Executive Office of Health and Human Services Review of a Patient Encounter at Morton Hospital

July 18, 2016

INTRODUCTION:

In the wake of the tragic events that occurred in Taunton Massachusetts on May 10, 2016, the Executive Office of Health and Human Services (EOHHS) initiated a multiagency review of the patient's encounter at Morton Hospital. This report is a summary of the findings of the inquiries conducted by the Department of Public Health (DPH), the Department of Mental Health (DMH) and MassHealth. Attached to this summary document is a copy of the full DPH and DMH reports, with certain information de-identified or redacted to protect the privacy of patients and to comply with the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rules.

As a result of the inquiries, EOHHS found that the Emergency Services Program (ESP) worker complied with clinical procedures and there were no deviations from standard practice. The licensed clinician has more than 30 years of experience, the clinical evaluation was thorough and comprehensive and the disposition, which a Morton Hospital physician agreed with, was appropriate.

Following a review of 21 patient files by DPH, authorized by the Centers for Medicare and Medicaid Services (CMS), there were 20 deficiencies identified by DPH that Morton was required to address. The deficiencies included Morton's internal credentialing of ESP clinicians, fidelity to medical record-keeping practices and appropriate monitoring protocols over the behavioral health vendor. CMS and DPH took these deficiencies seriously and required Morton to submit a plan of correction or face losing federal reimbursement. Currently, all 20 deficiencies have been addressed.

ESP's are an integral part of MassHealth's behavioral health system. As a result of DPH's findings, MassHealth initiated a review of the 21 ESP providers across its statewide network. MassHealth is reviewing hospitals' internal credentialing policies and how ESPs are complying with those policies to ensure ESP clinicians are appropriately credentialed. MassHealth will conclude its review in August. MassHealth also looked at the licensing status of all clinicians statewide. Nine of the 10 clinicians who were on the Norton ESP team that covers Morton Hospital are licensed; the other clinician is under the direct supervision of a licensed clinician.

Based on the multiagency review, there is no evidence to suggest that inappropriate care was provided during the patient's encounter at Morton Hospital.

OVERVIEW OF ESP ENCOUNTERS IN THE EMERGENCY DEPARTMENT:

When an individual presents at a hospital emergency department (ED) with a potential serious behavioral health issue, the process and procedures for responding to that individual is generally as follows. Upon arrival at the hospital, the individual is assessed and is "medically cleared" by hospital medical staff to ensure that there is no urgent medical condition requiring attention before a behavioral health assessment can be conducted. Once the individual is medically cleared, if the individual is a MassHealth member, the ED notifies an Emergency Services Program (ESP) that the individual is ready to be assessed for a behavioral health concern. At the same time, the ED may offer treatment to attempt to stabilize the individual's behavioral health condition.

The ESP will provide a behavioral health clinician, who will report to the hospital, to conduct an evaluation of the individual. That evaluation will typically involve a review of available medical and psychiatric history and a psychiatric assessment of the individual. If at the conclusion of that evaluation, it is determined that the individual demonstrates a substantial and imminent risk of harm to self or others due to mental illness, and that he or she requires inpatient psychiatric hospitalization, the individual will be held in the emergency department until a psychiatric bed is secured and the individual is transferred to that hospital.[1] If it is determined that the individual does not demonstrate a substantial and imminent risk of harm to self or others due to mental illness, then the hospital may not involuntarily hold the individual.

For individuals who do not require inpatient hospitalization the ESP clinician will provide the individual with treatment options, which may include entering a partial hospitalization program or alternative outpatient program for continued treatment. It is up to the individual to follow-up on their discharge plan. The individual will then be discharged from the hospital.

MULTIAGENCY REVIEW OF AN INDIVIDUAL'S CARE:

While we cannot comment on the specifics of a case, it has been publicly reported that an individual presented at the Morton Hospital ED on May 9, 2016, was assessed by Morton Hospital ED staff and the Department of Mental Health (the Department) ESP and was discharged from the hospital. Approximately 12 hours after discharge, it is alleged that the individual stabbed several individuals before being killed by law enforcement.

Subsequently, between May 18 and May 23, the Department of Mental Health conducted an internal investigation to determine whether the processes followed were appropriate and consistent with the ESP Program, whether the psychiatric evaluation conducted by the ESP clinician was consistent with appropriate standards of care, and whether the clinician's determination and the disposition of the case were appropriate and consistent with the standard of care. In conducting the review and investigation, the Department included on the review team clinicians with substantial experience and expertise in appropriate ESP Program compliance and behavioral health evaluations.[2]

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[1] Section 12 of chapter 123 of the General Laws authorizes an individual to be admitted to a psychiatric unit for up to three business days against the individual's will or without the individual's consent.

[2] Final report attached, Appendix G.

On May 12, 2016, DPH's Bureau of Health Care Safety and Quality (BHCSQ) conducted an investigation of Morton's emergency department response related to the individual. The goal of the investigation was to review the care provided to the individual to determine if applicable regulations regarding patient assessment, patient care and discharge were followed.

Based on the findings of the initial BHCSQ investigation, on May 12, 2016, DPH reported its findings to the Centers for Medicare & Medicaid Services (CMS).[3] CMS authorized DPH to conduct a federal survey to ensure that Morton was complying with Medicare Conditions of Participation in accordance with the Social Security Act. [4] In conducting the survey, CMS authorized DPH to review 21 patient files. DPH conducted the survey between May 12 and May 23rd.

On May 18, 2016, CMS authorized DPH to conduct a separate Emergency Medical Treatment & Labor Act (EMTALA)[5] investigation. The EMTALA investigation concluded on the 23rd of May.

During the course of its investigation and survey, DPH interviewed Morton Hospital management and medical staff and interviewed the Norton ESP worker, reviewed patient records, including ambulance records, reviewed Morton contracts, hospital ED crisis team meeting minutes, board of director meeting minutes and governing board committee meeting minutes, reviewed all complaints received over the past 12 months against Morton and reviewed any pending plan review[6] requests.

CONCLUSIONS:

DMH Investigation of a patient's encounter with the ESP
After its investigation, DMH determined that:

- The individual was evaluated and stabilized consistent with established clinical procedures and standards;
- The ESP clinician who conducted the evaluation has over thirty years of clinical experience, specializes in dual diagnosis, trauma and Post Traumatic Stress Disorder, and is licensed as an independent clinical social worker (LICSW);
- There was no deviation from the standard process protocols and procedures in connection with this encounter;

[3] DPH is the state survey agency for Centers for Medicare and Medicaid Services.
[4] Specifically, DPH reviewed Morton's compliance with 42 CFR §§ 482.12 (Governing Body), 482.21 (Quality Assessment Process Improvement), 482.22 (Medical Staff), 482.24 (Medical Record Services) and 482.55 (Emergency Services).
[5] Federal EMTALA law requires emergency departments to stabilize and treat all patients, regardless of their insurance status or ability to pay.
[6] Plan review is the review of construction documents for new health care facilities, and additions and renovations to existing healthcare facilities prior to the start of the construction.

- The clinical evaluation was thorough and comprehensive and the disposition was appropriate; and
- There was no basis to involuntarily hold the individual beyond the stabilization and evaluation.

DPH Investigation related to Morton Hospital

Initial Review

The initial DPH investigation reviewed the care provided to the individual to determine if applicable regulations regarding patient assessment, patient care and discharge were followed. During the initial review, DPH was not able to determine from the patient's file what resources were provided to the patient upon discharge. Additionally, DPH was unable to locate certain documentation related to the patient. As a result of this finding, CMS authorized DPH to expand the scope of the review beyond the patient's file.[7]

Expanded Review of Morton's Patient Files

DPH reviewed 21 patient files and reviewed materials to determine whether Morton was complying with Medicare Conditions of Participation in accordance with the Social Security Act. Upon conclusion of the survey, DPH found that Morton Hospital was not in substantial compliance with the following Medicare conditions of participation: 42 CFR § 482.12 (Governing Body), 42 CFR § 482.21 (Quality Assessment Process Improvement), 42 CFR §482.22 (Medical Staff), 42 CFR §482.24 (Medical Record Services) and 42 CFR §482.55 (Emergency Services). In total DPH identified sixteen separate deficiencies. The final report indicating the sixteen deficiencies was provided to Morton and sent to CMS.[8]

The main reason that Morton was found not to be in substantial compliance with 42 CFR §482.12 (Governing Body) and 42 CFR § 482.21 (Quality Assessment Process Improvement) is that it did not credential the behavioral health service vendor staff that provide behavioral health services in the Emergency Department. Moreover, Morton did not ensure that the emergency services provided by the behavioral health services vendor met quality and performance standards and did not conduct a quality assessment and performance evaluation on the services provided by the vendor. As a result, the vendor-provided services were not integrated in their Hospital's quality improvement activities. Additionally, Morton did not develop, implement and monitor a quality assessment and performance improvement program to address any identified opportunities to improve the vendor's services.

Morton was found not to be in substantial compliance with 42 CFR §482.22 (Medical Staff) because Morton did not credential the behavioral health service vendor staff but permitted vendor staff to have privileges. Morton also did not ensure that periodic appraisals of vendor staff were conducted.

Morton was found not to be in substantial compliance with 42 CFR §482.24 (Medical Record Services) because it did not ensure that entries in the medical records were complete and

[7] DPH reviewed 21 patient files to determine Morton's compliance with: 42 CFR §§ 482.12 (Governing Body), 482.21 (Quality Assessment Process Improvement), 482.22 (Medical Staff), 482.24 (Medical Record Services) and 482.55 (Emergency Services); and EMTALA.

[8] Final report attached, Appendix A

accurate and did not ensure that the behavioral health services vendor staff followed the hospital's procedures on medical record confidentiality.

Morton was found not to be in substantial compliance with 42 CFR §482.55 (Emergency Services) because Morton did not confirm the qualifications of the behavioral health services vendor's personnel. Morton also did not ensure that all discharge information related to aftercare instructions were given to the patients at the time of discharge.

EMTALA Review

Upon conclusion of the survey, DPH determined that there were four deficiencies.[9] A review of patients' records indicated that Morton did not document that appropriate medical records from the medical screening examination were sent to the receiving hospital when a patient was recommended for transfer. Morton did not ensure that ED physicians documented in the patient's medical record whether or not the patients' emergency medical condition was stabilized at the time of transfer. Morton did not ensure that behavioral health services vendor practitioners performed medical screening examinations only after they were determined to be qualified by the Hospital bylaws and rules and regulations. Morton did not ensure that the physician on-call list listed physician names consistent with hospital policy.

CORRECTIVE ACTION:

16 Deficiencies under 42 CFR §§ 482.12, 482.21, 482.22, 482.24, 482.55

On June 7, 2016, CMS issued a letter[10] to Morton indicating that it was not in substantial compliance with Medicare Conditions of Participation and its deemed status had been removed and survey jurisdiction had been transferred to the State Survey Agency (DPH). Furthermore, Morton was informed that a plan of correction needed to be submitted by June 17. If a plan of correction was timely submitted, then Morton would be revisited to verify necessary corrections. If corrections were not made, then Morton's agreement with Medicare would terminate on September 5, 2016.

On June 21, 2016, Morton submitted its plan of correction[11] to address the sixteen deficiencies. As part of its plan of correction Morton indicated that:

- In accordance with Morton Hospital's bylaws, only credentialed[12] providers will be permitted to evaluate patients in the Morton Hospital ED.
- Morton is in the process of executing a new affiliation agreement with the behavioral health services vendor, reflecting the requirement of credentialing and ongoing performance assessment.
- ESP clinical performance will be monitored, including timeliness. Should any performance issues arise, they will be addressed through identified review policies.

[9] Final report attached, Appendix B
[10] June 7, 2016 letter from CMS attached, Appendix C
[11] Plan of correction attached, Appendix A
[12] Morton's Hospital Staff Bylaws, require that Licensed Independent Certified Social Workers (LICSW) must be credentialed under the category of Allied Health Professionals. Credentialing is an internal Morton process, which is used to confirm that medical staff, including LICSWs, are licensed. During this process medical staff are provided a copy of corporate compliance and privacy policies as well as the code of conduct. CMS requires Morton to follow its bylaws.

- ESP quality data will be reviewed monthly by Morton. Data will be submitted semi-annually to Morton's Quality Council and the Patient Care Assessment and Quality Committee (PCAC).
- The following reeducation training occurred:
    - ED providers on the use of Script Rx, an electronic discharge plan documentation system. Providers were instructed not to save specific patient information in a template form;
    - ED staff on Section 12 forms[13] and the requirement that the form be placed in the medical record upon completion;
    - ED nursing staff on the requirement for complete and accurate documentation;
    - ED physician and nursing staff on the requirement of a physician order for each restraint episode;
    - ED physician and nursing staff regarding EMTALA training about patient rights, medical screening and required documentation.
- All ED physicians received notification regarding the requirement for documentation of medical clearance prior to a psychiatric evaluation.
- Going forward the nurse discharging the patient will communicate with the behavioral health provider and/or the patient to ensure the patient has received his/her discharge instructions.
- The Chief of Emergency Services and the Patient Care Director of the ED will audit a minimum of 10 medical records per week for four months or until 100% compliance is achieved.

On July 6, 2016 DPH revisited Morton to verify necessary corrections. DPH determined that all 16 deficiencies were corrected. A formal notification was provided to Morton on July 13, 2016.

On July 14, 2016 CMS issued a letter[14] to Morton Hospital indicating that subsequent to DPH's revisit survey CMS determined that the hospital was in compliance with the Medicare Conditions of Participation for Hospitals and all 16 deficiencies were corrected. Accordingly the planned termination from the Medicare program was rescinded and the hospital was returned to deemed status.

EMTALA Review

On June 21, 2016, CMS issued a letter[15] to Morton indicating that Morton had violated EMTALA, along with its implementing regulations found at 42 CFR §§489.20 and 489.24. Furthermore, Morton was informed that a plan of correction needed to be submitted by July 6. If a plan of correction was timely submitted, then Morton would be revisited to verify necessary corrections. If corrections were not made, then Morton's agreement with Medicare would terminate on September 19, 2016.

[13] Forms that are used to indicate that a patient is being held pursuant to section 12 of chapter 123 of the General Laws.
[14] CMS letter attached, Appendix D
[15] June 21, 2016 letter from CMS attached, Appendix E

On June 28, 2016 Morton submitted its plan of correction[16] to address the four deficiencies. As part of its plan of correction Morton indicated that:

- The on call schedule was revised and redistributed to the ED on June 27, and now complies with federal regulations.
- In accordance with Morton Hospital's bylaws, only credentialed[17] providers will be permitted to evaluate patients in the Morton Hospital ED.
- Morton is in the process of executing a new affiliation agreement with the behavioral health services vendor, reflecting the requirement of credentialing and ongoing performance assessment.
- All staff completed EMTALA training and training regarding required elements of transfer documentation.
- The Chief of Emergency Services and the Patient Care Director of the ED will audit a minimum of 10 medical records per week for four months or until 100% compliance is achieved.
- ED staff was retrained about the requirement for complete and accurate documentation.

On July 6, 2016 DPH revisited Morton to verify necessary corrections. DPH determined that all 4 deficiencies were corrected.

On July 14, 2016 CMS issued a letter[18] to Morton Hospital indicating that the hospital's plan of correction for the EMTALA deficiency was found acceptable and all four deficiencies were corrected.

OTHER STATE ACTION:

The Emergency Services Program provides crisis behavioral health services 24 hours per day, seven days per week, 365 days per year (24/7/365) to MassHealth members who are experiencing a behavioral health crisis. This service includes crisis screening, short-term crisis counseling, crisis stabilization and medication evaluation. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows an individual to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care.

There are 21 emergency service programs throughout the Commonwealth; 4 of which are operated by the Department of Mental Health, the remaining programs are operated by private healthcare providers under contracts managed by Massachusetts Behavioral Health Partnership (MBHP) on behalf of MassHealth. Collectively, these programs serve 63 emergency departments throughout the Commonwealth.

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[16] Plan of correction attached, Appendix B

[17] Morton's Hospital Staff Bylaws, require that Licensed Independent Certified Social Workers (LICSW) must be credentialed under the category of Allied Health Professionals. Credentialing is an internal Morton process, which is used to confirm that medical staff, including LICSWs, are licensed. During this process medical staff are provided a copy of corporate compliance and privacy policies as well as the code of conduct. CMS requires Morton to follow its bylaws.

[18] CMS letter attached, Appendix F

As a result of this multiagency review MassHealth, in coordination with MBHP is reviewing all agreements in place between each ESP and each emergency department to ensure that the agreement conforms to the hospital's internal policies about credentialing of medical staff. This review will be completed in August, 2016. MassHealth has also reviewed each ESP to ensure all clinicians are either licensed or under the direct supervision of a licensed clinician. Pursuant to the review, MassHealth determined 90% of all clinicians in the Norton ESP are licensed; 68% of all ESP clinicians statewide are licensed; and the remaining 32% are under the direct supervision of a licensed clinician. MassHealth is coordinating with Morton to ensure that ESP clinicians, who may respond to Morton Hospital, are appropriately credentialed by them. Currently, all ESP clinicians who may be called upon to respond to Morton have submitted their credentialing information to Morton for review.