hospitalization.

Actions Taken:

The Department has calendared the template change requests to be reviewed at the May Data Meeting 5/6/19 with Information Systems management. The Department has submitted a JIRA Request for Modification of the note templates with the POC changes (see attached). JIRA is a project and issue tracking software solution designed to improve code quality and speed development for software development teams used by The Department.

The Department in coordination with Transitions Behavioral Health has scheduled an MD training on documentation of medical necessity and improving inpatient documentation on 5/7/19 (see attached).

**ITEM 3, Section J: Chart Review – SD/MC Hospital Services, Part III:
ADMINISTRATIVE DAY SERVICES (AS), A(1-3):**

PLAN OF CORRECTION: To ensure that documentation meets criteria for administrative day services for days claimed to Medi-Cal The Department will:

- 1) Provide in person training on documentation procedures for Administrative Status claimed to Medi-Cal to Social Work staff (see attached)
- 2) Provide ongoing technical assistance on documentation procedures for Administrative Status claimed to Medi-Cal to Social Work staff (see attached)

COUNTY: SANTA BARBARA

DATES OF REVIEW: 10/22/2018 through 10/26/2018

Actions Taken:

The Department's Quality Care Management (QCM) staff has updated training material on Administrative Day Services Documentation requirements and will present to SW staff at staff meeting on 5/9/2019. QCM provides technical assistance and support as needed to SW staff regarding documentation of AS days claimed to Medi-Cal.

**ITEM (#), Section J: Chart Review – SD/MC Hospital Services, Part VII:
WRITTEN PLAN OF CARE REQUIREMENTS, A(1-9):**

PLAN OF CORRECTION: To ensure that each beneficiary Plan of Care includes a detailed description of the beneficiary's current level of functioning, The Department will:

- 1) Update the Master Treatment Plan Problem List (Plan of Care) template to clearly indicate Functional Impairment section instead of former title of 'Liabilities/Weaknesses'
- 2) Require MDs to rate beneficiary's level of functioning per each category
- 3) Provide training to MD staff on new Functional Impairment description in the Master Problem List (Plan of Care).

Actions Taken:

Updated the Master Treatment Plan Problem List (see attached) to clearly identify level of functioning of the beneficiary at the time the Plan of Care is written.



Service Entry, Individual

Clients

Welcome:

WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Service #: New Title: PHF Admission Evaluation

Client: Number Last Name First Name
Unknown

Service date:
Plan due date:

Procedures:

Service Location: Select Location
Med. Compliant: Side Effects: W -- .1
Emergency D Pregnant? D

Principal Diagnosis: (Select ICD-10 ID... (Select ICD-10 description

Staff Time

Primary Clinician:
Provider: Select Provide:

Primary Total Time: 0000

Counseling & Coordination of Care Time: Primary Service Face To Face Time: Primary Service Travel/Documentation Time:

service Code: r --- Time Spent: r site Level: w ---

Dates

Date Of Admission: r --- m | Date Of Discharge: r --- ' --- g |

Identification

Previous Entries: f (Select Note)

Chief Complaint

Previous Entries: f (Select Note)

History Of Present Illness

Previous Entries: j (Select Note) 3

Past Psychiatric History

Previous Entries: f (Select Note) G(j)

Substance Abuse History

Previous Entries: (Select Note)

r ---

Medical History And Medication Allergies

Previous Entries:

Family Psychiatric History

Previous Entries:

Brief Social History

Previous Entries:

Forensic History

Previous Entries:

Work History

Previous Entries:

Strengths, Weaknesses And Assets

Previous Entries:

Mental Status Examination

Previous Entries:

Admitting Diagnoses

Axis	Description
1	
2	
3	
4	
5	

Medical Necessity

Previous Entries:

1) Describe the qualifying impairment(s) for admission, and,
 2) Describe behaviors/symptoms that cannot be managed at a lower level of care

Initial Treatment Plan/Discussion

Previous Entries:

Additional Narrative

Previous Entries:

PERSONAL INFO | SECURITY (PASSWORD) !

Chnictan's Gateway version 3.6.0
Built 6/20/2016 (4:19 PM)

LabOrder #	Order Date	Draw Date	Select
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Service Entry, Individual

Clients ▼

Welcome:

WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Service #: New **Title:** PHF Physician Daily Note

Client:	Number: <input type="text"/> Last Name: <input type="text"/> First Name: <input type="text"/>	Service date: <input type="text"/>	
	unknown: <input type="text"/> ; <input type="text"/>	Plan due date: <input type="text"/>	
Procedures:	<input type="text"/> Select Procedure		
Service Location:	<input type="text"/> Select Location		
Med. Compliant:	<input type="text"/> Y/N <input type="text"/> Side Effects: <input type="text"/> INA		
	Emergency <input type="text"/> D Pregnant? <input type="text"/> 0		
Principal Diagnosis:	<input type="text"/> (Select ICD-10.. <input type="text"/> (Select ICD-10 description)		

Staff Time

Primary	Clinician: <input type="text"/>	Primary Total Time: <input type="text"/>
	Provider: <input type="text"/> Select Provider	

Counseling & Coordination of Care Time: <input type="text"/>	Primary Service Face To Face Time: <input type="text"/>	Primary Service Travel/Documentation Time: <input type="text"/>
--	---	---

Start Time & Current DX

Please select the Language!																				
Start Time (HH:MM)	Services were provided in <input type="text"/> Select One	by <input type="text"/>																		
	<input type="checkbox"/> Interpreter <input type="text"/>																			
			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="font-size: x-small;">Axis I</th> <th style="font-size: x-small;">Axis II</th> <th style="font-size: x-small;">Axis III</th> <th style="font-size: x-small;">Axis IV</th> <th style="font-size: x-small;">Axis V</th> </tr> <tr> <td style="font-size: x-small;">DSM-IV</td> <td style="font-size: x-small;"><input type="text"/></td> <td style="font-size: x-small;"><input type="text"/></td> <td style="font-size: x-small;"><input type="text"/></td> <td style="font-size: x-small;"><input type="text"/></td> </tr> <tr> <td style="font-size: x-small;">ICD-10</td> <td style="font-size: x-small;"><input type="text"/></td> <td style="font-size: x-small;"><input type="text"/></td> <td style="font-size: x-small;"><input type="text"/></td> <td style="font-size: x-small;"><input type="text"/></td> </tr> </table>	Axis I	Axis II	Axis III	Axis IV	Axis V	DSM-IV	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ICD-10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Axis I	Axis II	Axis III	Axis IV	Axis V																
DSM-IV	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																
ICD-10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint:

Pertinent Review of Systems (ROS):

Mental Status Examination

Appearance:	<input type="text"/> Dnormal grooming	<input type="text"/> Dpoor hygiene	<input type="text"/> Ddisheveled	<input type="text"/> Dmalodorous
Behavior/Activity:	<input type="text"/> Onormal	<input type="text"/> Oagitated	<input type="text"/> Dretarded	<input type="text"/> Oinbed
Speech:	<input type="text"/> Dnormal rate/rhythm	<input type="text"/> Oslowed	<input type="text"/> O pressured	<input type="text"/> Dnat
Affect:	<input type="text"/> Dnormal range	<input type="text"/> O sad	<input type="text"/> Dexpansive	<input type="text"/> Drestricted
Mood:	<input type="text"/> O euthymic	<input type="text"/> O moderately depressed	<input type="text"/> O severely depressed	<input type="text"/> O expansive
Thought Form:	<input type="text"/> Dlinear/goal directed	<input type="text"/> Dcircumstantial	<input type="text"/> Dtangential	<input type="text"/> O concrete
Thought Content:	<input type="text"/> Dno abnormalities	<input type="text"/> O hallucinations	<input type="text"/> Ddelusions	<input type="text"/> Dideas of reference
Suicidal Ideation:	<input type="text"/> Dnone	<input type="text"/> Dpassive	<input type="text"/> Dactive (clarify)	<input type="text"/> Drecent attempt
Orientation:	<input type="text"/> Dfully oriented	<input type="text"/> O mildly impaired	<input type="text"/> Dmoderately impaired	<input type="text"/> Dseverely impaired
Memory:	<input type="text"/> Onormal	<input type="text"/> Dmildly impaired	<input type="text"/> Dmoderately impaired	<input type="text"/> Dseverely impaired
Judgment/Insight:	<input type="text"/> Ointact	<input type="text"/> Dmildly impaired	<input type="text"/> Dmoderately impaired	<input type="text"/> Dseverely impaired
Attention/Concentration:	<input type="text"/> Ogood	<input type="text"/> Otair	<input type="text"/> O poor	<input type="text"/> Oeasily distracted

Other:

Current Psychiatric Medications



Master Treatment Plan Problem List

Date Identified	Prob #	Name of Problem	Assm't	Code	Date Resolved
Primary Problem		Acute Psychiatric Problems			
		Risk for Harm: Self/Other			
		Altered Thought Process			
		Self-care Deficit			
		Altered Mood			
Other Pertinent Diagnosis		Medical Problems / Social Stressors: support group, financial, housing			

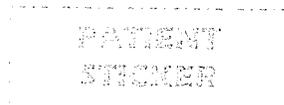
Substantiated Diagnosis:
(This section to be completed by MD)

Primary Diagnosis: _____

Other Pertinent Diagnosis: _____

MD Signature: _____ Date/Time: _____ ELOS: _____ days

Assessment Key								
I	N	P	H	S	R	PT	D	PN
Intake	Nursing	Psych Eval	History and Physical	Psych/social	Recreation Therapy	Patient Perception	Nutrition	Progress Note
Code Key								
1			2			3		
Active Treatment Plan			Deferred to next level of care			Stable, no action needed		





(This section to be completed by MD)

Patient Strengths <small>Check all that apply</small>	Patient Challenges <small>Check all that apply</small>	Impact on Patient Functioning <small>Rate level of impact: 0) none, 1) mild, 2) moderate, 3) severe</small>
Intelligent	Developmentally delayed	Understanding and communicating with the world (cognition)
Stable housing	Housing problems	Learning and applying knowledge
Motivation for treatment	Treatment non-adherence	General tasks and demands
Able to live independently	Legal problems	Communication
Work Skills	Occupational problems	Mobility
Financial means	Financial difficulties	Self-care/Activities of Daily Living
Physical health	Health problems	Social functioning
Supportive	Limited support network	Getting along with people
Education	Relationship conflict	Interpersonal interactions and relationships
Capable of insight	Education problems	Domestic/Life activities
Communication skills	Limited/poor ADLs	Occupational functioning (education, employment)
Religious affiliation	Limited social skills	
	Traumatic events	
	Substance	
	Loss:	
Suggested Discharge Criteria <small>Check all that apply</small>		
Ability to meet basic life and health needs		
Adequate post-discharge level of care/housing		
Stabilization of mood, thinking, behavior to baseline		
Problems can be managed in out-patient setting		
Reduction of life endangering symptoms		
Verbal commitment to aftercare and medication adherence		

MD Signature: _____ Print Name: _____ date/time: _____

RN Signature: _____ Print Name: _____ date/time: _____

SW Signature: _____ Print Name: _____ date/time: _____

PATIENT
STICKER

Sanchez, Sara

From: Garcia, Lucero
Sent: Wednesday, April 24, 2019 10:06 AM
To: Sanchez, Sara; Huddleston, Deana; Andersen, Celeste; Behrendtsen, Ole; Hidrobo, Jennifer; Zeitz, Laura
Cc: Huthsing, Jamie; Ramsey, Marshall
Subject: RE: DHCS POC issues and JIRA

Hello all,

Item will be added to the Data meeting agenda on 5/6/19.\

Best,

Lucero Garcia

From: Sanchez, Sara
Sent: Wednesday, April 24, 2019 10:03 AM
To: Huddleston, Deana <dhuddleston@co.santa-barbara.ca.us>; Andersen, Celeste <candersen@co.santa-barbara.ca.us>; Behrendtsen, Ole <obehrendtsen@co.santa-barbara.ca.us>; Hidrobo, Jennifer <jhidrobo@co.santa-barbara.ca.us>; Zeitz, Laura <lazeitz@co.santa-barbara.ca.us>
Cc: Huthsing, Jamie <jhuthsing@co.santa-barbara.ca.us>; Ramsey, Marshall <mramsey@sbcbwell.org>; Garcia, Lucero <lugarcia@co.santa-barbara.ca.us>
Subject: RE: DHCS POC issues and JIRA

Thank you so much!

Warm Regards,

Sara Sanchez, LMFT #45367, CCHP
Quality Care Management Coordinator
5385 Hollister Ave Bldg #14 Box 102
Santa Barbara CA 93111

Ph: 805-681-5287
Fax: 805-681-5117



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From: Huddleston, Deana
Sent: Wednesday, April 24, 2019 8:25 AM
To: Andersen, Celeste <candersen@co.santa-barbara.ca.us>; Sanchez, Sara <sasanchez@co.santa-barbara.ca.us>; Behrendtsen, Ole <obehrendtsen@co.santa-barbara.ca.us>; Hidrobo, Jennifer <ihidrobo@co.santa-barbara.ca.us>; Zeitz, Laura <lazeitz@co.santa-barbara.ca.us>
Cc: Huthsing, Jamie <jhuthsing@co.santa-barbara.ca.us>; Ramsey, Marshall <mramsey@sbcbswell.org>; Garcia, Lucero <lugarcia@co.santa-barbara.ca.us>
Subject: RE: DHCS POC issues and JIRA

The form is attached.

From: Andersen, Celeste
Sent: Tuesday, April 23, 2019 1:48 PM
To: Sanchez, Sara <sasanchez@co.santa-barbara.ca.us>; Behrendtsen, Ole <obehrendtsen@co.santa-barbara.ca.us>; Hidrobo, Jennifer <ihidrobo@co.santa-barbara.ca.us>; Zeitz, Laura <lazeitz@co.santa-barbara.ca.us>
Cc: Huthsing, Jamie <jhuthsing@co.santa-barbara.ca.us>; Huddleston, Deana <dhuddleston@co.santa-barbara.ca.us>; Ramsey, Marshall <mramsey@sbcbswell.org>; Garcia, Lucero <lugarcia@co.santa-barbara.ca.us>
Subject: RE: DHCS POC issues and JIRA

Hi Sara,

This should first go to the Data Meeting. Lucero puts together the agenda for that meeting so I am adding her to this e-mail. Deana has a form that you would need to complete to create a JIRA item. That is all you need to get started.

Celeste

From: Sanchez, Sara
Sent: Tuesday, April 23, 2019 1:38 PM
To: Behrendtsen, Ole <obehrendtsen@co.santa-barbara.ca.us>; Hidrobo, Jennifer <ihidrobo@co.santa-barbara.ca.us>; Zeitz, Laura <lazeitz@co.santa-barbara.ca.us>
Cc: Huthsing, Jamie <jhuthsing@co.santa-barbara.ca.us>; Huddleston, Deana <dhuddleston@co.santa-barbara.ca.us>; Andersen, Celeste <candersen@co.santa-barbara.ca.us>; Ramsey, Marshall <mramsey@sbcbswell.org>
Subject: DHCS POC issues and JIRA

Good afternoon all,

How would we get the PHF EHR POC issues (requesting addition of required drop downs for level of care rationale upon admission and on continued stay days in MD Notes) put on the agenda for initial discussion at the next JIRA meeting? I am not sure if this was already requested by someone, and I am new to the world of JIRA. Thank you all for your help and direction!

Warm Regards,

Sara Sanchez, LMFT #45367, CCHP
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Cc: Huthsing, Jamie; Ramsey, Marshall; Garcia, Lucero
Subject: RE: DHCS POC issues and JIRA
Attachments: CG request form update dec 2018.pdf

The form is attached.

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Sent: Tuesday, April 23, 2019 1:48 PM
To: Sanchez, Sara <sasanchez@co.santa-barbara.ca.us>; Behrendtsen, Ole <obehrendtsen@co.santa-barbara.ca.us>; Hidrobo, Jennifer <jhidrobo@co.santa-barbara.ca.us>; Zeitz, Laura <lazeitz@co.santa-barbara.ca.us>
Cc: Huthsing, Jamie <jhuthsing@co.santa-barbara.ca.us>; Huddleston, Deana <dhuddleston@co.santa-barbara.ca.us>; Ramsey, Marshall <mramsey@sbcswell.org>; Garcia, Lucero <lugarcia@co.santa-barbara.ca.us>
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Cc: Huthsing, Jamie <jhuthsing@co.santa-barbara.ca.us>; Huddleston, Deana <dhuddleston@co.santa-barbara.ca.us>; Andersen, Celeste <candersen@co.santa-barbara.ca.us>; Ramsey, Marshall <mramsey@sbcswell.org>
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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Alice Gleghorn, PhD
Director

Dr. Leslie Lundt, QCM Psychiatrist, Presenter
5/7/19 4:00pm-5:00pm

Conference Line 1 800 356 8278 with conference code 664813

PHF Training on Medical Necessity Criteria for M.D. Admission and Progress Notes

Behavioral Wellness' Plan of Correction in response to DHCS Findings Report

Review of Medical Necessity Criteria for Admissions

Review of Medical Necessity for Continued Stays

Review of Disallowed Admission and Continued Stay Notes

Review of Administrative Status

What can we learn for future? Any questions?

PHF MD progress notes

Tips for documentation on medical necessity for acute continued stay patients...

- Does the patient *still exhibit acute medical necessity criteria* (DTO, GDA, DTS) which required their initial admission to the PHF?
- Explicit description of why this *patient cannot be managed* at any lower level of care.
- What has changed since yesterday? New BHs or SXs meeting acute medical necessity?
- Has patient required significant PRN medications?
 - Look at the Medication Communication Sheet which will list all PRNs given in last 24 hours
 - **document any IM meds given
 - Any seclusion and restraint episodes?
 - 1:1 staffing needs?
- Vital signs *including daily weight* for GDA concerns
- Hours of sleep (found on census menu)
- Amount eaten (found under flow sheet in chart) for GDA concerns
- Describe *specific* behavioral descriptions that justify keeping pt in hospital: malodorous beyond accommodation at lower LOC, refusing/unable to answer suicide risk or safety assessment questions, yelling, pounding fists, gesturing threats with fighting stance, throwing feces/urine, believes food is poisoned- refusing meals, entering other patients rooms, masturbating in public view, inability to feed self, inability to keep clothing on, verbal or physical threats or actions, BHs which lead to serious risk of medical compromise, evidence of continued self-harming behaviors, refusing life sustaining medical medication or treatment.
- MSE pertinent positives and negatives needing requiring inpatient care
- Ask for patient's reply to question: "What would you do if you left the hospital today?"
 - "I would fly to heaven and confront the devil" supports grave disability
 - "I would get my knife and stab my neck until I die" supports danger to self
 - "I would run by car over my brother like a dog" supports danger to othersHowever,
 - "I would go to rescue mission and eat out of trash cans" does not support continued acute admission criteria.
- Justify any medication changes you are making, describe any need for inpatient monitoring.

Bottom line for acute continued stays after admission:

Document why they need to be in locked acute psychiatric facility today.

Bottom line for placing patient on AS:

Document why patient is now safe to be discharged to lower level of care (not aggressive, doing ADLs, not incontinent, no SI/HI/GD concerns)



**DEPARTMENT OF HEALTH CARE SERVICES
PROGRAM OVERSIGHT & COMPLIANCE BRANCH**

**IMPROVING DOCUMENTATION FOR
ACUTE PSYCHIATRIC INPATIENT
HOSPITAL SERVICES**

**THE MEDICAL SPECIALTY MENTAL HEALTH
SERVICES PROGRAM
August/September 2015**





IMPROVING INPATIENT DOCUMENTATION

5. Plans of Care
 - a) Requirements: Federal and Contractual
 - b) Guidance and Recommendations
6. Administrative Day Services
 - a) Documentation Requirements
 - b) Guidance and Recommendations
7. A Reminder Regarding Interpreter Services
8. Examples of Documentation Deficiencies and Some Recommendations





IMPROVING INPATIENT DOCUMENTATION

- Pursuant to Section 1810.380 of Title 9 of the *California Code of Regulations (CCR)*, the State Department of Health Care Services (DHCS) is responsible for monitoring the 18 Short-Doyle/Medi-Cal acute psychiatric inpatient hospitals and the Mental Health Plans (MHPs) with which they are associated to ensure their compliance with the provisions of the following:
- Section 1820.205 of CCR Title 9, "Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services"
- Section 1820.220 of CCR Title 9, "MHP Payment Authorization by a Point of Authorization"
- Section 1820.230 of CCR Title 9, "MHP Payment Authorization by a Utilization Review Committee"
- Sections 5325.1 and 5325.1(a) of the *Welfare and Institutions Code*, "Same Rights and Responsibilities Guaranteed Others; Discrimination by Programs or Activities Receiving Public Funds; Additional Rights"





IMPROVING INPATIENT DOCUMENTATION

- Provisions of the contract between DHCS and the MHPs

Table 2 - Included ICD-9 Diagnoses - Hospital Inpatient Place of Service

290.12 – 290.21	299.10 - 300.15	308.0 – 309.9
290.42 – 290.43	300.2 - 300.89	311 – 312.23
291.3	301.0 - 301.5	312.33 - 312.35
291.5 - 291.89	301.59 - 301.9	312.4 – 313.23
292.1 - 292.12	307.1	313.8 – 313.82
292.84 – 292.89	307.20 - 307.3	313.89 - 314.9
295.00 – 299.00	307.5 - 307.89	787.6



THE LANGUAGE WE USE

- The biggest problems reviewers encounter is documentation which is:
 - Unclear
 - Vague
 - Not Behaviorally Specific
- You should:
 - AVOID JARGON
 - USE LANGUAGE WHICH IS BEHAVIORALLY SPECIFIC
 - USE VERBS RATHER THAN ADJECTIVES
 - MAKE SURE WHAT YOU WRITE IS CLEAR



THE LANGUAGE WE USE

- Despite the fact that this paragraph contains six syntactically and grammatically correct sentences, it **conveys very little precise meaning.**
- What do we really know about the patient's behavior from this note?
- Was the patient a danger to others? Gravely disabled?



THE LANGUAGE WE USE

- Here are a few examples of behaviorally non-specific words/phrases and their behaviorally specific counterparts:

DON'T WRITE THIS	THIS WOULD BE BETTER
Impulsive	Acts without anticipating consequences as exhibited by grabbing items from other patients' hands.
Aggressive	Shoved other patients out of the cafeteria line so that he could be served first.
Postured Aggressively	Shook a closed fist in the therapist's face.
Threatening	She said, "If you ask me another question I will slap you."
Hostile	He shouted, "Go to Hell" when he was asked to join the therapy group.
+HI	Describe the ideation. Is it active or passive? Is it directed at a particular person? Is it directed at an identifiable group of people? Is it accompanied by homicidal intent? Is there a specific plan? Opportunity? Means? Timing?



THE LANGUAGE WE USE

DON'T WRITE THIS

THIS WOULD BE BETTER

Despondent

The patient said, "I feel there is no hope for me. There is nothing I can do to change my life."

Psychotic

Appears preoccupied with listening to voices. Frequently shouts in response to what she hears.

Disorganized

In what specific ways is the patient being "disorganized"?
 Example: "Patient smeared feces on the walls of his bathroom."

+CAH

What are the voices commanding him to do? Is he able to resist obeying the commands?

Poor ADLs

Refuses to brush teeth. Has not showered X 2 days.
 Describe reasons for behaviors. E.g., are poor ADLs secondary to skill deficits, delusional beliefs, social phobia?

Paranoid

Describe the specific behaviors/statements which cause the writer to describe the patient as "paranoid."

Regressed

"Patient refused to put on clothing, and continued to sit, rocking back and forth, in the corner of his room."



MEDICAL NECESSITY CRITERIA FOR ADMISSION-- DIAGNOSIS

- There must be an included diagnosis. Here is a list of the **families of diagnoses** which are covered for inpatient services:
- (A) Pervasive Developmental Disorders (including Autistic Disorder)
- (B) Disruptive Behavior and Attention Deficit Disorders
- (C) Feeding and Eating Disorders of Infancy or Early Childhood
- (D) Tic Disorders
- (E) Elimination Disorders
- (F) Other Disorders of Infancy, Childhood, or Adolescence



GUIDANCE & RECOMMENDATIONS—DIAGNOSIS

- The diagnosis used for audit purposes is the **DIAGNOSIS ON THE DISCHARGE SUMMARY**

- If the admitting and discharge diagnoses are different, the **medical record should include:**
 - The date on which the change was made

 - A description of the clinical information which led to the change. “Clinical information” may include behavioral observation, interview findings, psychometric test data, laboratory studies, imaging studies, responses to treatment, newly received information about the patient’s medical/psychiatric/psychological history, and so forth. **This is especially important when a diagnosis changes from a covered to a non-covered one, or from a non-covered to a covered one.**



GUIDANCE & RECOMMENDATIONS—DIAGNOSIS

- Type 2 Example (Included to Excluded):
 - Admitting Diagnosis: Psychotic Disorder NOS
 - Discharge Diagnosis: Dementia of the Alzheimer’s Type
 - Medical record should include:
 - Date on which the diagnosis was changed
 - Clinical data which led to the change. In this case, for example, the clinical data may have been one or more of the following:
 - The results of an MRI which revealed diffuse cortical atrophy or other pathological findings
 - Behavioral observation that the patient had difficulty finding his room, even after several days in the hospital
 - No recognition of the attending psychiatrist and other medical personnel with whom he worked on a daily basis



GUIDANCE & RECOMMENDATIONS—DIAGNOSIS

- The way in which diagnoses are **written** is very important:
 - Diagnoses which are followed by such words/phrases as “By History” or “Versus Diagnosis XXX,” or which are preceded by words such as “Provisional,” “Preliminary,” “Working,” or “Consider” do not meet medical necessity criteria.



GUIDANCE & RECOMMENDATIONS—DIAGNOSIS

The example on Slide 24 illustrates two important points:

- Eliminate competing diagnoses wherever possible. In this case, a urine drug screen and a carefully taken history could have eliminated or established Substance-Induced Mood Disorder and Methamphetamine Abuse.
- A thorough diagnostic interview, including a comprehensive mental status examination, should have made it possible to eliminate one or more of the following:
 - Anxiety Disorder NOS
 - Obsessive-Compulsive Disorder
 - Panic Disorder with Agoraphobia
 - Social Anxiety Disorder
 - Generalized Anxiety Disorder



GUIDANCE & RECOMMENDATIONS—DIAGNOSIS

Here is a second example of a diagnosis in need of clarification:

Admitting Diagnosis:

- Psychotic Disorder NOS, Rule Out Methamphetamine-Induced Psychotic Disorder

Laboratory Findings on Hospital Day #1:

- Urine Drug Screen Positive for Methamphetamine

Discharge Diagnosis:

- Psychotic Disorder NOS



GUIDANCE & RECOMMENDATIONS—DIAGNOSIS

The following diagnoses/diagnostic groups are among those which do NOT qualify for Medi-Cal reimbursement for acute psychiatric inpatient hospital services:

- a. Mental Retardation
- b. Learning Disorders
- c. Motor Skills Disorder
- d. Communication Disorders
- e. Delirium
- f. Dementia (except Vascular Dementia with Delusions or Depressed Mood)
- g. Amnesic Disorders
- h. Cognitive Disorder NOS



GUIDANCE & RECOMMENDATIONS—DIAGNOSIS

- Diagnoses—especially the one which is used to establish medical necessity—must be clearly and legibly written or typed on the Discharge Summary.
- Diagnoses must be written out and should preferably be accompanied by the appropriate ICD code. Acronyms (e.g., PDNOS) are NOT acceptable.



FREQUENTLY ASKED QUESTIONS: ADMISSION

1. What determines the actual date and time of admission?

ANSWER: Admission is timed from the moment when the beneficiary is physically brought onto the inpatient unit and begins to receive care, which is usually documented in a nursing progress note or assessment. For purposes of Medi-Cal reimbursement, the admission is **NOT** considered to have occurred on the date and time of the physician's admitting order.

2. Is Autistic Disorder a covered diagnosis for inpatient services?

ANSWER: Yes, it is covered for inpatient services but **not** for outpatient services.



IMPROVING INPATIENT DOCUMENTATION

REASONS FOR RECOUPMENT—INPATIENT HOSPITAL SERVICES

Admission—Reason #22

- Documentation does not establish that the beneficiary had an included diagnosis.
- Documentation does not establish that the beneficiary could not have been safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.



IMPROVING INPATIENT DOCUMENTATION

- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that could reasonably be provided only if the patient were hospitalized



MEDICAL NECESSITY CRITERIA—LEVEL OF CARE

- This criterion is based upon Sections 5325.1 and 5325.1(a) of the *Welfare and Institutions Code*, which state:
 - It is the intent of the Legislature that persons with mental illness shall have rights including, but not limited to, the following:
 - (a) A right to treatment services which promote the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual.



MEDICAL NECESSITY CRITERIA—LEVEL OF CARE

Residential treatment facilities do provide limited prompting and assistance with activities of daily living, but they are not able to handle the needs of total care patients.

Residential treatment facilities are not able to accept patients whose behavior is grossly disorganized or disruptive of the treatment milieu (e.g., fecal smearing, refusal to remain clothed, sexual aggression toward others, prolonged screaming or yelling).



IMPROVING INPATIENT DOCUMENTATION

Hospital Plan: Patient is appropriate for inpatient level of care for close monitoring for safety, continued adjustment in medications to target depression, and for coordination of outpatient care for continued control of symptoms after discharge.

Could this patient have been evaluated and treated at a lower level of care?



MEDICAL NECESSITY CRITERIA—INDICATORS FOR ADMISSION

- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Need for psychiatric evaluation, medication treatment, or other treatment which can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital

❖ **REMEMBER: The qualifying impairment must be the direct result of the included diagnosis.**





GUIDANCE AND RECOMMENDATIONS—INDICATORS FOR ADMISSION/IMPAIRMENT CRITERIA

1. **CURRENT** Danger to Self (DTS), Danger to Others (DTO), or Danger to Property (DTP). In order to meet one of these three impairment criteria, there must be documentation of suicidal, homicidal or property destruction ideation, **together with either documented intent or a specific plan.**

(a) If the beneficiary is experiencing command auditory hallucinations to harm self or others, or to destroy property, this fact should be documented together with an assessment of the beneficiary's ability to resist obeying the commands. In the absence of such documented assessments, the presence of command auditory hallucinations alone does not establish that the beneficiary is a DTS, DTO or DTP.





MEDICAL NECESSITY CRITERIA—INDICATORS FOR ADMISSION/IMPAIRMENT CRITERIA

Many times beneficiaries make these conditional statements because :

- 1) they fear being discharged to a place where they would not have adequate support and professional attention
- 2) they do not have access to food and shelter or the means to purchase them.

If the assessment reveals that the beneficiary would feel safe in a residential treatment facility, then admission (or continued stay services) would not be appropriate.





GUIDANCE AND RECOMMENDATIONS—INDICATORS FOR ADMISSION/IMPAIRMENT CRITERIA

2. Beneficiary is unable to provide for or utilize food, clothing or shelter.
- (a) The correct standard to apply when evaluating for this criterion is whether the beneficiary is able to utilize (rather than formulate / carry out a plan for obtaining) the food, clothing and shelter which is provided. The reason this is the correct standard is that in the step-down levels of care to which the beneficiary could be diverted or discharged, food, clothing and shelter are provided.
-





GUIDANCE AND RECOMMENDATIONS—INDICATORS FOR ADMISSION/IMPAIRMENT CRITERIA

3. Beneficiary has symptoms/behaviors that present a severe risk to his/her health.
- (a) The essential element is that the symptoms / behaviors which present a severe risk to the beneficiary's physical health must be a direct result of the covered diagnosis. In order to qualify, **the behaviors creating the risk cannot be the result of a deliberate, rational decision reached by the beneficiary.**





GUIDANCE AND RECOMMENDATIONS—INDICATORS FOR ADMISSION/IMPAIRMENT CRITERIA

4. Beneficiary has symptoms/behaviors that represent a recent, significant deterioration in ability to function.
 - (a) The level of care criterion still applies here: Even if there is a “recent, significant deterioration in ability to function,” **when the beneficiary could be evaluated and treated at a lower level of care admission (and continued stay services) may not be reimbursable.**
 - (b) Documentation should include a description of the patient’s previous level of functioning as well as an explanation of why the patient could not be safely and effectively treated at a lower level of care.





GUIDANCE AND RECOMMENDATIONS—INDICATORS FOR ADMISSION/IMPAIRMENT CRITERIA

5. Beneficiary requires further psychiatric evaluation.

The level of care criterion applies here:

- (a) If the evaluation which the beneficiary requires could be provided at a lower level of care, the admission is **not** reimbursable.
- (b) If the justification for the admission is based upon convenience to the beneficiary (or the staff), the admission is **not** reimbursable.



GUIDANCE AND RECOMMENDATIONS—INDICATORS FOR ADMISSION/IMPAIRMENT CRITERIA

If, however, a patient has experienced a life threatening reaction to a medication in the past (e.g., agranulocytosis or neuroleptic malignant syndrome), and there is a clinically compelling reason why the patient needs to be restarted on the same medication, this could constitute a valid reason for restarting the medication in an inpatient hospital setting.



FOCUS OF TREATMENT REQUIREMENT

The primary focus of the treatment must be to address the qualifying indicator which establishes medical necessity for admission.

Example: If a patient is admitted with a diagnosis of Alcohol-Induced Mood Disorder and is determined to be a Danger to Self, the focus of the treatments must be to address the dysthymia and to reduce the impairments which constitute the “Danger to Self”—e.g., suicidal ideation and either intent or a specific plan. The primary (or only) focus of the treatment may NOT be on preventing withdrawal symptoms—although it may be a secondary focus of treatment.



EFFICACY REQUIREMENT

- Antipsychotic medication prescribed as the primary treatment for a patient with Intermittent Explosive Disorder in the absence of hallucinations, delusions or thought disorder.



IMPROVING INPATIENT DOCUMENTATION

2. Does there have to be a physician's note for every claimed hospital day?

ANSWER: Although this is a highly desirable practice, Medi-Cal regulations do not require that there be a physician's note for each hospital day (or, for that matter, *any* physician's notes). What is required is that there be documentation which establishes medical necessity for each claimed day.



IMPROVING INPATIENT DOCUMENTATION

- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Need for further evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital
- Presence of one of the following:
 - o A serious adverse reaction to medications
 - o Procedures or therapies requiring continued hospitalization
 - o The presence of new indications that meet medical necessity criteria
 - o The need for continued medical evaluation
 - o Treatment that can only be provided if the beneficiary remains in a hospital



IMPROVING INPATIENT DOCUMENTATION

3. When a beneficiary is admitted following a high lethality suicide attempt, a serious attempt to harm another, or a serious attempt to destroy property, it is understandable that the hospital professional staff may be reluctant to discharge the beneficiary as soon as the denial of symptoms has begun. In these cases, it is appropriate to grant one or more stabilization days during which the staff may continue to assess the beneficiary in a protected setting and determine whether this improvement is genuine or only apparent. Stabilization days should be used **only following a high lethality event and then very cautiously.**



IMPROVING INPATIENT DOCUMENTATION

Documentation Example:

Patient was observed to be isolative, withdrawn, pacing most of the time in the hallways. Patient was observed talking to himself and seeing people. Patient was agreeable with starting psychotropic medication and he signed the consent for medication.

What do you think of this note?



FREQUENTLY ASKED QUESTIONS

1. Does a history of previous psychiatric hospitalizations affect the likelihood that the beneficiary's current hospital stay will be Medi-Cal reimbursable?

ANSWER: In general, medical necessity determinations are based upon an evaluation of the patient's **current** symptoms and behavior. However, if a patient has a history of multiple hospitalizations resulting from high-lethality suicide or homicide attempts, these historical events may be taken into account indirectly if circumstances or triggers similar to those which were associated with previous incidents are present during the current admission.





IMPROVING INPATIENT DOCUMENTATION

REASONS FOR RECOUPMENT—INPATIENT HOSPITAL SERVICES

Continued Stay Services—Reason #23

- Documentation does not establish the continued presence of an included diagnosis
- Documentation does not establish that the beneficiary could not have been safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion



IMPROVING INPATIENT DOCUMENTATION

- Presence of symptoms or behaviors that require further psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the patient is hospitalized
- Presence of a serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
- Presence of new indications that meet medical necessity criteria specified for admission
- Presence of symptoms or behaviors that require continued medical evaluation or treatment that can only be provided if the beneficiary remains in an acute psychiatric inpatient hospital



IMPROVING INPATIENT DOCUMENTATION

-
- (b) The plan of care must include—
- (1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
 - (2) A description of the functional level of the individual;
 - (3) Objectives;
 - (4) Any orders for—
 - (i) Medications;
 - (ii) Treatments;
 - (iii) Restorative and rehabilitative services;
 - (iv) Activities;
 - (v) Therapies;
 - (vi) Social services;
 - (vii) Diet; and
 - (viii) Special procedures recommended for the health and safety of the patient;
-





IMPROVING INPATIENT DOCUMENTATION

Contract Between DHCS and the MHPs

- (1) The Contractor shall ensure that Client Plans:
- (a) Have specific observable and/or quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
 - (b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;
 - (c) Have a proposed frequency and duration of intervention(s);
 - (d) Have interventions that focus and address the identified functional impairments as a result of the mental disorder; have interventions that are consistent with the client plan goal;
 - (e) Be consistent with the qualifying diagnoses;
 - (f) [Not Applicable to inpatient client plans.]
 - (g) Include documentation of the beneficiary's participation in and agreement with the client plan.



IMPROVING INPATIENT DOCUMENTATION

FREQUENTLY ASKED QUESTIONS/POINTS OF CONFUSION

1. May the physician's signature be on a progress note which refers to the client plan?

ANSWER: No. The physician's signature establishing the plan of care must be on the plan itself.

2. What if there is a signature on the client plan but it is illegible?

ANSWER: If the signature can be verified through a signature sheet it may be counted.





IMPROVING INPATIENT DOCUMENTATION

Interdisciplinary Treatment Plan Example

Problem #1:

- DTS AEB pt. wants P.D. to shoot her.

Problem #2:

- Alteration in cardiac output AEB pt. Hx of HTN.

Short-Term Goal #1 for Problem #1:

- Pt. will not be a risk to herself while hospitalized. Intervention: Monitor pt. q 15 min, provide safe environment.

Short-Term Goal #2 for Problem #1:

- Pt. will attend and participate in daily Tx team prior to D/C. Interventions: Build rapport and develop level of trust on a daily basis.

Comments?



REQUIREMENTS FOR ADMINISTRATIVE DAY SERVICES

The requirements for administrative day services are located in two places in Title 9 of the *California Code of Regulations*:

- Section 1820.220(j)(5) (Point of Authorization)
- Section 1820.230(d)(2) (Utilization Review Committee).

The contents of these two sections are the same. The following is from Section 1820.230(d)(2):

- (2) Requests for MHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the following conditions are met:





REQUIREMENTS FOR ADMINISTRATIVE DAY SERVICES

- (2) The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:
- a. The status of the placement option.
 - b. Date of the contact.
 - c. Signature of the person making the contact.



GUIDANCE AND RECOMMENDATIONS- ADMINISTRATIVE DAY SERVICES

- Augmented board and care facilities may qualify, depending upon the type, duration and frequency of services provided to beneficiaries.
- **Case management does not count as “treatment” for purposes of this definition.**
- For children and adolescents, the definition of “non-acute residential treatment facility” usually consists of a designation by the MHP in its Implementation Plan of certain RCL levels.



GUIDANCE AND RECOMMENDATIONS— ADMINISTRATIVE DAY SERVICES

- For each week, the number of contacts which meet all requirements should be summed and multiplied by 1.4. This product (# of days meeting requirements X 1.4) yields the number of reimbursable days in that particular week.

- If acute days are interspersed between administrative days, the marking off of weeks should begin when administrative days resume.

- The rule of multiplying the number of qualifying contacts X 1.4 days works for “weeks” with fewer than seven days.





GUIDANCE AND RECOMMENDATIONS— ADMINISTRATIVE DAY SERVICES

5. When a patient who has been on administrative days is discharged home, or back to the facility from which he/she was admitted, the medical record must be examined to determine whether this abrupt change in the discharge plan was foreseeable.
- In other words, if the hospital was, in good faith, searching for a placement to which it fully intended to discharge the patient, but unforeseeable events outside of the hospital's control operated to abort its discharge plan, then credit may be given for those administrative days which meet Title 9 criteria.



IMPROVING INPATIENT DOCUMENTATION

3. If a hospital deals with corporate entities which control multiple non-acute residential treatment facilities, does one call to a corporate entity which controls five facilities count as the five contacts for a one-week period?

ANSWER: No. If, for example, there are three corporate entities which control all of the non-acute residential facilities within a reasonable geographic area, and those entities control five, three, and seven facilities, respectively, then the hospital is expected to contact all three. Although calling one corporate entity may reach five or more potential placements, the hospital in making that one call has not exceeded the required five contacts per week. There is no acceptable justification for not calling the other two corporate entities.



IMPROVING INPATIENT DOCUMENTATION

Two Reminders Regarding Interpreter Services

1. When a patient whose preferred language is other than English is admitted to an inpatient unit, the hospital must make interpreter services available to the patient so that he or she can communicate with treatment staff. These interpreter services may be provided by staff who are fluent in the patient's preferred language, or by an interpreter service via telephone. **Family members should not be asked to act as interpreters unless the patient specifically requests this and refuses other options for interpreter services.**



IMPROVING INPATIENT DOCUMENTATION

EXAMPLES OF DOCUMENTATION DEFICIENCIES AND SOME RECOMMENDATIONS

The most frequent reasons for disallowance—both for admission and for continued stay services—are failure to establish that (1) the patient could not have been treated at a lower level of care, and (2) the patient met impairment criteria for admission or continued stay services. Here are some examples, together with additional suggestions:

- a. The symptoms/behaviors for the day of admission are actually those which characterized the beneficiary during his/her stay in the CSU or PES, rather than upon the actual day of admission.



IMPROVING INPATIENT DOCUMENTATION

- ii. The documentation states that the patient is “at risk” for self-harm, harm to others, etc., but no basis for this type of assertion is provided.
- iii. The patient is said to be “GD, unable to formulate/carry out a plan for self-care.” As noted previously, the correct standard to apply in determining grave disability is whether the patient is able to avail himself/herself of the food, clothing and shelter which could be provided at a lower level of care.



IMPROVING INPATIENT DOCUMENTATION

- d. There is little or no exploration of the patient's symptomatology. For example, with beneficiaries complaining of depression, which is the most frequent cause for hospitalization, one or more of the following is often observed:
- i. No assessment of the quality of the beneficiary's affective state: Is the depression experienced as a poignant feeling, or is there a generalized flattening of emotionality?
 - ii. No assessment of the patient's cognitive status. For example, is there significant cognitive "narrowing," or either/or thinking. The presence of cognitive narrowing is an important indicator that psychotherapy may be indicated (especially cognitive restructuring) in addition to other treatment modalities.



IMPROVING INPATIENT DOCUMENTATION

Treatment Plans

Plans of care frequently exhibit the following deficiencies:

- a. Treatment goals focus exclusively on keeping the beneficiary safe (or keeping him/her from harming others) rather than upon keeping him/her safe **AND** treating the biopsychosocial problems which caused the beneficiary to come to the hospital in the first place.



IMPROVING INPATIENT DOCUMENTATION

- c. Interventions tend to be standardized rather than customized for the individual beneficiary. Not only should the interventions themselves be tailored to the needs and characteristics of a particular beneficiary, but the manner of approach to the patient should also be customized and spelled out in the plan of care.

- d. Most interventions tend to be milieu-based rather than being actions which are carried out within the context of a therapeutic relationship—whether group or individual.



IMPROVING INPATIENT DOCUMENTATION

- The diagnosis was Mood Disorder NOS.
- The patient was discharged home on the eighth hospital day, with follow-up by a local mental health clinic.
- Nowhere in the chart was there documentation of any attempt to **understand this young man’s predicament or to develop a comprehensive conceptualization which would provide an understanding of his state of mind and the reasons for his behavior.**
- When the case was discussed by DHCS reviewers with hospital staff they said only, “Well, he was very depressed, he tried to commit suicide. He came to the hospital, and then he received medication treatment.”



IMPROVING INPATIENT DOCUMENTATION

- The patient was experiencing Major Depressive Disorder with Melancholic Features, a condition which had led his maternal aunt to commit suicide. He had chosen the anniversary of her suicide as the day on which to commit the act himself.
- The young man had come to a realization that he was homosexual, and did not believe there was any hope of his living a normal, happy, and fulfilling life. Suicide appeared to him to be his only option.



IMPROVING INPATIENT DOCUMENTATION

Symptoms Supporting the Diagnosis

- Depressed mood by self report (feels “empty,” “flat”), which is worse in the morning
- Significantly diminished interest in almost all activities
- Marked decrease in reactivity to formerly pleasurable stimuli
- Pronounced psychomotor retardation
- Hypersomnia (sleeps 10-12 hours per day)
- Feels that what is happening to him is his “fault,” that it could have been avoided had he been “a different sort of person”
- Cognitive “narrowing” which causes him to believe that death is the only possible “solution” for how he feels





IMPROVING INPATIENT DOCUMENTATION

Over the next two weeks additional symptoms appeared (the feeling of emptiness, intense guilt, an overriding sense of not knowing what to do to “make things right”). The patient began sleeping during the day as well as at night. Finally, he began to think of the possibility of killing himself as his only “way out.” These feelings culminated in his attempt to hang himself in the family garage.



IMPROVING INPATIENT DOCUMENTATION

Goal 1-1: Decrease frequency of suicidal ideation from the current level of 15-20 times per hour to five or fewer times per hour. Decrease intensity of suicidal ideation from current intensity of 7 on a scale from 1 (very easy to ignore) to 10 (impossible to ignore and results in fantasizing about various specific plans) to 3 or below.

Intervention 1-1: Nursing to assess patient each shift to ensure that no suicidal intent or specific plan is reported. If either is reported, notify attending psychologist/psychiatrist immediately and place patient on line of sight observation. Provide a safe, supportive environment. Provide opportunity for conversations with nursing and other staff each shift. Encourage participation in group treatment. Duration: 7 hospital days.



IMPROVING INPATIENT DOCUMENTATION

Goal 1-3: Reduce “cognitive narrowing” to a point where patient believes (by self report) that there are positive alternatives to his sexual orientation other than suicide.

Intervention 1-3: Individual psychotherapy 50 minutes twice per day with staff psychologist. Focus on assisting patient in understanding that cognitive narrowing is a symptom of depression. Provide alternative ways of viewing and understanding what the patient sees as his current “predicament.” Reinforce the notion that these symptoms are transitory and can be modified by psychological and psychiatric treatment. Duration: 7 hospital days.



IMPROVING INPATIENT DOCUMENTATION

Impairment #3: Hypersomnia.

Goal 3-1: Reduce number of hours slept per day from 10-12 to 8-9.

Intervention 3-1: Monitor number of hours slept each night and during the day. Encourage participation in recreational therapy. Encourage participation in group exercise program prior to bed time. Duration: 10 hospital days.



IMPROVING INPATIENT DOCUMENTATION

Discharge Plan

Patient has agreed to discharge to a crisis residential treatment center, which will allow additional time in which to evaluate potential out-of-home placements. **In view of the father's continuing staunch opposition to and disapproval of his son's sexual orientation (which he has expressed during family meetings), discharge home is strongly opposed by the treatment team.**



IMPROVING INPATIENT DOCUMENTATION

5. If patient as well as his mother and father are willing, family therapy following discharge from the crisis residential treatment center is recommended. This should be coordinated by his outpatient psychiatrist.





DENIED ADMISSION NOTE

①

View Finalized Service

Clients
 Search:

Welcome: Sara Sanchez

Home Menu Log out

WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99222 - Initial E/M, Inpatient/PHF, comprehensive,

Service Date:

Service Location: Inpatient Hospital

Emergency: No

Med. Compliant: Unc Side Effects: N/A

Principal Diagnosis : ICD-10: F20.9 - Schizophrenia, unspecified

Role	Staff #	Staff Name	Time	Approved
			01:00 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time:	Primary Service Face To Face Time: 00:30	Primary Service Travel/Documentation Time:
---	--	--

Dates

Date Of Admission: 10/12/2017 Date Of Discharge:

Identification

Pt is a 37 yo M with a history of stimulant-induced psychosis and alcohol use disorder on a 5150 DTO/GD. Per hold, pt's parents took him to the ED as he has been non-compliant with medications for the past 2 weeks, has not eaten for the past 4 days as he thinks there is poison in his food and has not slept for 3 days. He reported AH, that his parents are trying to kill him and "throwing things at his head". He was searching for knives to stab his parents who are aware of the situation. He was pacing outside the house with no shoes or appropriate clothing on for the weather.

Chief Complaint

"I was having problems with my neighbors because they were throwing things at my head and using lasers on me"

History Of Present Illness

Pt reports using methamphetamines 4 days ago. Accuses people of throwing things at his head and using lasers on him. History of altercations with people and endorses he wants to hurt them for using the lasers on him, "but I don't know where they are". Seen RITS, states he is seeing shadows outside the window near the palm trees and asks if the treatment team sees them as well. Denies depression or anxiety.

Past Psychiatric History

DENIED ADMIT NOTE

2

States this is his first hospitalization, but hold states he was at VDM 2 years ago. Dx: schizophrenia. Abuses meth, denies history of other substance (chart notable for ETOH abuse). No suicide attempts.

Rx per chart review

last note Invega Sustenna 156 mg IM q 4 weeks, last injection 2/10/17 (pt states last injection was 5 months ago)
11/2016 note indicated invega 156 mg, Lamictal 100 mg qhs, Cogentin 1 mg qhs. Pt claims he is compliant with medication

Also on invega 6 mg per note on 6/12/17

Per chart review, "assessment on 2/24/2017 client no longer met criteria for specialized mental health services due to improvement of symptoms during periods of sobriety and treatment of severe substance abuse disorder and stimulant induced psychosis" 6/12/17

Substance Abuse History

methamphetamines, alcohol

Medical History And Medication Allergies

Denies

Family Psychiatric History

Mother with anxiety, no suicides or substance abuse in family

Brief Social History

Lives with mother and father. On SSDI obtaining \$1600 a month.

Forensic History

Deferred

Work History

Former truck driver.

Strengths, Weaknesses And Assets

S: family involvement, therapeutic alliance
W: psychosis

Mental Status Examination

Latino male appearing stated age, hair is disheveled, wearing paper scrubs that are too large for him (pants falling off), fair eye contact, some latency with speech, slow, simplistic, mood "ok", appears mildly paranoid, RTIS, paranoid delusions as noted above, VH as noted above, no AH, no SI/II, insight and judgement are poor

Admitting Diagnoses

Axis	Description
1	Unspecified psychotic disorder, r/o amphetamine-induced psychotic disorder, methamphetamine abuse r/o schizophrenia
2	
3	
4	

DENIED ADMIT NOTE

5

2

Medical Necessity

Pt psychotic which is likely 2/2 to substance use, however endorsed HI against his parents with which he lives (wanted to get a knife and stab them). He has a history of anger issues and in his current psychotic state poses a danger to others. He is disheveled and needs direction to pull up his pants to prevent him from tripping on the legs and falling. He continues to meet hold criteria in his current state.

Initial Treatment Plan/Discussion

Will give Invega 234 mg when available, then 156 mg in 5 days (previous documented maintenance dose was 156 mg given in 2016)
Cogentin 1 mg QHS
Risperdal 2 mg BID then DC when given invega 156 mg
Hold lamictal for now
Encourage abstinence from substances

Additional Narrative

Cancel	Default Summary	Custom Summary	Print
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4



DENIED ADMISSION NOTE

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Client:
 Search

Welcome: Sara Sanchez

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Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99221 - Initial E/M, Inpatient/PHF, detailed, low

Service Date:

Service Location: Inpatient Psychiatric Facility

Emergency: No

Med. Compliant:	Yes	Side Effects:	No
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Pregnant: No

Principal Diagnosis : ICD-10: F15.959 - Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified

Role	Staff #	Staff Name	Time	Approved
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Counseling & Coordination of Care Time:	Primary Service Face To Face Time:	Primary Service Travel/Documentation Time:
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Dates

Date Of Admission: 12/23/2017 Date Of Discharge:

Identification

22-year-old female admitted on a 5150 for grave disability.

Chief Complaint

"I don't want to be here."

History Of Present Illness

5150 allegations indicate that patient was acting bizarrely, reporting that people were following her, trying to kill her. She told police that she had thoughts of suicide, but we did not want to disclose a plan. Patient was booked in jail due to methamphetamine use. She claimed that she also takes Adderall for PTSD. She presented manic, with agitated behavior and was not compliant with assessment. Patient stated that she did not feel safe anywhere. She admitted to smoking methamphetamine this week.

Past Psychiatric History

Patient denies any current outpatient treatment. Records indicate that patient was first serviced by the Lompoc children outpatient services in March 2009. She was diagnosed by her pediatrician as having ADHD and was prescribed Adderall. Patient was described as having borderline intellectual functioning. She continued to receive outpatient services through the children's clinic until 2010. She received mental health services at the juvenile hall in Santa Maria in 2013. Patient also

DENIED ADMIT NOTE



received treatment in the past through the child abuse listening and mediation (CALM) intensive in-home care. Patient denied history of psychiatric hospitalizations. She denied history of suicidal attempts, but admitted to history of cutting. Last time she cut was 9 months ago. Old scars are visible on left forearm.

Substance Abuse History

Patient admits to methamphetamine and alcohol use, but doesn't want to provide additional details on her use of these substances.

Medical History And Medication Allergies

Patient denied medical problems or drug allergies.

Family Psychiatric History

Patient's mother used methamphetamine and alcohol while pregnant with patient. Patient was unable to identify any other history of psychiatric illness in her family.

Brief Social History

Patient states she lives in Santa Barbara with her mother and sister.

Forensic History

Patient reports she has been in jail several times for, "several things." She couldn't elaborate further.

Work History

Patient is unemployed. Patient attended multiple schools when growing up and did poorly academically.

Strengths, Weaknesses And Assets

Strength: lives with family.
Weakness: methamphetamine abuse.

Mental Status Examination

The patient was somewhat disheveled. Her speech was normal. Her eye contact was poor. There was no evidence of psychomotor disturbances or abnormal involuntary movements. She denied a/v hallucinations. She admitted to paranoid ideas, "there are people following me that want to kill me." There was evidence of hypomania, "I want to be a cop or a detective." Her thought process was at times tangential. She denied suicidal/homicidal ideas. She was alert and oriented to person, place, and time. Her short-term and long-term memory were intact as evidenced by 3/3 recall immediately and after 5 minutes. Her concentration and attention span were somewhat decreased. Her intelligence appears to be below average based on vocabulary. Her mood was, "I am ready to go home. I am just afraid of the people who are following me." Her affect was mildly labile. Her insight and judgment were poor.

Admitting Diagnoses

Axis	Description
1	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified (F15.959); Stimulant Use, Unspecified.
2	
3	
4	
5	

DENIED ADMIT NOTE

6

Medical Necessity

Patient is paranoid. She believes there are people following her and trying to kill her. She admitted to the police that she was having suicidal ideas, but did not want to elaborate on the plan. She lacks insight into her need for treatment and wants to be discharged.

Initial Treatment Plan/Discussion

1. Place on 5250.
2. Start Zyprexa 5mgs PO BID for psychosis.

Additional Narrative

Cancel	Default Summary	Custom Summary	Print
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7



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Clients

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Evaluation

Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99221 - Initial E/M, Inpatient/PHF, detailed, low

Service Date:

Service Location: Inpatient Psychiatric Facility

Emergency: No

Med. Compliant:	N/A	Side Effects:	N/A
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Principal Diagnosis :

Role	Staff #	Staff Name	Time	Approved
			01:00	Edit <input checked="" type="checkbox"/>

Counseling & Coordination of Care Time:	Primary Service Face To Face Time:	Primary Service Travel/Documentation Time:
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Dates

Date Of Admission: 04/12/2019 Date Of Discharge:

Identification

52-year-old male admitted on a 5150 for danger to self.

Chief Complaint

"I don't remember."

History Of Present Illness

5150 allegations indicate patient was brought to Lompoc Valley Medical Center for evaluation after a suicidal attempt by overdose. During 5150 evaluation, patient stated he didn't remember "doing anything." Patient's family stated he has been decompensating and that he is unpredictable. Patient with another recent suicidal attempt by hanging self.

Past Psychiatric History

Past with past history of psychosis secondary to meth use. He was admitted to PHF in August 2018 on a 5150 for danger to self after suicide attempt by overdose on 8 bottles of his medical medications, including metformin, loratadine, hydroxyzine, Plavix and hydrochlorothiazide, requiring 2 weeks in the hospital. After discharge from medical floor and on his way to a sober living facility, he attempted suicide again by hanging in the bathroom of the hospital. Patient reported stressors then as finances, social isolation, family relationships, and paranoia that others are out to get him. Patient has stated in the past he hears voices and believes he has a chip implanted in his brain and does not know who put it there or why. Patient states he has stuttered since he was a child.

DENIED ADMIT NOTE

8

Substance Abuse History

Patient smokes cigarettes. He denied alcohol use. Chart indicates past history of polysubstance abuse (methamphetamine, benzodiazepines).

Medical History And Medication Allergies

Diabetes Mellitus Type 2, COPD, PVD, GERD, and HTN. Left TMA 2ry to diabetic foot. NKDA.

Family Psychiatric History

Patient denied history of psychiatric illness in his family. Records indicate he has a son with history of psychosis, who has been a patient here in the past. Records also indicate that patient said in the past he has a daughter is in the juvenile justice system.

Brief Social History

Patient states he is married with 3 children. Past records indicate that he is homeless.

Forensic History

Patient denied legal problems.

Work History

Unemployed due to disability. Records indicate he reported working in a nursery in the past.

Strengths, Weaknesses And Assets

Strength: supportive family.
Weakness: apparent cognitive problems.

Mental Status Examination

Presentation: guarded, disheveled, confused.
Speech: soft, monotone, stutters, disorganized.
Psychomotor: no abnormal involuntary movements present, no psychomotor disturbances.
Mood: "I don't know."
Affect: blunted.
Thought Content: denied auditory/visual hallucinations or suicidal/homicidal ideas.
Thought process: disorganized, incoherent at times.
Judgement: poor.
Insight: poor.
Cognitive: alert, but disoriented x2, short term memory poor as evidenced by 0/3 recall in 5 minutes. Long-term memory poor as evidenced by inability to recall events leading to hospitalization.
Intelligence: below average based on vocabulary.

Admitting Diagnoses

Axis	Description
1	Unspecified psychosis. Unspecified mood disorder. Diabetes Mellitus Type 2, COPD, PVD, GERD, and HTN. Left TMA 2ry to diabetic foot.
2	
3	
4	
5	

Medical Necessity

DENIED ADMIT NOTE

9

Patient with a recent serious suicidal attempt by overdosing on medications and another recent suicidal attempt by hanging himself. He is at high risk of attempting suicide again if discharged from the PHF. He cannot be managed at a lower level of care.

Initial Treatment Plan/Discussion

Start Risperdal 2 mg PO QHS and Lexapro 10 mg PO QAM.

Additional Narrative

Cancel		Default Summary	Custom Summary	Print
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DENIED CONT'D STAY NOTE

10



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Clients

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I.

Client:)
 Provider: Psychiatric Health Facility-SB - Inpa...
 Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fc
 Service Location: Inpatient Hospital
 Emergency: No

Service Date:

Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	Time	Approved
			00:13 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time: Primary Service Face To Face Time: Primary Service Travel/Documentation Time:

Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by																			
18:03	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	<table border="1"> <thead> <tr> <th></th> <th>Axis I</th> <th>Axis II</th> <th>Axis III</th> <th>Axis IV</th> <th>Axis V</th> </tr> </thead> <tbody> <tr> <td>OSM-IV</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ICD-10</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Axis I	Axis II	Axis III	Axis IV	Axis V	OSM-IV						ICD-10					
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OSM-IV																				
ICD-10																				

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: "Can I go now"

Pertinent Review of Systems (ROS): Pt slept 5 hrs, withdrawn, internally preoccupied, no interaction with others, needed prompting to shower and eat, not going to groups, stutters at baseline

Mental Status Examination

- | | | | | |
|--------------------------|--|---|--|---|
| Appearance: | <input type="checkbox"/> normal grooming | <input type="checkbox"/> poor hygiene | <input checked="" type="checkbox"/> disheveled | <input type="checkbox"/> malodorous |
| Behavior/Activity: | <input type="checkbox"/> normal | <input type="checkbox"/> agitated | <input checked="" type="checkbox"/> retarded | <input type="checkbox"/> in bed |
| Speech: | <input type="checkbox"/> normal rate/rhythm | <input type="checkbox"/> slowed | <input type="checkbox"/> pressured | <input checked="" type="checkbox"/> flat |
| Affect: | <input type="checkbox"/> normal range | <input type="checkbox"/> sad | <input type="checkbox"/> expansive | <input checked="" type="checkbox"/> restricted |
| Mood: | <input type="checkbox"/> euthymic | <input type="checkbox"/> moderately depressed | <input checked="" type="checkbox"/> severely depressed | <input type="checkbox"/> expansive |
| Thought Form: | <input checked="" type="checkbox"/> linear/goal directed | <input type="checkbox"/> circumstantial | <input type="checkbox"/> tangential | <input type="checkbox"/> concrete |
| Thought Content: | <input checked="" type="checkbox"/> no abnormalities | <input type="checkbox"/> hallucinations | <input type="checkbox"/> delusions | <input type="checkbox"/> ideas of reference |
| Suicidal Ideation: | <input type="checkbox"/> none | <input type="checkbox"/> passive | <input checked="" type="checkbox"/> active (clarify) | <input type="checkbox"/> recent attempt |
| Orientation: | <input type="checkbox"/> fully oriented | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input checked="" type="checkbox"/> severely impaired |
| Memory: | <input type="checkbox"/> normal | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input checked="" type="checkbox"/> severely impaired |
| Judgment/Insight: | <input type="checkbox"/> intact | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input checked="" type="checkbox"/> severely impaired |
| Attention/Concentration: | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input checked="" type="checkbox"/> poor | <input type="checkbox"/> easily distracted |

DENIED CONT'D STAY NOTE



Other:

Current Psychiatric Medications zyprexa 5mg po qam/10mg po qhs

Medical Decision Making (Note new problems, management options, dangerousness risks) acute status, pt has si, does not state what plan is, attempted to strangle mom, if discharged is high risk for suicide and homicide

Assessment: as above

Diagnoses: no change

Treatment Plan: acute status, encourage groups, cont meds

Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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12



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Clients Search

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In:

Client: CUCE, JOHN A. (137020540)
 Provider: Psychiatric Health Facility-SB - Inpa...
 Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fo
 Service Location: Inpatient Hospital
 Emergency: No

Service Date:

Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	Time	Approved
			00:11 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time:	Primary Service Face To Face Time:	Primary Service Travel/Documentation Time:
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Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by																			
15:19	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	<table border="1"> <thead> <tr> <th></th> <th>Axis I</th> <th>Axis II</th> <th>Axis III</th> <th>Axis IV</th> <th>Axis V</th> </tr> </thead> <tbody> <tr> <td>DSM-IV</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ICD-10</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Axis I	Axis II	Axis III	Axis IV	Axis V	DSM-IV						ICD-10					
	Axis I	Axis II	Axis III	Axis IV	Axis V															
DSM-IV																				
ICD-10																				

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: Pt refused to come to treatment team

Pertinent Review of Systems (ROS): Pt slept 6.5 hrs, pt was interviewed at bedside, isolative, withdrawn, has thought blocking, AH

Mental Status Examination

- Appearance:
 - normal grooming
 - poor hygiene
 - disheveled
 - malodorous
- Behavior/Activity:
 - normal
 - agitated
 - retarded
 - in bed
- Speech:
 - normal rate/rhythm
 - slowed
 - pressured
 - flat
- Affect:
 - normal range
 - sad
 - expansive
 - restricted
- Mood:
 - euthymic
 - moderately depressed
 - severely depressed
 - expansive
- Thought Form:
 - linear/goal directed
 - circumstantial
 - tangential
 - concrete
- Thought Content:
 - no abnormalities
 - hallucinations
 - delusions
 - ideas of reference
- Suicidal Ideation:
 - none
 - passive
 - active (clarify)
 - recent attempt
- Orientation:
 - fully oriented
 - mildly impaired
 - moderately impaired
 - severely impaired
- Memory:
 - normal
 - mildly impaired
 - moderately impaired
 - severely impaired
- Judgment/Insight:
 - intact
 - mildly impaired
 - moderately impaired
 - severely impaired
- Attention/Concentration:
 - good
 - fair
 - poor
 - easily distracted
- Other:

DENIED CONT'D STAY NOTE

13

Current Psychiatric Medications Seroquel 100mg po bid, Cogentin 1mg po bid

Medical Decision Making (Note new problems, management options, dangerousness risks) Acute status, pt requires staff to eat, drink, groom, if discharged pt will fail lower level care without assistance

Assessment: as above

Diagnoses: no change

Treatment Plan: acute status, encourage treatment team, encourage groups

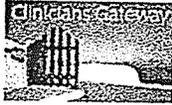
Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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14



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Clients Search

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Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fo

Service Date:

Service Location: Inpatient Psychiatric Facility

Emergency: No

Med. Compliant:	Yes	Side Effects:	No
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Role	Staff #	Staff Name	Time	Approved
			00:30 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time:	Primary Service Face To Face Time:	Primary Service Travel/Documentation Time:
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Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	<table border="1"> <tr> <td></td> <td>Axis I</td> <td>Axis II</td> <td>Axis III</td> <td>Axis IV</td> <td>Axis V</td> </tr> <tr> <td>DSM-IV</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ICD-10</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Axis I	Axis II	Axis III	Axis IV	Axis V	DSM-IV						ICD-10					
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DSM-IV																				
ICD-10																				
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Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: "I hear the voices. They are many people talking."

Pertinent Review of Systems (ROS): Patient presents with thought blocking. He responds to internal stimuli. He admits to auditory hallucinations, which he describes as multiple people talking. He admits to suicidal ideas, but is unable to specify a plan. States he is suicidal because he feels lonely. He has been compliant with medications and denied side effects. His attention and concentration are decreased.

Mental Status Examination

- Appearance:
 - normal grooming
 - poor hygiene
 - disheveled
 - malodorous
- Behavior/Activity:
 - normal
 - agitated
 - retarded
 - in bed
- Speech:
 - normal rate/rhythm
 - slowed
 - pressured
 - flat
- Affect:
 - normal range
 - sad
 - expansive
 - restricted
- Mood:
 - euthymic
 - moderately depressed
 - severely depressed
 - expansive
- Thought Form:
 - linear/goal directed
 - circumstantial
 - tangential
 - concrete
- Thought Content:
 - no abnormalities
 - hallucinations
 - delusions
 - ideas of reference
- Suicidal Ideation:
 - none
 - passive
 - active (clarify)
 - recent attempt
- Orientation:
 - fully oriented
 - mildly impaired
 - moderately impaired
 - severely impaired
- Memory:
 - normal
 - mildly impaired
 - moderately impaired
 - severely impaired
- Judgment/Insight:
 - intact
 - mildly impaired
 - moderately impaired
 - severely impaired
- Attention/Concentration:
 - good
 - fair
 - poor
 - easily distracted

DENIED CONT'D STAY NOTE

15

Other:

Current Psychiatric Medications Clozaril 150mg PO QHS and Clonazepam 2mg PO QHS.

Medical Decision Making (Note new problems, management options, dangerousness risks) Patient admits to suicidal ideas. He is unable to describe a plan due to his decreased concentration/attention that appear to be directly correlated to the fact that he is hearing voices. He is at risk of attempting against his life, if discharged from the PHF.

Assessment: Psychosis present. Depressed with suicidal ideas.

Diagnoses: No change.

Treatment Plan: Continue current medications.

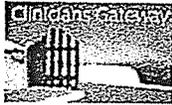
Cancel		Default Summary	Custom Summary	Print
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16



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Clients
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Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fo

Service Date:

Service Location: Inpatient Hospital

Emergency: No

Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	Time	Approved
			00:11 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time: Primary Service Face To Face Time: Primary Service Travel/Documentation Time:

Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by																
21:58	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	<table border="1"> <thead> <tr> <th></th> <th>Axis I</th> <th>Axis II</th> <th>Axis IV</th> <th>Axis V</th> </tr> </thead> <tbody> <tr> <td>DSM-IV</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ICD-10</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Axis I	Axis II	Axis IV	Axis V	DSM-IV					ICD-10				
	Axis I	Axis II	Axis IV	Axis V													
DSM-IV																	
ICD-10																	

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: "I hear voices"

Pertinent Review of Systems (ROS): Pt slept 6.5 hrs, had family visit, reports ah, still reports si, appears to respond to internal stimuli, reports multiple people talking at same time

Mental Status Examination

- | | | | | |
|--------------------------|--|---|--|---|
| Appearance: | <input type="checkbox"/> normal grooming | <input type="checkbox"/> poor hygiene | <input checked="" type="checkbox"/> disheveled | <input type="checkbox"/> malodorous |
| Behavior/Activity: | <input type="checkbox"/> normal | <input type="checkbox"/> agitated | <input checked="" type="checkbox"/> retarded | <input type="checkbox"/> in bed |
| Speech: | <input type="checkbox"/> normal rate/rhythm | <input type="checkbox"/> slowed | <input type="checkbox"/> pressured | <input checked="" type="checkbox"/> flat |
| Affect: | <input type="checkbox"/> normal range | <input type="checkbox"/> sad | <input type="checkbox"/> expansive | <input checked="" type="checkbox"/> restricted |
| Mood: | <input type="checkbox"/> euthymic | <input type="checkbox"/> moderately depressed | <input checked="" type="checkbox"/> severely depressed | <input type="checkbox"/> expansive |
| Thought Form: | <input type="checkbox"/> linear/goal directed | <input type="checkbox"/> circumstantial | <input checked="" type="checkbox"/> tangential | <input type="checkbox"/> concrete |
| Thought Content: | <input type="checkbox"/> no abnormalities | <input type="checkbox"/> hallucinations | <input checked="" type="checkbox"/> delusions | <input type="checkbox"/> ideas of reference |
| Suicidal Ideation: | <input type="checkbox"/> none | <input checked="" type="checkbox"/> passive | <input type="checkbox"/> active (clarify) | <input type="checkbox"/> recent attempt |
| Orientation: | <input checked="" type="checkbox"/> fully oriented | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input type="checkbox"/> severely impaired |
| Memory: | <input type="checkbox"/> normal | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input type="checkbox"/> severely impaired |
| Judgment/Insight: | <input type="checkbox"/> intact | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input checked="" type="checkbox"/> severely impaired |
| Attention/Concentration: | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input checked="" type="checkbox"/> poor | <input type="checkbox"/> easily distracted |

DENIED CONT'D STAY NOTE

17

Other:

Current Psychiatric Medications Clozaril 150mg po qhs, clonazepam 2mg po qhs

Medical Decision Making (Note new problems, management options, dangerousness risks) acute status, pt reports si, is vague about his plan but has voices telling him to kill self, if discharged pt is high risk of suicide

Assessment: as above

Diagnoses: no change

Treatment Plan: acute status, cont meds, anc tues, encourage groups

Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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DENIED CONT'D STAY NOTE

18



View Finalized Service

Clients Search

Welcome: Sara Sanchez

Home Menu Logout

WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure:

Service Date:

Service Location: Inpatient Hospital

Emergency: No

Med. Compliant:	Yes	Side Effects:	Yes
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Ro'e	Staff #	Staff Name	Time	Approved
				<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time:	Primary Service Face To Face Time: 00:10	Primary Service Travel/Documentation Time:
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Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	<table border="1"> <tr> <td></td> <td>Axis I</td> <td>Axis II</td> <td>Axis III</td> <td>Axis IV</td> <td>Axis V</td> </tr> <tr> <td>DSM-IV</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ICD-10</td> <td>F31.2</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Axis I	Axis II	Axis III	Axis IV	Axis V	DSM-IV						ICD-10	F31.2				
			Axis I	Axis II	Axis III	Axis IV	Axis V													
DSM-IV																				
ICD-10	F31.2																			
00:00	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician																			

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint:

Perinent Review of Systems (ROS): Pt's prolactin elevated at 63.7 (nl 2.5-17.4). Hepatitis panel negative for B and C. Slept 5 hours. VS: 98.3 95 134/83 16. Family visited and they said he is slightly better but not at baseline and they are refusing to have him return home. Pt continues to dominate groups and peers are upset that cannot contribute to them. He sits closely to a male nursing student and shakes his hand for a long time. Student needs to forcefully remove his hand from the grip. He again talks about computers and provider needs to redirect him to focus. Complains of urinary frequency (pharmacist reports clonazepam can cause urinary frequency). Pt updated that it was discontinued last night and he will be monitored. Updated that his family not ready to have him home. Does not want to go elsewhere. Pt agrees to lamictal for further mood stability as he does not like needles (also LFTs elevated, preventing use of Depakote). Pt also asks for alternate medication than Invega. Informed that he could follow up with outside psychiatrist consider Ability.

Mental Status Examination

- | | | | | |
|--------------------|--|---|---|---|
| Appearance: | <input checked="" type="checkbox"/> normal grooming | <input type="checkbox"/> poor hygiene | <input type="checkbox"/> disheveled | <input type="checkbox"/> malodorous |
| Behavior/Activity: | <input type="checkbox"/> normal | <input checked="" type="checkbox"/> agitated | <input type="checkbox"/> retarded | <input type="checkbox"/> in bed |
| Speech: | <input type="checkbox"/> normal rate/rhythm | <input type="checkbox"/> slowed | <input checked="" type="checkbox"/> pressured | <input type="checkbox"/> flat |
| Affect: | <input type="checkbox"/> normal range | <input type="checkbox"/> sad | <input checked="" type="checkbox"/> expansive | <input type="checkbox"/> restricted |
| Mood: | <input type="checkbox"/> euthymic | <input type="checkbox"/> moderately depressed | <input type="checkbox"/> severely depressed | <input checked="" type="checkbox"/> expansive |
| Thought Form: | <input type="checkbox"/> linear/goal directed | <input type="checkbox"/> circumstantial | <input checked="" type="checkbox"/> tangential | <input type="checkbox"/> concrete |
| Thought Content: | <input checked="" type="checkbox"/> no abnormalities | <input type="checkbox"/> hallucinations | <input type="checkbox"/> delusions | <input type="checkbox"/> ideas of reference |
| Suicidal Ideation: | <input checked="" type="checkbox"/> none | <input type="checkbox"/> passive | <input type="checkbox"/> active (clarify) | <input type="checkbox"/> recent attempt |
| Orientation: | <input checked="" type="checkbox"/> fully oriented | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input type="checkbox"/> severely impaired |
| Memory: | <input type="checkbox"/> normal | <input type="checkbox"/> mildly impaired | <input checked="" type="checkbox"/> moderately impaired | <input type="checkbox"/> severely impaired |

DENIED

CONT'D

STAY

NOTE

19

Judgment/Insight: intact mildly impaired moderately impaired severely impaired
 Attention/Concentration: good fair poor easily distracted

Other:

Current Psychiatric Medications s/p Invega sustenna 155 mg on 3/31, Risperidone 2 mg BID with Haldol 5mg IM backup

Medical Decision Making (Note new problems, management options, dangerousness risks) Pt with slightly improved sleep, but continues to dominate groups and peers are upset that cannot contribute to them. His family still feels that he is not stable to return home and pt does not want to go to ANKA. Pt's LFTs elevated so cannot use Depakote as an adjunct for mania. Pt agrees to Lamictal. Will start Lamictal 25 mg. Pt also with elevated prolactin so will DC additional Risperdal.

Assessment: Above

Diagnoses: Bipolar disorder type 1 MRE manic, severe, with psychotic features. Prolactin elevated at 63.7

Treatment Plan: DC Risperdal as Prolactin elevated at 63.7. May consider transition to Abilify in the outpt setting. Start lamictal 25 mg QAM.

Addendums

Date	Staff	Addendum

Cancel | Default Summary | Custom Summary | Print

PERSONAL INFO | SECURITY (PASSWORD) |

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CONT'D

STAY DAY

DENIED

(20)



View Finalized Service

Clients

Welcome: Sara Sanchez

Home Menu Log out

WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem fo

Service Date:

Service Location: Inpatient Psychiatric Facility

Emergency: No

Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	Time	Approved
			00:30 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time: Primary Service Face To Face Time: Primary Service Travel/Documentation Time:

Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	Axis I	Axis II	Axis III	Axis IV	Axis V
15:00	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	DSM-IV				
		ICD-10				

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: "I'm not young anymore"

Pertinent Review of Systems (ROS): Pt's vitals were reviewed and within normal limits. He continues to refuse accuchecks and diabetes management. Pt tolerating invertebra sustenna dose well with no noted issues. He has been sleeping and eating well. Pt is more verbal, less agitated, now greeting staff and holding short conversations before terminating instead of refusing. On direct interaction, he is still guarded and withdrawn pan-denying symptoms. However, he is also noted to be talking to self at times throughout day, sometimes shouting loudly to self nonsensical statements. He was able to speak with social work about dispo options and is considering ANKA as a potential for where he can live.

Mental Status Examination

Appearance:	<input type="checkbox"/> normal grooming	<input type="checkbox"/> poor hygiene	<input checked="" type="checkbox"/> disheveled	<input type="checkbox"/> maioorous
Behavior/Activity:	<input checked="" type="checkbox"/> normal	<input type="checkbox"/> agitated	<input type="checkbox"/> retarded	<input type="checkbox"/> in bed
Speech:	<input checked="" type="checkbox"/> normal rate/rhythm	<input type="checkbox"/> slowed	<input type="checkbox"/> pressured	<input type="checkbox"/> flat
Affect:	<input type="checkbox"/> normal range	<input type="checkbox"/> sad	<input type="checkbox"/> expansive	<input checked="" type="checkbox"/> restricted
Mood:	<input checked="" type="checkbox"/> euthymic	<input type="checkbox"/> moderately depressed	<input type="checkbox"/> severely depressed	<input type="checkbox"/> expansive
Thought Form:	<input type="checkbox"/> linear/goal directed	<input type="checkbox"/> circumstantial	<input type="checkbox"/> tangential	<input checked="" type="checkbox"/> concrete
Thought Content:	<input type="checkbox"/> no abnormalities	<input type="checkbox"/> hallucinations	<input checked="" type="checkbox"/> delusions	<input type="checkbox"/> ideas of reference
Suicidal Ideation:	<input checked="" type="checkbox"/> none	<input type="checkbox"/> passive	<input type="checkbox"/> active (clarity)	<input type="checkbox"/> recent attempt
Orientation:	<input checked="" type="checkbox"/> fully oriented	<input type="checkbox"/> mildly impaired	<input type="checkbox"/> moderately impaired	<input type="checkbox"/> severely impaired
Memory:	<input type="checkbox"/> normal	<input type="checkbox"/> mildly impaired	<input type="checkbox"/> moderately impaired	<input checked="" type="checkbox"/> severely impaired
Judgment/Insight:	<input type="checkbox"/> intact	<input type="checkbox"/> mildly impaired	<input type="checkbox"/> moderately impaired	<input checked="" type="checkbox"/> severely impaired
Attention/Concentration:				

DENIED CONT'D STAY NOTE

21

good

fair

poor

easily distracted

Other:

Current Psychiatric Medications Loading dose of 234 given on 2/26/19. Pending second loading dose of 156mg on 3/2/19.

Medical Decision Making (Note new problems, management options, dangerousness risks) Acute status, pt requires acute inpatient hospitalization due to safety and stabilization as he is at risk for danger to others and for grave passive neglect. If discharged pt is at risk for hurting others given recent fire setting and past prior history of similar behavior. He is also unable to attend to his needs in his current state given his level of paranoia towards current inhabitants at room/board and his current level of disorganization. He is neglecting his medical conditions by refusing glucose monitoring and is not able to maintain his medical conditions/treatment. Pt is gravely disabled and cannot be managed in a lower setting like ANKA given his level of disorganization and concerns for safety with refusal of assistance/treatment and destructive behavior in residential setting.

Assessment: Pt has a long history of schizophrenia controlled on invega but with a history of fire setting, flooding and other destructive behaviors when off medication. At present he is amenable to restarting treatment and is tolerating re-initiation of invega without current side effects.

Diagnoses: Schizophrenia

Treatment Plan: Invega sustenna 234mg IM maintenance last given 1/03/19. In process of re-initiation. Loading dose of 234 given on 2/26/19. Pending second loading dose of 156mg on 3/2/19.

Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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CONT'D STAY - DENIED

22



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Clients

Search

Welcome: Sara Sanchez

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WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Client:
 Provider: Psychiatric Health Facility-SB - Inpa...
 Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fo
 Service Location: Inpatient Psychiatric Facility
 Emergency: No

Service Date:

Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	Time	Approved
			00:30 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time:	Primary Service Face To Face Time:	Primary Service Travel/Documentation Time:
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Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	Axis I	Axis II	Axis III	Axis IV	Axis V
11:00	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	DSM-IV				
		CD-10				

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: "I don't have diabetes...It's all government propaganda"

Pertinent Review of Systems (ROS): Vitals reviewed, within normal limits. Pt slept 7.5 hours. Pt has been going to some groups. Has been visible on unit, playing basketball with peers. On interview, pt is noted to be guarded, paranoid, stating repeatedly "It's government propogand" and refusing in-depth discussion about treatment or symptoms with pt denying all symptoms or problems. Pt also denies having diabetes stating it is all false information planted by the government. When told he was diagnosed with diabetes based on lab work, he becomes slightly agitated and again refers to government propoganda. He says he refuses diabetes treatment because he does not have diabetes. He is unable to describe where he will live and how he will take care of himself. He denies side effects to invenga. Pt noted to be talking to self, yelling loudly at times.

Mental Status Examination

- Appearance: normal grooming poor hygiene disheveled malodorous
- Behavior/Activity: normal agitated retarded in bed
- Speech: normal rate/rhythm slowed pressured flat
- Affect: normal range sad expansive restricted
- Mood: euthymic moderately depressed severely depressed expansive
- Thought Form: linear/goal directed circumstantial tangential concrete
- Thought Content: no abnormalities hallucinations delusions ideas of reference
- Suicidal Ideation: none passive active (clarify) recent attempt
- Orientation: fully oriented mildly impaired moderately impaired severely impaired
- Memory: normal mildly impaired moderately impaired severely impaired
- Judgment/Insight: intact mildly impaired moderately impaired severely impaired

DENIED CONT'D STAY NOTE

23

Attention/Concentration: good fair poor easily distracted

Other:

Current Psychiatric Medications Loading dose of 234 given on 2/26/19. Pending second loading dose of 156mg on 3/2/19.

Medical Decision Making (Note new problems, management options, dangerousness risks) Acute status, pt requires acute inpatient hospitalization due to safety and stabilization as he is at risk for danger to others and for grave passive neglect. If discharged pt is at risk for hurting others given recent fire setting and past prior history of similar behavior. He is also unable to attend to his needs in his current state given his level of paranoia towards current inhabitants at room/board and his current level of disorganization. He is neglecting his medical conditions by refusing glucose monitoring and is not able to maintain his medical conditions/treatment. Pt is gravely disabled and cannot be managed in a lower setting like ANKA given his level of disorganization and concerns for safety with refusal of assistance/treatment and destructive behavior in residential setting.

Assessment: Pt has a long history of schizophrenia controlled on invega but with a history of fire setting, flooding and other destructive behaviors when off medication. At present he is amenable to restarting treatment and is tolerating re-initiation of invega without current side effects.

Diagnoses: Schizophrenia

Treatment Plan: Invega sustenna 234mg IM maintenance last given 1/03/19. In process of re-initiation. Loading dose of 234 given on 2/26/19. Pending second loading dose of 156mg on 3/2/19.

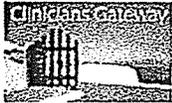
Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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DEEMED CONT'D STAY NOTE

24



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Clients Search

Welcome: Sara Sanchez

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It e

Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fo

Service Date:

Service Location: Inpatient Hospital

Emergency: No

Pregnant: No

Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	Time	Approved
			00:35 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time: Primary Service Face To Face Time: Primary Service Travel/Documentation Time:

Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	Axis I	Axis II	Axis III	Axis IV	Axis V
13:15	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	DSM-IV				
		ICD-10				

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint:

Pertinent Review of Systems (ROS): Pt slept 8.5 hrs, afebrile, vitals wnl, pt is reported by nursing staff to be "tearful, misses family", pt reports she continues to miss her family and suffers from unrequited love of a male RA on staff, she has amorous delusions that she and the male RA staff member will be married and have children, male RA staff member does not reciprocate, she is crying during exam, she states that her family doesn't love her and proceeded to go on a vacation without her (CM states this may be true), on unit she is helpful and pleasant with staff and peers, but is childlike, smiles inappropriately, wants to hold hands with staff

Mental Status Examination

Appearance:	<input type="checkbox"/> normal grooming	<input type="checkbox"/> poor hygiene	<input checked="" type="checkbox"/> disheveled	<input type="checkbox"/> malodorous
Behavior/Activity:	<input type="checkbox"/> normal	<input type="checkbox"/> agitated	<input checked="" type="checkbox"/> retarded	<input type="checkbox"/> in bed
Speech:	<input type="checkbox"/> normal rate/rhythm	<input type="checkbox"/> slowed	<input type="checkbox"/> pressured	<input checked="" type="checkbox"/> flat
Affect:	<input type="checkbox"/> normal range	<input type="checkbox"/> sad	<input type="checkbox"/> expansive	<input checked="" type="checkbox"/> restricted
Mood:	<input type="checkbox"/> euthymic	<input type="checkbox"/> moderately depressed	<input checked="" type="checkbox"/> severely depressed	<input type="checkbox"/> expansive
Thought Form:	<input type="checkbox"/> linear/goal directed	<input type="checkbox"/> circumstantial	<input type="checkbox"/> tangential	<input checked="" type="checkbox"/> concrete
Thought Content:	<input type="checkbox"/> no abnormalities	<input type="checkbox"/> hallucinations	<input checked="" type="checkbox"/> delusions	<input type="checkbox"/> ideas of reference
Suicidal Ideation:	<input checked="" type="checkbox"/> none	<input type="checkbox"/> passive	<input type="checkbox"/> active (clarify)	<input type="checkbox"/> recent attempt
Orientation:	<input type="checkbox"/> fully oriented	<input checked="" type="checkbox"/> mildly impaired	<input type="checkbox"/> moderately impaired	<input type="checkbox"/> severely impaired
Memory:	<input type="checkbox"/> normal	<input checked="" type="checkbox"/> mildly impaired	<input type="checkbox"/> moderately impaired	<input type="checkbox"/> severely impaired
Judgment/Insight:	<input type="checkbox"/> intact	<input type="checkbox"/> mildly impaired	<input type="checkbox"/> moderately impaired	<input checked="" type="checkbox"/> severely impaired

DENIED

CONT'D

STAY NOTE

25

Attention/Concentration: good fair poor easily distracted

Other:

Current Psychiatric Medications Invega Sustenna 234 mg LAI last given on 12/18/18, Melatonin 3 mg QHS, Benzotropine 1 mg BID, Clonazepam 1 mg BID, Seroquel 200 mg QHS, Depakote ER 500 mg BID, Wellbutrin XL 300 mg QAM, Seroquel 50 mg q4h PRN agitation NTE 4x/24 hours

Medical Decision Making (Note new problems, management options, dangerousness risks) Acute status, pt has intent to stab family, as she feels they abandoned her in order to go on a winter trip without her, if discharged pt is high risk for danger to others

Assessment: 43 yo F with a history of Schizophrenia, Paranoid Type, anoxic brain injury on a 5150 DTO/GD. Pt said she felt like hurting family members. X-Ct endorses thoughts of "sometimes" harming her family. On unit pt continues to laugh and smile inappropriately, is childlike in her behaviors

Diagnoses: Schizophrenia, Paranoid Type, anoxic brain injury

Treatment Plan: Acute status, encourage journaling, encourage groups, encourage journaling, monitor response to meds, appreciate CM assistance in trying to help pt contact family by phone

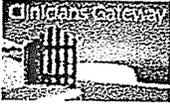
Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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DEMED CONT'D STAY NOTE

26



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Clients Search

Welcome: Sara Sanchez

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WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fc

Service Date: ...

Service Location: Inpatient Hospital

Emergency: No

Med. Compliant: N/A Side Effects: N/A

Pregnant: No

Role	Staff #	Staff Name	Time	Approved
			00:35 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time: Primary Service Face To Face Time: Primary Service Travel/Documentation Time:

Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	Axis I	Axis II	Axis III	Axis IV	Axis V
17:17	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	DSM-IV				
		ICD-10				

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint:

Pertinent Review of Systems (ROS): Pt slept 8.25 hrs, afebrile, vitals wnl, pt is reported by RN staff to have "refused snack, isolative, no social interaction, no groups, seems depressed", pt continues to act childlike by asking to hold hands with staff, laughing and smiling inappropriately, she is less visible on unit today and stated she was depressed her family has not visited, pt continues to be tearful, when asked why she is here she is tangential and talks about her sadness that her sister is married and employed and she is not

Mental Status Examination

- Appearance:
 - normal grooming
 - poor hygiene
 - disheveled
 - malodorous
- Behavior/Activity:
 - normal
 - agitated
 - retarded
 - in bed
- Speech:
 - normal rate/rhythm
 - slowed
 - pressured
 - flat
- Affect:
 - normal range
 - sad
 - expansive
 - restricted
- Mood:
 - euthymic
 - moderately depressed
 - severely depressed
 - expansive
- Thought Form:
 - linear/goal directed
 - circumstantial
 - tangential
 - concrete
- Thought Content:
 - no abnormalities
 - hallucinations
 - delusions
 - Ideas of reference
- Suicidal Ideation:
 - none
 - passive
 - active (clarify)
 - recent attempt
- Orientation:
 - fully oriented
 - mildly impaired
 - moderately impaired
 - severely impaired
- Memory:
 - normal
 - mildly impaired
 - moderately impaired
 - severely impaired
- Judgment/Insight:
 - intact
 - mildly impaired
 - moderately impaired
 - severely impaired
- Attention/Concentration:

DENIED

CONT'D

STAY

NOTE

27

good

fair

poor

easily distracted

Other:

Current Psychiatric Medications Invega Sustenna 234 mg LAI last given on 12/18/18, Melatonin 3 mg QHS, Benzotropine 1 mg BID, Clonazepam 1 mg BID, Seroquel 200 mg QHS, Depakote ER 500 mg BID, Wellbutrin XL 300 mg OAM, Seroquel 50 mg q4h PRN agitation NTE 4x24 hours

Medical Decision Making (Note new problems, management options, dangerousness risks) Acute status, if discharged pt is high risk for danger to others, as pt has intent to stab family, as she feels they abandoned her in order to go on a winter trip without her

Assessment: 43 yo F with a history of Schizophrenia, Paranoid Type, anoxic brain injury on a 5150 DTO/GD. Pt said she felt like hurting family members, X-Ct endorses thoughts of "sometimes" harming her family. On unit pt is tearful and more isolative today

Diagnoses: Schizophrenia, Paranoid Type, anoxic brain injury

Treatment Plan: Acute status, appreciate CM assistance in trying to help pt contact family by phone, encourage journaling, encourage groups, encourage journaling, monitor response to meds

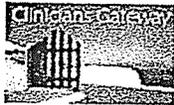
Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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Built: 6/20/2018 (4:19 PM)

DENIED CONT'D STAY NOTE

28



View Finalized Service

Clients Search

Welcome: Sara Sanchez

Home Menu Logout

WARNING: THIS IS NOT AN OFFICIAL OR COMPLETE REPRODUCTION OF THE INFORMATION SHOWN. DO NOT USE FOR RECORD KEEPING OR CLINICAL PURPOSES.

Client:

Provider: Psychiatric Health Facility-SB - Inpa...

Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-fo

Service Date:

Service Location: Inpatient Psychiatric Facility

Emergency: No

Med. Compliant: N/A Side Effects: N/A

Role	Staff #	Staff Name	Time	Approved
	3		00:26 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time: 00:13	Primary Service Face To Face Time: 00:13	Primary Service Travel/Documentation Time:
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Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	<table border="1"> <tr> <td></td> <td>Axis I</td> <td>Axis II</td> <td>Axis III</td> <td>Axis IV</td> <td>Axis V</td> </tr> <tr> <td>DSM-IV</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ICD-10</td> <td>F29</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Axis I	Axis II	Axis III	Axis IV	Axis V	DSM-IV						ICD-10	F29				
	Axis I	Axis II	Axis III	Axis IV	Axis V															
DSM-IV																				
ICD-10	F29																			
12:30	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician																			

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: "the same....just tired....no suicide....no depression...."

Pertinent Review of Systems (ROS): Ortho BPs: laying 106/66, sitting 107/76, standing 103/82, slept 8 hours daytime, 6.75 hours nighttime. Pt reportedly had diarrhea recently, according to the nurses report. Attempts to collect his fecal sample has been unsuccessful. Pt also allegedly told the Noc Shift that "I will not smile; other people have issues when I smile..." Nursing staff reports that the patient is rude and smiles and coughs inappropriately. Upon being approached by this writer and staff Ms. Joanne Evans today, the pt is found in his bed in his room. Keeps his eyes closed during the interview. Mumbles his replies to this writer and Ms. Evans so that some of his brief, terse responses are incomprehensible due to lack of articulation.

Mental Status Examination

- Appearance:
 - normal grooming
 - poor hygiene
 - disheveled
 - malodorous
- Behavior/Activity:
 - normal
 - agitated
 - retarded
 - in bed
- Speech:
 - normal rate/rhythm
 - slowed
 - pressured
 - flat
- Affect:
 - normal range
 - sad
 - expansive
 - restricted
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- Thought Form:
 - linear/goal directed
 - circumstantial
 - tangential
 - concrete
- Thought Content:
 - no abnormalities
 - hallucinations
 - delusions
 - ideas of reference
- Suicidal Ideation:
 - none
 - passive
 - active (clarify)
 - recent attempt
- Orientation:
 - fully oriented
 - mildly impaired
 - moderately impaired
 - severely impaired
- Memory:
 - normal
 - mildly impaired
 - moderately impaired
 - severely impaired
- Judgment/Insight:
 - intact
 - mildly impaired
 - moderately impaired
 - severely impaired

WONT'D STAY - DENIED NOTE

29

Attention/Concentration: good fair poor easily distracted

Other:

Current Psychiatric Medications Clozaril 50 mg po QAM, 50 mg po QHS, Depakene 500 mg po QAM, Depakene 1000 mg po QHS, Invega Sustenna 234 was given on 02/02/19 and 156 mg IM given on 02/25/2019 for psychosis

Medical Decision Making (Note new problems, management options, dangerousness risks) Pt reportedly is having some physical issues with diarrhea, reporting dizziness within the past 24 hours. Will keep patient's Clozaril at the current dose, and not titrate further up at this point in time, until the patient is physically back to baseline or cleared by Internal Medicine.

Assessment: Acute. Pt reportedly continues to be delusional and psychotic and currently also experiencing some GI problems in addition to his acute psychotic sxs, which is keeping this patient bed-bound.

Diagnoses: Schizophrenia Rule out substance induce psychosis

Treatment Plan: Titrate Clozaril up further, after the patient's medical issues have been evaluated and for when the patient is back to his baseline health with no complaints of dizziness or signs of orthostasis. Continue current Clozaril doses and Depakene in the meantime and continue to monitor this patient for sxs and responses. Frequent staff interventions.

Cancel	Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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DEMEO CONTID STAY NOTE

30



View Finalized Service

Clients

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Welcome: Sara Sanchez

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Client:

Provider:

Procedure: 99231 - Subsequent E/M, Inpatient/PHF, problem-to

Service Date: --

Service Location: Inpatient Psychiatric Facility

Emergency: No

Med. Compliant: Yes Side Effects: No

Pregnant: No

Role	Staff #	Staff Name	Time	Approved
			00:30 Edit	<input checked="" type="checkbox"/>

Counseling & Coordination of Care Time:	Primary Service Face To Face Time:	Primary Service Travel/Documentation Time:
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Start Time & Current DX

Start Time (HH:MM)	Services were provided in English by	Axis I	Axis II	Axis III	Axis IV	Axis V
10:00	<input type="checkbox"/> interpreter or <input checked="" type="checkbox"/> primary clinician	DSM-IV				
		ICD-10				

Note

INPATIENT PSYCHIATRY PROGRESS NOTE

Interval History/Chief Complaint: "I am not hearing the voices today."

Perinent Review of Systems (ROS): Patient states she hears "noises," but not voices today. She continues to eat small amounts of her meals. She stays in bed most of the day. Isolates, is withdrawn, and doesn't interact with peers or staff. She appears depressed and is delayed in her responses.

Mental Status Examination

- | | | | | |
|--------------------------|---|--|--|---|
| Appearance: | <input type="checkbox"/> normal grooming | <input type="checkbox"/> poor hygiene | <input checked="" type="checkbox"/> disheveled | <input type="checkbox"/> malodorous |
| Behavior/Activity: | <input type="checkbox"/> normal | <input type="checkbox"/> agitated | <input checked="" type="checkbox"/> retarded | <input checked="" type="checkbox"/> in bed |
| Speech: | <input type="checkbox"/> normal rate/rhythm | <input checked="" type="checkbox"/> slowed | <input type="checkbox"/> pressured | <input type="checkbox"/> flat |
| Affect: | <input type="checkbox"/> normal range | <input checked="" type="checkbox"/> sad | <input type="checkbox"/> expansive | <input type="checkbox"/> restricted |
| Mood: | <input type="checkbox"/> euthymic | <input type="checkbox"/> moderately depressed | <input checked="" type="checkbox"/> severely depressed | <input type="checkbox"/> expansive |
| Thought Form: | <input type="checkbox"/> linear/goal directed | <input type="checkbox"/> circumstantial | <input type="checkbox"/> tangential | <input checked="" type="checkbox"/> concrete |
| Thought Content: | <input type="checkbox"/> no abnormalities | <input checked="" type="checkbox"/> hallucinations | <input checked="" type="checkbox"/> delusions | <input type="checkbox"/> ideas of reference |
| Suicidal Ideation: | <input checked="" type="checkbox"/> none | <input type="checkbox"/> passive | <input type="checkbox"/> active (clarify) | <input type="checkbox"/> recent attempt |
| Orientation: | <input type="checkbox"/> fully oriented | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input checked="" type="checkbox"/> severely impaired |
| Memory: | <input type="checkbox"/> normal | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input checked="" type="checkbox"/> severely impaired |
| Judgment/Insight: | <input type="checkbox"/> intact | <input type="checkbox"/> mildly impaired | <input type="checkbox"/> moderately impaired | <input checked="" type="checkbox"/> severely impaired |
| Attention/Concentration: | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input checked="" type="checkbox"/> poor | <input type="checkbox"/> easily distracted |

DENIED CONT'D STAY - NOTE

31

Other:

Current Psychiatric Medications s/p Aristada 1,064 mg IM and Aristada inicio 675 mg IM. Lexapro 10 mg PO QAM.

Medical Decision Making (Note new problems, management options, dangerousness risks) Even with staff encouragement and support, patient eats minimal amounts of her meals. (She didn't eat her dinner last night.) She cannot be managed at a lower level of care.

Assessment: 51-year-old female with a history of schizoaffective disorder, bipolar type, remote history of methamphetamine abuse and likely PTSD who was admitted to the PHF on a 5150 for grave disability after walking in the street, taking her clothing off as she was hearing the KKK commanding her to do so. She also reports the KKK told her to hit police officers and that she and her family will die if she eats and gets psychiatric help.

Diagnoses: Schizoaffective disorder, bipolar type.

Treatment Plan: Monitor response to Aristada and Lexapro.

Addendums

Date	Staff	Addendum
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Cancel		Default Summary	Custom Summary	Print
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PERSONAL INFO | SECURITY (PASSWORD) |

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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Alice Gleghorn, PhD
Director

Sara Sanchez, LMFT C.C.H.P. QCM Coordinator

5/9/19 1:30pm-2:00pm @ PHF

PHF Training on Documentation for Administrative Status

Quick Review of DHCS Findings Report

Administrative Day Services Documentation Procedures

What can we learn for future? Any questions?

P.S. THANK YOU ALL FOR YOUR OUTSTANDING WORK AT THE PHF!

PHF Administrative Stay (AS) Documentation Procedures

FOR MEDICAL BENEFICIARIES

Let's look at patients who will not qualify to claim AS to DHCS?

2

- ▶ Patients who are 1370/IST or Jail 5150/4011
- ▶ Patients who do not have Medi-Cal
- ▶ Patients who did not meet acute criteria during their hospital stay (i.e. non-acute patients placed at PHF for conservatorship proceedings, non-acute patients placed at PHF voluntary by conservators for placement issues.
- ▶ Patients with Medi-Cal who are not being discharged to a structured treatment environment (going home, to a shelter, to a non-augmented board & care).

Now lets look at patients who are eligible to claim AS to Medi-Cal...

- ▶ Patient has active Medi-Cal
- ▶ Patient must have met acute status criteria during their hospital stay
- ▶ Patient's only appropriate level of care discharge placement is a structured treatment setting including:
 - ▶ Augmented Board & Care with Mental Health Treatment (90 min./day min.)
 - ▶ IMD/MHRC Mental Health Rehabilitation Center
 - ▶ State Hospital
 - ▶ CRT/CSU Crisis Residential Treatment or Unit

So- What documentation is needed to claim AS to Medi-Cal?

4

- ▶ Upon MD placement of patient on AS, SW must document first contact to non-acute treatment programs within 24 hours.
- ▶ Continue making and documenting 5 contacts per every five business days after patient is placed on AS until patient is discharged
- ▶ Documentation of contacts must include but is not limited to:
 - ▶ Why this is the appropriate placement for the patient
 - ▶ Name of placement, facility type, status of placement option, date of contact, signature of person making contact, any relevant comments
 - ▶ Document efforts to resolve issues preventing discharge (both patient related or placement availability related)

SW Documentation of Contacts:



Weekly Note

PHF SOCIAL SERVICE WEEKLY NOTE: Administrative Status

Patient's Psychosocial, Clinical Status, and Legal Status:

Patient remains on a SZ70 which will expire on 9-16-17 but a request for LPS Conservatorship is being drafted and should be submitted sometime next week. Patient is showing some signs of slowly reconstituting; less time in bizarre, intense "praying" or chanting in "origines". Patient did reports one "blow up" yesterday but was to a much lesser degree.

Discharge/Aftercare/Placement Plan:

Patient is recommended by her Treatment Team to be placed on LPS Conservatorship and into an IMD level of care at this time.

Obstacles to Achieving Plan:

Patient has not been placed onto an LPS Conservatorship by Santa Barbara County. Recent history of aggression. No IMD bed has been located.

Social Worker's Activities Toward Achieving Plan, Other Relevant Information:

Getting patient onto some "wait lists" is the best that we can do at this time in order to minimize the time it will take to find a bed once her LPS Conservatorship is established.

For Administrative Status Awaiting Placement, List Non-Acute Residential Treatment Options:

Date of Contact	Facility Name	Facility Type	Aug/Non-Aug	Accepted/Rejected	Comments
08/25/2017	symmar health & Rehab	IMD		Rejected	no beds
08/25/2017	Crestwood Sacramento	IMD		Rejected	no beds
08/25/2017	Crestwood Wakersfield	IMD		Rejected	No Beds
08/25/2017	Crestwood San Jose	IMD		Rejected	No beds
08/25/2017	Merced	IMD		Rejected	No beds

Above listed facilities represent all possible appropriate placements. All less than five contacts are made, document reason above.
 Admin Day Waiver Request Form completed and forwarded to QCM.

Hold On- the AS Waiver- when do I need to complete one?

- ▶ If there are less than 5 appropriate placements available, SW must complete and submit a signed, dated AS Waiver to QCM and in the EHR. This waives the 5 otherwise required placement contacts.
- ▶ In ALL AS Waiver cases, there must be no less than one placement contacted per every 5 business days
- ▶ Documentation of contacts must include but is not limited to:
 - ▶ Why this is the appropriate placement for the patient
 - ▶ Name of placement, facility type, status of placement option, date of contact, signature of Social Worker making contact, any relevant comments
 - ▶ Document efforts to resolve issues preventing discharge (both patient related or placement avail ability related)

Looking at the AS Waiver...

Admission Date
8/3/17

Date Made AS
8/18/17

Level of Placement to be Contacted: CRT

Facilities to be Contacted Weekly: Anka

Please ensure documentation in chart is complete as to the reasoning for the level of care and appropriate placement options. Please submit a new waiver if there are changes to the discharge plan regarding level of placement.

Location	Augmented Board and Care	Residential Treatment	IMD	SNF	MHRC
Santa Barbara County	Mountain House McMillan Ranch Casa Juana Maria	Phoenix House ANKA Crisis Res Santa Maria ANKA Crisis Res Santa Barbara	None	None	None
Out of County	Nueva Vista-Morgan Hill Nueva Vista-Sacramento Cielo Vista-Greenfield Davis Guest Homes (5 houses)	Crestwood Bridge Program	Sierra Vista	Merced Behavioral Health Laywood Care	California Psychiatric Transitions Symanar Crestwood: Bakerfield, San Jose, Angwin, Vallejo, Solano, Redding, Stockton, Modesto, Freemont, Eureka,

Helpful Hints on AS from DHCS:

9

- ▶ Non-augmented or regular board and care facilities do NOT qualify as “residential treatment facilities.”
- ▶ “The status of the placement option” means a definite status—e.g., “patient accepted, bed will be available on September 2, 2010,” “patient accepted, is second on waiting list,” “patient rejected for admission.”
- ▶ Corporate entities which control multiple non-acute residential treatment facilities with one point of entry only count as ONE contact. An AS Waiver must be submitted waiving the required 5 contacts.
- ▶ QUESTIONS?