ADMISSION TO LAGUNA HONDA ACUTE AND SNF SERVICES AND RELOCATION BETWEEN LAGUNA HONDA SNF UNITS

POLICY:

Prospective residents are welcome to Laguna Honda Hospital and Rehabilitation Center (LHH) regardless of race, color, creed, religion, national origin, ancestry, gender, sexual orientation, disability, HIV status or related condition, marital status, political affiliation, or age over 16. LHH shall comply with California and federal laws pertaining to non-discrimination.

1. LHH shall accept and care for those San Francisco residents:

   a. Who meet skilled nursing facility (SNF), SNF rehabilitation, acute medical or acute rehabilitation inpatient rehabilitation facility (IRF) care criteria;

   b. For whom it can provide safe and adequate care; and/or

   c. Who are at least 16 years of age.

2. Applicants for admission to LHH shall be screened prior to any admission.

3. LHH shall assess the physical, mental, social and emotional needs of new and current residents to determine whether ~~each resident's~~Laguna Honda Hospital's care environment is best able to meet these needs.

4. LHH shall accept pre-scheduled admissions of new and returning patients Monday through Friday.

5. LHH shall accept residents to the first available SNF bed appropriate to meet their clinical care needs when they have lost their bed hold.

6. New and returning patients ~~from Zuckerberg San Francisco General Hospital (ZSFG)~~ may ~~also~~ be admitted on Sundays if pre-arranged on Friday. ~~Returning patients from UCSF may also be readmitted on Sundays if pre-arranged on Friday.~~

7. LHH shall centrally coordinate resident relocations to:

   a. Optimize utilization of resources;

   b. Optimize bed availability for new admissions; and

   c. Minimize the potential for adverse impact on the resident.

8. LHH shall notify residents and their surrogate decision-makers of plans for relocation within the facility.

9. In case of emergency and/or medical surge conditions:

    a. Physician may temporarily admit a patient to an in-patient acute care or skilled nursing facility bed.

    b. The patient's stay shall be documented according to established procedures (i.e.: Inpatient, Acute, SNF and/or Outpatient Clinic/Rehab).

PURPOSE:

1. To assure that all San Francisco residents in need of skilled nursing, acute or rehabilitation services who are admitted to LHH receive care in the most appropriate service setting.

2. To allocate services in coordination with available hospital resources.

3. To provide a standard procedure for relocation of residents within the facility.

DEFINITIONS:

1. A&E means Admissions and Eligibility Department.

2. Bed hold means a bed shall be held for a specific resident discharged to an acute unit or facility. A bed may be held up to seven (7) days, with the date of discharge being day 1. A bed hold may not be placed on LHH acute unit beds.

3. PFC means Patient Flow Coordinator.

4. RCT means Resident Care Team.

PROCEDURE:

1. **Admissibility and Screening Procedures**

    a. In accordance with Section 115.1 of the San Francisco Health Code, admission priority to LHH shall be given to residents of San Francisco. Exceptions may be made by the LHH Chief Executive Officer (CEO) or designee based on special clinical or humanitarian circumstances. Non-San Francisco residents will be reviewed periodically, if appropriate, for return to services in their county of origin.

    b. The LHH Chief Medical Officer (CMO) or designee shall be responsible for screening patients for admission to LHH to ensure that the facility admits only those patients for whom it can provide adequate care. The LHH CMO is the ultimate authority over admissions. The following sequential priority will be followed unless the LHH CMO or designee in his/her professional judgment, based on risk

assessment and the totality of circumstances consistent with the patient's best interest determines otherwise.

c. LHH cannot adequately care for prospective residents with the following:

i. Communicable diseases for which isolation rooms are unavailable

ii. In police custody unless approved by CMO, CEO, Chief Nursing Officer (CNO) or designees.

iii. Ventilator

iv. Medical problem requiring Intensive Care Unit care

v. Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care

vi. Highly restrictive restraints

vii. Significant likelihood of unmanageable behavior endangering the safety or health of another resident, such as:

- Actively suicidal
- Violent or assaultive behavior
- Criminal behavior including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia
- Sexual predation
- Elopement or wandering not confinable with available elopement protections
- Applicants who will not sign the Laguna Honda House Rules and Responsibilities

d. People are accepted to LHH who are confirmed residents of San Francisco ~~and~~ and in need of skilled nursing and/or rehabilitation services based on ~~with~~ the following priority guidelines:

i. 1st Priority:
Residents who were involuntarily transferred and meet the criteria for care at LHH will be considered new admissions and given first priority when we begin to evaluate new admission requests based on LHH's admission criteria

~~ii. 1st~~ 2nd Priority:

ii.

Persons not in a medical facility, as well as persons who are wards of the Public Guardian or clients of Adult Protective Services, who cannot receive adequate care in the present circumstances. Persons not in a medical facility (e.g. home) who are currently receiving skilled nursing and/or rehabilitation services -(e.g. home care for wounds) and are now in need of skilled nursing / rehabilitation care in a facility. or in need of this care initiation

iii. 3rd 2nd Priority:
Patients at ZSFGa San Francisco Health Network facility who need skilled nursing and/or rehabilitation services ready for discharge to SNF level of care.

iv. 3rd 4th Priority:
Persons not in a medical facility who are receiving skilled nursing and/or rehabilitation services adequate care in their present circumstances.

v. 4th 54th 3rd Priority:
v.
Patients at other non-San Francisco Health Network San Francisco medical facilities who requires skilled nursing and/or rehabilitation services.

vi. 5th Priority:
Patients who are San Francisco residents presently in a medical facility or private circumstance outside of San Francisco.

b. LHH cannot adequately care for prospective residents with the following:

i. Communicable diseases for which isolation rooms are unavailable

ii. In police custody unless approved by CMO, CEO, Chief Nursing Officer (CNO) or designees.

iii. Ventilator

iv. Medical problem requiring Intensive Care Unit care

v. Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care

vi. Highly restrictive restraints

vii. Significant likelihood of unmanageable behavior endangering the safety or health of another resident, such as:

- Actively suicidal

- ~~Violent or assaultive behavior~~
- ~~Criminal behavior including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia~~
- ~~Sexual predation~~
- ~~Elopement or wandering not confinable with available elopement protections~~
- ~~Applicants who will not sign the Laguna Honda House Rules and Responsibilities~~

~~c.~~e. Screening of applicants:

i. The Screening Committee which includes the following: CMO or designee, CNO or designee, Admissions Coordinator, Patient Flow Coordinator and other members as designated by the CEO, is responsible for screening referrals to LHH and accepting residents for admission.

ii. Patient/Resident referrals to the specialty units (Rehabilitation, Positive Care, and Palliative Care) will be screened and accepted by the unit screening physician or screener.

iii. When an immediate decision is needed outside the regularly scheduled meeting times of the Screening Committee, the CMO or designee, and the CNO or designee will screen and approve resident referrals.

iv. The Screening Committee and/or the LHH Specialty Unit will request behavioral screening of potential admissions that have behavioral or psychiatric problems and/or history of substance misuse.

~~d.~~f. Admission of applicants:

i. LHH shall admit a patient only on a LHH Admitting Physician's order.

ii. With the exception of admission to acute care units (Acute Rehab and Acute Medical), all admissions must meet SNF-level criteria as defined by Title 22.

iii. Decisions about admitting a resident in a setting that restricts his/her movements at LHH must be made in accordance with each resident's individual needs and preferences and with the participation of the resident or surrogate in the placement decision and continuing care planning. [1]Residents lacking

[1] If stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired then placement in the unit is not

capacity for placement decisions may not have their movements restricted on a secure unit without the participation of a surrogate or conservator.

iv. In all cases of admission from another facility, a physician to physician clinical hand off and a dictated discharge summary is required.

~~e.~~g. Resolution of problem screening and admissions:

i. Problems shall be brought to the LHH CMO and LHH CEO for resolution.

ii. The LHH CEO shall have the final authority over admissions to LHH.

~~f.~~h. The LHH CEO shall serve as the LHH's review board in regard to any perceived discriminatory admission practices. Allegations from staff, patients, families, or others of perceived discriminatory admission practices shall be forwarded to this Committee for investigation and review.

2. Specific Admission Procedures

a. Pre-Admission Procedures

i. The Conditions of Admission agreement shall state that all residents are assessed upon admission for appropriate placement and/or relocation within the facility.

ii. Residents (or their representatives) shall receive a copy of the Conditions of Admission agreement upon admission to the LHH. The Conditions of Admission agreement shall be reviewed and signed by the resident or the resident's surrogate decision-maker.

iii. Residents (or their representatives) shall receive a copy of the Laguna Honda House Rules and Responsibilities. As a condition of admission, the resident or resident's surrogate decision-maker must agree to these conditions by signing these agreements prior to admission.

iv. The Screening Committee shall make placement decisions based on the identified physical, mental, social and emotional needs of the resident; family connection with staff, if any; and bed availability. The Screening Committee shall communicate with the nursing unit and the RCT, including the primary physician and nurse manager admitting the new resident.

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considered involuntary seclusion, as long as care and services are provided in accordance with each residents' individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident's needs and preferences." CMS Guidance To Surveyors, LTC Facilities/State Operating Manual F223(b).

v. Referral sources may discuss the appropriateness of referrals with staff of admitting units, but no final admission decision can be made until the Admissions Coordinator has evaluated the referral packet.

vi. The specialty unit RCTs may place and take care of residents on other units, e.g., in isolation rooms or in other satellite beds.

b. Acute Medical Unit

Policies Specific to Acute Medical Unit Neighborhood

i. Only acutely ill LHH residents for whom appropriate medical care is available are admitted. Residents requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on the Acute Medical Unit.

ii. All admissions to the Acute Medical Unit are subject to ongoing utilization review as outlined in the Utilization Management Plan.

iii. SNF residents who require blood transfusions, but who are not acutely ill, shall be provided care on the Acute Medical Unit as "come and go" cases.

iv. SNF residents who are not acutely ill but require close monitoring while receiving a subcutaneous or intravenous medication, and for the post treatment period, shall be provided for in the Acute Medical Unit as a "come and go" case, after approval by the CMO.

Procedures Specific to the Acute Medical Unit

i. All residents admitted to the Acute Medical Unit, except those residents admitted on a "come and go" basis, shall have a separate complete medical record covering the period of their acute hospitalization

ii. ~~.~~ Residents being evaluated for admission to LHHs Acute Medical unit with suspicion of COVID-19 will have a minimum of one negative antigen test within 24 hours of transfer. If resident acuity is unstable and a testing delay would impact care, the resident will be transferred to a facility outside LHH, if within goals of care. Residents with a positive COVID-19 test will be transferred to a facility outside LHH unless they have an advance directive requesting that care be provided only at LHH. Decisions to admit/transfer will be a joint discussion between the resident, their family, and the attending physician.

~~i.~~ iii. Whenever a resident is admitted to the Acute Medical Unit from either a LHH SNF care unit or from the Rehabilitation Department, she/he is discharged from

the previous care unit and resident's medical record is closed, except in those cases where residents "come and go" for transfusion.

~~ii.~~iv. A new SNF resident record shall be started upon the resident's re-admission to a SNF care unit.

c. Acute and SNF Rehabilitation Care Units

Admission Criteria Specific to Acute and SNF Rehabilitation Care Units

i. Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an intensive interdisciplinary approach to effectively improve functional status.

ii. Patient must be medically stable.

iii. Patient requires rehabilitation physician management.

iv. Patient requires the availability or supervision of rehabilitation nursing 24 hours daily in one or more of the following:

- Training in bowel and bladder management
- Training in self-care
- Training or instruction in safety precautions
- Cognitive function training
- Behavioral modification and management
- Training in communication

Admission Criteria Specific to Acute Rehabilitation Unit

i. The LHH Pavilion Mezzanine Acute Rehabilitation Unit is designated as an Inpatient Rehabilitation Facility (IRF).

ii. Patients must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:

- Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation.
- 24 hour availability of nurses skilled in rehabilitation.

- Active and ongoing intensive rehabilitation therapy program by multiple other licensed rehabilitation professionals (e.g., physical therapists, occupational therapists, speech language pathologists, and prosthetists and orthotists) in a time-intensive and medically-coordinated program. One of the therapy disciplines shall be physical or occupational therapy.

iii. The medical and/or surgical stability and comorbidities of patients admitted to the unit must be:

- Manageable in the rehabilitation program
- Permit participation in the rehabilitation program

iv. Patients must be capable of fully participating in the patient rehabilitation program as evidenced by:

- Ability to respond to verbal, visual and/or tactile stimuli and to follow commands.
- Ability to participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day, 5 days per week).

v. Patients must demonstrate the ability to progress towards objective and measurable functional goals that:

- Will offer practical and beneficial improvements.
- Are expected to be achieved within a reasonable period of time.

vi. Patients must require and intensive and coordinated interdisciplinary team approach to care.

vii. Patients in most circumstances, has a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

<u>Admission Criteria Specific to SNF Rehabilitation Unit</u>

i. Rehabilitation needs shall include at least one of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or other medical problems best addressed on the SNF-level Rehabilitation Unit.

ii. Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

iii. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a long term care unit.

Admission Procedures Specific to Acute Rehabilitation Unit

i. A physiatrist or designee shall perform pre-admission screening (PAS) to assess the patient's ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services. Pre-screening performed by a non-physiatrist must have a physiatrist co-sign that the patient meets the requirements for acute rehab (IRF) admission.

ii. A new SNF record shall be started if the patient is discharged to a LHH SNF Care Unit.

iii. Refer to Guidelines for Inpatient Rehabilitation Facility Documentation LHHPP 27- 06.

Admission Procedures specific to SNF Rehabilitation Unit

i. The Chief of Rehabilitation Services or designee shall perform PAS to assess the patient's ability to achieve significant improvement in a reasonable period of time with rehabilitation services.

d. Positive Care Unit

Admission Criteria Specific to the Positive Care Unit

i. Patients who have HIV infection and require SNF level or palliative care and prefer an HIV / AIDS focused unit.

e. Palliative Care Unit

Admission Criteria Specific to Palliative Care Unit

i. Patients who have a terminal disease or would benefit from a palliative approach.

f. Secure Memory Care Unit

Policies Specific to Secure Memory Care Unit

i. The goals of the Secure Memory Care Unit are:

- To promote the well-being and protect the health and safety of cognitively-impaired residents who might harm themselves by wandering or elopement; and

- To meet the needs of cognitively-impaired residents with a stable and structured environment and specialized dementia programming while minimizing the use of individual restraints.

Admission Criteria Specific to Secure Memory Care Unit

i. Residents who are mobile;

ii. Residents assessed by a physician as having serious cognitive impairment which prevents the resident from making medical decisions for him/herself;

iii. Residents assessed by clinical staff as being at risk for unsafe wandering or elopement; and

iv. Resident who has a conservator or surrogate decision maker that agrees to placement of the resident in a secured setting, or who is a ZSFG patient or LHH resident with a conservatorship proceeding pending and the intended conservator does not disagree with placement of the resident in a secured setting.

v. The requirements above do not preclude LHH from placing a resident in the memory care unit on an emergency basis to ensure the resident's safety but the placement must be authorized by the CMO.

Exclusion Criteria Specific to Secure Memory Care Unit

i. Residents whose aggressive behavior cannot be safely managed in this setting.

ii. Residents without surrogate or conservator.

Procedures Specific to Secure Memory Care Unit

i. The Admissions Coordinator and Screening Committee personnel will coordinate admission in collaboration with the Secure Memory Care Neighborhood RCT.

ii. On admission the attending physician will coordinate an interdisciplinary assessment including cognitive and/or behavioral consultation.

iii. The RCT shall reevaluate residents for unit appropriateness one month after admission, then quarterly. The RCT shall explore interventions that may reduce

the wandering/elopement risk and permit relocation to another unit. For cognitively incapacitated residents whose movements throughout the facility are restricted, the RCT shall document participation of the conservator or surrogate decision-maker in placement decision-making and care planning.

iv. A resident of the LHH Secure Memory Care Unit shall be relocated as soon as practicably feasible to other LHH units or transferred to another facility or the community if the resident's status changes such that the resident is no longer mobile, the resident's cognitive status improves such that secured placement no longer is needed; or the resident's cognitive impairment is discovered to be caused primarily by a psychiatric rather than organic brain disorder.

v. Permissible Exception: If a resident ceases wandering but demonstrates or expresses preferential adaptation to the unit and benefits from the specialized programming, continued residence in the unit may be allowed at the discretion of the physician and RCT. To ensure availability of Secure Memory Care Unit beds when needed, attempts shall be made to adapt such a resident to another unit.

3. Sunday Admissions

a. From ZSFG

i. LHH primary physician shall refer the ZSFG team to LHH A&E once the patient is accepted.

ii. Pre-scheduled admissions shall be accepted for Palliative Care, Positive Care, General SNF, SNF and Acute Rehab (IRF) patients on Sundays.

iii. Sunday admissions from ZSFG must be approved by the LHH admissions Screening Committee, and accepted by the primary LHH team (including primary physician) by the Friday afternoon preceding admission.

iv. LHH A&E shall inform ZSFG (UM and MSW) via LHH tracking and text page by 3pm on Friday of admissions scheduled for Sunday. LHH A&E shall inform ZSFG MSW of LHH primary physician's pager number.

v. Approval by LHH weekend admitting physician is not required for admission.

vi. LHH A&E shall complete the admission referral sheet and deliver this along with the referral packet to the unit scheduled to receive the weekend admission by Friday afternoon.

vii. LHH primary physician shall receive clinical hand off from ZSFG physician by the Friday preceding the weekend admission, and a discharge summary must be available at the time of admission.

viii. LHH nursing shall receive report from ZSFG nursing on the day of transfer.

ix. LHH A&E shall remind ZSFG MSW to arrange ambulance transport to leave ZSFG no later than 11 am.

x. Admissions are scheduled to arrive to LHH early in the day and no later than 12 noon.

~~b. From UCSF~~

~~i. Only pre-scheduled readmissions are accepted, under the conditions and processes stated above in section 3.a.ii.~~

4. Procedures Related to Coming and Going from the Hospital

a. Return of current residents after come-and-go procedures at other acute facilities.

i. Before return of a LHH resident who has been referred to another facility for come-and-go surgery or other invasive medical care, the physician responsible for the resident at the other facility must provide a summary of information on the procedure that includes:

- Procedures done
- Complications, if any, both intra- and postoperative
- New orders recommended for the first 24 hours at LHH
- Recommendations for special studies and follow-up care

ii. A checklist reminding the responsible physician of the need for this information shall be sent with the resident from LHH to the other facility. The physician responsible for the resident at that facility may complete either the checklist or another form from their facility that provides the same information.

iii. If a resident is returned from another facility after come-and-go surgery or other medically invasive procedure without recommendations for follow-up care, the Laguna Hospital attending physician shall contact the physician responsible for the resident at the other facility and shall document the information in the medical record. If the regular unit attending physician is not present when the resident returns, the charge nurse will contact the on-call physician to carry out this policy.

5. Relocation of Current Resident From One SNF Unit to Another SNF Unit

a. Relocation Guidelines

i. Nurse Manager will explain process. Upon admission to a resident care unit, the nurse manager shall be responsible for explaining to the resident or surrogate decision maker (SDM) the process by which the RCT assesses the resident for the purpose of appropriate placement.

ii. Decision criteria. Criteria for determining the appropriate unit shall be based on an assessment of the resident's needs and knowledge of services available, including knowledge of available shift staffing and skills within the respective care units. Decisions regarding resident relocation between units shall be made by the PFC in collaboration with the CMO or designee and CNO or designee and the respective referring and receiving resident care teams of the neighborhoods.

iii. Relocation requests. Requests for relocation to another unit by the resident, surrogate, or RCT shall be evaluated by the PFC who facilitates the decision-making process.

iv. Relocation. In the event that a resident is to be relocated involuntarily in order to better match the resident's needs with unit focus and resources, the nurse manager shall give the resident or representative notice in advance of relocation. This shall be documented by completing the Transfer of Room Notification form, which includes:

- Reasons for the relocation;
- Date the relocation will occur;
- The care unit to which the resident will be relocated; and

The RCT shall take into consideration the resident's response in deciding whether to continue with the relocation. This discussion must be documented in the medical record. In a contested relocation the medical social worker shall notify the ombudsman.

v. Problem resolution. Prior to making a relocation referral to the PFC for a reason other than a change in level of care, the RCT shall utilize resources at its disposal to resolve the problem, address the concern, or meet the need behind the referral.

vi. Re-evaluation of problematic relocations. RCTs shall re-evaluate complex or problematic relocations and roommate assignments at least one month after the relocation.

vii. Appeal route for conflict intervention. Conflicts about relocation process shall be referred to the CNO and CMO for joint resolution.

viii. Neighborhood moves. When large scale, permanent or temporary care unit moves are anticipated, the details of the move, such as how and when residents and families shall be informed, must be worked out in advance by the RCT.

b. Relocation Procedures

i. All relocation requests, including plans for relocation to and from specialty units which accept direct admission from the community, shall be routed through the designated PFC. For relocations to specialty units, the PFC shall communicate with the unit RCT and A&E.

ii. The resident and appropriate family/surrogate decision maker(s) shall be notified when the relocation is being planned and be informed of the reason and the estimated waiting period, if known. They shall be offered an opportunity to visit the new location, if possible.

iii. The sending unit nurse manager shall communicate with the receiving unit nurse manager prior to relocation and the sending physician shall communicate with the receiving unit physician, if possible, at least one day in advance of the relocation.

iv. Once an appropriate bed becomes available, the PFC shall confirm relocation plans and confirm that the sending and receiving care units are notified.

v. A physician's order is required for the relocation.

vi. To promote continuity in care, the sending physician shall document in the medical record, a relocation note.

vii. The receiving RCT shall review the existing treatment plans initiated by the previous team, and review the plan and all changes with the resident.

viii. Each discipline shall take appropriate measures to assure continuity of care.

ix. Ancillary Service departments, who receive the Daily Census report, shall make this information available to clinical staff on a daily basis so that caregivers can track resident transfers and readmissions.

ATTACHMENT:
Appendix A: Relocation Checklist for Individual Resident
Appendix B: Behavioral Screening
Appendix C: LHH Palliative Care Program

REFERENCE:
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-03 Resident Rights
LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)Development & Implementation of an Interdisciplinary Resident Care Plan
LHHPP 24-06 Resident and Visitor Complaints/GrievancesResident Suggestions and Complaints
Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual
Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual

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Original adoption: This is a consolidation of 12 previous policies

PAYOR ELIGIBILITY, CERTIFICATION AND COVERAGE

POLICY:

Utilization Management (UM) Nurse shall conduct admission ~~and/readmission~~and readmission reviews for patients/residents who are admitted to the Acute Medical Unit, Acute Rehab Unit, or a Skilled Nursing (SNF) Unit based on primary payor sources.

PURPOSE:

Admission and ~~/~~readmission reviews shall be conducted by the UM Nurse following the criteria set by the primary payor sources. Patients/residents who meet the eligibility requirements of Medicare Part A care shall be covered under Medicare Part A benefits.

PROCEDURE:

1. Provision of Medicare Rights Form

a. All Medicare recipients upon admission or re-admission to SNF or Acute Rehab or Acute Medical must sign the Medicare Rights form. The financial counselor shall meet with the patient/resident and review the Medicare Rights form and secure a signature from the patient/resident or responsible party. All Medicare recipients upon final discharge must receive a copy of their original signed Medicare Rights form. If a patient/resident from SNF or Acute Rehab or Acute Medical discharges before a copy can be given, a copy shall be mailed to patient/resident.

2. Determination of Primary Payor, Level of Care, Certification and Coverage

a. The UM Nurse shall review the patient's/resident's face sheet.

i. If the patient's/resident's face sheet indicates that the patient/resident has Medicare Part A, go to Procedure A.

ii. If the patient's/resident's face sheet indicates Medi-Cal fee-for-service (FFS), go to Procedure B.

iii. If the patient's/resident's face sheet indicates SFHP-CHN, go to Procedure C.

iv. If the patient's/resident's face sheet indicates SFHP-UCSF, go to Procedure D.

v. If the patient's/resident's face sheet indicates Anthem Blue Cross Medi-Cal Managed Care, go to Procedure E.

vi. For other payor sources, go to Procedure F.

b. UM Nurse completes the Utilization Review (UR) Daily Analysis form to identify sequence of payor sources (refer to Appendix L8).

3. Procedure A – Medicare Part A Coverage

a. The UM Nurse confirms from the Medicare contracted vendor that the patient/resident:

i. has Part A Medicare eligibility,

ii. is not currently enrolled in a Medicare Advantage Plan, or HMO Plan, and

iii. has not exhausted his/her Medicare Acute Care or SNF benefits.

b. Acute Medical Unit

i. The Acute Care Admitting Physician enters the order of Admit to Inpatient in EHR. After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification.

ii. The UM Nurse tracks the patient admitted to PMA acute. ~~enters the patient information in the log of PMA Admission and updates log as needed (refer to Appendix L4).~~ The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria.

iii. If the patient's admission does not meet the InterQual Adult Acute Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. If the Physician concurs the patient's admission was not medically necessary, the UM Nurse issues the Preadmission or Admission Hospital-Issued Notice of Noncoverage on the day of admission (refer to Appendix A2). The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

iv. If the patient's stay meets criteria, the UM Nurse shall conduct the following procedures:

- Enter acute care reviews (Admission, Continued Stay) using InterQual Adult Acute Level of Care Criteria in EHR.
- Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.

v. When the patient does not meet InterQual Adult Acute Level of Care Criteria for continued stay, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

vi. The UM Nurse shall refer the case to the UM Committee Chair or Physician advisor as needed. If the UM Chair or Physician advisor concurs the patient needs to be discharged, the UM Nurse shall issue the Hospital-Issued Notice of Noncoverage Noncovered Continued Stay (refer to Appendix A3).

c. Acute Rehab Unit

The UM Nurse sends a notification on the day of admission or as soon as possible and after patient discharge to Resident Assessment Instrument-Minimum Data Set (RAI-MDS), A & E, Billing, Pharmacy, Rehabilitation, PM Acute Rehab Team, MSW, staff responsible for completing Hudman Bed Call list, and other staff involved to complete the Patient Assessment Instrument (PAI).

~~i.~~

The Hudman Calls are based on the Hudman v. Kizer court order applies to all eligible Medi-Cal recipients and Managed Care Plan member in need of long term skilled nursing care. The Distinct Part/Nursing Facilities (DP/NF) shall be reimbursed at the DP/NF rate when the medical necessity for long term nursing care has been documented and all adminitrative requirements have been met based on the Department of Health Care Services (DHCS) Long Term Care manual.

The RAI-MDS is a tool for implementing standardized assessment and for facilitating care management in nursing homes. It is also a core set of screening, clinical and functional status data elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents.

The RAI specialist will ~~Charge Nurse (CN)/designee~~ complete~~s~~ the PAI with input from other staff
and transmit the information.~~notifies RAI Specialist/designee when PAI is ready for transmission~~. RAI Specialist or designee notifies UM, Billing, CN/NM/designee when PAI was transmitted. Status of PAI is reviewed during Triple Check meeting.

During an Interrupted Stay (patient was discharged to the acute hospital for an acute medical intervention and is readmitted to the same Acute Rehab Unit prior to the third consecutive midnight after discharge from Acute Rehab Unit), the previous PAI prior to the discharge shall be continued.

~~ii.~~i. The UM Nurse ~~enters patient information in the log of PMR Admission and updates as needed (refer to Appendix L5).~~tracks the admission of the acute rehab patient to Pavilion Medical Rehab (PMR).~~-~~The UM nurse will use use the ~~of~~ InterQual Adult Acute Rehab Level of Care Criteria. ~~started for admissions~~

beginning 02/01/19. If the patient's admission does not meet InterQual Adult Acute Rehab level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

ii. The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, and Physiatrists.

iii. The UM Nurse will complete the Pre-AdmisisonAdmission Screening Resident Review (PASRR) prior to admission or readmission from PMA and PMR back to LHH SNF.

d. SNFSkilled Nursing

i. The UM Nurse shall ensure completion of Pre-Admission Screening Resident Review (PASRR). Refer to File 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.

ii. The UM Nurse reviews the resident's medical record and determines if the resident's care meets the criteria for coverage under Medicare Part A SNF benefits.

iii. If the resident's stay does not meet criteria for Medicare Part A SNF coverage, the UM Nurse issues the appropriate Medicare Denial letter (refer to Appendix M1, M2a, M2b).

iv. If the resident's stay meets criteria for Medicare Part A SNF coverage, the UM Nurse shall conduct the following procedures

- Completes and submits the SNF Physician Certification to the admitting physician for his/her signature of initial certification. Subsequent signatures shall be submitted to the attending/covering physician for continued certification according to the required time frames (see Appendix M3). When Medicare coverage is discontinued, the completed Certification form shall be filed in the EHR. If the form was signed after the due date, the

Delayed Physician Medicare Certification needs to be filled out/completed by the Physician (see Appendix M8).

- Notifies the appropriate administrative and clinical team members that the resident's stay shall be covered under Medicare Part A SNF benefits. The administrative team consists of a designee from Admissions and Eligibility, pharmacy and staff responsible for entering Hudman Calls.
  - The Hudman Calls are based on the Hudman v. Kizer court order applies to all eligible Medi-Cal recipients and Managed Care Plan member in need of long term skilled nursing care. The Distinct Part/Nursing Facilities (DP/NF) shall be reimbursed at the DP/NF rate when the medical necessity for long term nursing care has been documented and all adminitrative requirements have been met based on the Department of Health Care Services (DHCS) Long Term Care manual.

- The clinical team consists of the RAI Coordinator, Unit Nurse Manager, Physician and designated members of the Rehabilitation Department. During Medicare coverage, Licensed staff are to have at least daily nurses' notes to document the focus of skilled nursing care. The UM Nurse shall enter an order for Medicare Charting in EHR and discontinue the order after Medicare coverage.

- Conducts and documents periodic reviews to determine that the resident continues to meet Medicare Part A SNF coverage and benefits. Reviews shall be conducted on a weekly basis and no more than ten days shall lapse between reviews.

- Documents all pertinent reviews on the Medicare Information Summary (refer to Appendix M5). The reviews shall document the resident's qualifying stay, diagnosis, qualifying criteria for Medicare coverage and MDS Payment Categories which started under Payment Driven Payment Model (PDPM).

- Maintains a monthly log of all residents covered on Medicare Part A SNF coverage (refer to Appendix M6).

v. Completion of the Minimum Data Set (this is applicable only for SNF stays)

- The MDS is a clinical assessment tool that is completed by the resident care team and are used to classify resident into payment categories. The two required SNF PPS Assessments are: 5-Day Assessment and the PPS Discharge Assessment. The Interim Payment Assessment (IPA) shall be completed when providers determine the resident has undergone a significant change in condition.

- During an Interrupted Stay (patient was discharged from Part A covered SNF care due to an acute hospitalization and subsequently readmitted to Part A covered SNF care in the same SNF prior to the third consecutive midnight after discharge from the SNF), the previous MDS prior to the discharge shall be continued

vi. Medicare Denial Determination

- When the resident no longer meets Medicare criteria for coverage under Part A benefits; the UM Nurse, as the designated Administrative Officer shall issue the appropriate Notice of Medicare Non-Coverage letter (NOMNC) no later than 2 days before covered services shall end. The UM Nurse shall notify the resident and all appropriate administrative and resident care team members of the resident's non-coverage determination. UM nurses shall document the resident notification on the notice. The UM Nurse must also provide a Detailed Explanation of Skilled Nursing Non-Coverage letter, also known as the Detailed Notice, to the resident or the responsible party, if the resident or responsible party chooses to appeal the Medicare denial determination with the Quality Improvement Organization (QIO). If the patient shall remain in the SNF after Medicare coverage, the SNF Advance Beneficiary Notice of Non-coverage (SNFABN) shall be issued (refer to Appendix M4A, M4B and M1 for the NOMNC, Detailed Notice, and SNFABN) and copies shall be given to Admission and Eligibility Manager/designee. The Admission and Eligibility Manager/designee shall sign as verification of the receipt of the Generic notice. The UM Nurse obtains the patient's/resident's or responsible party's signature for NOMNC and/or SNFABN. If the patient or representative is unable to sign the NOMNC and/or SNFABN, the UM nurse will indicate and note the date and time of the notification on the signature area of the form.

vii. If the resident is not discharged from the skilled nursing facility and the resident or responsible party disagrees with the Medicare denial determination, the resident or responsible party can request for an intermediary review. The UM Nurse shall notify the Billing department regarding the beneficiary's request for a Demand Bill on a monthly basis.

viii. The MDS Coordinators shall also be notified regarding the Demand Bill. The payment category for 5-day PPS Assessment shall be used if the patient/resident request for the demand bill.

ix. The Utilization Management department shall be notified by the Billing department regarding the outcome of the Intermediary's decision. Any decisions made by the Intermediary that is contrary to the facility's Medicare coverage determination shall be reported and reviewed at the monthly Utilization Management Committee.

x. Medicare Reinstatement (applicable only for SNF stays)

- When a resident who has been issued a Medicare Denial letter experiences a change in condition that requires daily skilled services and is within 30 days of the last Medicare covered day, s/he may be reinstated Medicare Part A benefits if s/he meets Medicare coverage criteria. The UM Nurse shall complete the Skilled Nursing Facility Reinstatement letter (see Appendix M7) to reinstate the resident's Medicare coverage and notify the appropriate administrative and clinical team members, resident care team and the Billing department of the change in coverage.

xi.x. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

xii.xi. The UM Nurse shall enter a Utilization Review note.

4. Procedure B - Medi-Cal Fee for Service

a. Acute Medical Unit

i. The Acute Care Admitting Physician enters the order of Admit to Inpatient in the EHR. After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification.

ii. The UM Nurse enters the patient information in the log of PMA Admission and updates log as needed (refer to Appendix L4).trackestracks the admission to PMA. The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria.

iii. If the patient's admission does not meet the InterQual Adult Acute Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

iv. If the patient's stay meets criteria, the UM Nurse shall conduct the following procedures:

- Enter acute care reviews (Admission, Continued Stay) using InterQual Adult Acute Level of Care Criteria in EHR.
- Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.

- When the patient does not meet InterQual Adult Acute Level of Care Criteria for continued stay, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

b. Acute Rehab Unit

i. The UM Nurse ~~enters patient information in the log of PMR Admission and updates as needed (refer to Appendix L5)~~tracks admissions to PMR.~~.~~ The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission does not meet InterQual Adult Acute Rehab Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

ii. The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, and Physiatrists.

c. SNF

i. The UM Nurse reviews the resident's medical record and determines the resident's care needs and the reason for admission.

~~ii.~~i. The UM Nurse enters/updates the Medi-Cal SNF Log (refer to Appendix L9)

~~iii.~~ii. The UM Nurse ensures the completion of PASRR. Refer to File: 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.

~~iv.~~iii. The UM Nurse ensures the completion of Treatment Authorization Request (TAR). Refer to File: 55-02 Processing of Long Term Care Treatment Authorization Requests Policy.

~~v.~~iv. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

~~vi.~~v. The UM ~~Nuse~~Nurse shall complete a Utilization Review note in EHR.

5. Procedure C - SFHP CHN Coverage

a. Acute Medical Unit

i. The UM Nurse verifies patient’s membership with SFHP via SFHP website.

ii. The UM Nurse notifies SFHP of patient’s admission. The UM Nurse ~~enters the patient information in the log of PMA Admission and SFHP Patient List and updates as needed (refer to Appendix L4 and L2)~~tracks the ~~admisison~~admission to PMA..

iii. The UM Nurse sends a notification on the day of admission or soon thereafter to A & E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient’s coverage under SFHP-CHN.

iv. The Acute Care Admitting Physician enters the order of Admit to Inpatient in EHR. After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification.

v. The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria. If the patient's admission does not meet criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

vi. If the patient's stay meets criteria, the UM Nurse shall conduct the following procedures:

- Enter acute care reviews (Admission, Continued Stay) using InterQual Adult Acute Level of Care Criteria in EHR.
- Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.

vii. When the patient does not meet InterQual Adult Acute Level of Care Criteria for continued stay, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician advisor as needed.

b. Acute Rehab Unit

i. The UM Nurse verifies patient’s membership with SFHP via SFHP website.

ii. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-CHN.

iii. The UM Nurse notifies SFHP of patient's admission. The UM Nurse ~~enters the patient information in the log of PMR Admission and SFHP Patient List and updates as needed (refer to Appendix L5 and Appendix L2).~~ tracks the admission to PMR.

iv. The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission does not meet InterQual Adult Acute Rehab Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

v. The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, Physiatrists.

c. SNF

i. The UM Nurse ensures the completion of PASRR. Refer to File: 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.

ii. The UM Nurse verifies patient's membership with SFHP via SFHP website.

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iii. The UM Nurse sends a notification on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-CHN.

iv. The UM Nurse enters the patient information in the SFHP List and updates as needed (refer to Appendix L2). The UM Nurse reviews the medical record for skilled nursing/rehab needs.

v. The UM Nurse obtains information from review of medical record or from RCT re discharge plan. Communicates with A & E as needed.

vi. The UM Nurse sends to SFHP on the 1st working day of the month via fax the list of patients who are due for disenrollment which includes patient name, admit date, discharge location/date, SFHP ID, date of service, term date (refer to Appendix L2). Facesheets are also sent as needed.

vii. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

viii. The UM Nurse shall complete a Utilization Review note in EHR.

6. Procedure D – SFHP-UCSF Coverage

a. Acute Rehab Unit

i. The UM Nurse ensures that pre-authorization is received from A & E.

ii. The UM Nurse verifies patient's membership with SFHP via SFHP website.

iii. The UM Nurse notifies SFHP-UCSF of patient's admission on the day of admission or soon thereafter by sending via fax the facesheet and admission orders.

iv. The UM Nurse sends a notification on the day of admission or soon ~~therafter~~thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF. Sends updates to the group as needed.

v. The UM Nurse enters the patient information in the log of PMR Admission and SFHP Patient List and updates as needed (refer to Appendix L5 and Appendix L2).

vi. The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission is not meeting the criteria, the case shall be referred to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

vii. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

viii. The UM Nurse sends copies of medical records to SFHP-UCSF weekly via fax to obtain authorization for continued stay.

ix. The UM Nurse sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, Physiatrists.

x. If the patient is still meeting the InterQual Adult Acute Rehab Level of Care Criteria and denial received from SFHP-UCSF, the UM Nurse shall discuss case with SFHP-UCSF contact person. If no resolution obtained, follow the next step as recommended by SFHP-UCSF such as peer-to-peer review or appeal the denial.

xi. When the patient is discharged either to the acute hospital or to home, the UM Nurse notifies SFHP-UCSF.

b. SNF

i. The UM Nurse shall ensure the completion of PASRR. Refer to LHHPP 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.

ii. The UM Nurse shall ensure that pre-authorization is received from A & E.

iii. The UM Nurse verifies patient's membership with SFHP via SFHP website.

iv. The UM Nurse notifies SFHP-UCSF of patient's admission on the day of admission or soon thereafter by sending via fax the facesheet and admission orders.

v. The UM Nurse sends a notification on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF. Sends updates to the group as needed.

vi. The UM Nurse enters the patient information in the SFHP Patient List and updates as needed (refer to Appendix L2). The UM Nurse reviews the medical records and progress notes for determination of skilled needs.

vii. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

viii. The UM Nurse sends copies of medical records weekly to SFHP-UCSF via fax to obtain authorization for continued stay.

ix. If denial for continued stay received from SFHP-UCSF, the UM Nurse shall discuss case with SFHP-UCSF contact person. If no resolution obtained, follow the next step as recommended by SFHP-UCSF such as peer-to-peer review or appeal the denial.

x. When the patient is discharged either to the acute hospital or to home, the UM Nurse notifies SFHP-UCSF contact person.

xi. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

xii. The UM Nurse shall complete a Utilization Review note.

7. Procedure E – Anthem Blue Cross Medi-Cal Managed Care Coverage

a. Acute Rehab Unit

i. The UM Nurse ensures that pre-authorization is received from A & E.

ii. The UM Nurse notifies Anthem Blue Cross UM RN of patient's admission on the day of admission or soon thereafter by sending via fax the Facesheet and admission orders.

iii. The UM Nurse sends a notification on the day of admission or soon thereaftersoon thereafter to A & E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under Anthem Blue Cross Medi-Cal Managed Care. Sends updates to the group as needed.

iv. The UM Nurse enters the patient information in the Log of PMR Admission and Anthem Blue Cross Medi-Cal Managed Care Patient List (refer to Appendix L5 and Appendix L6).

v. The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission review is not meeting the criteria, the case shall be referred to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

vi. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

vii. The UM Nurse sends copies of medical records to Anthem Blue Cross UM RN weekly via fax to obtain authorization for continued stay. The UM Nurse shall receive the authorization for continued stay via fax.

viii. The UM Nurse sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Coordinators, Physiatrists.

ix. If the patient is still meeting the InterQual Adult Acute Rehab Level of Care Criteria and denial received from Anthem, the UM Nurse shall discuss case with Anthem Blue Cross UM RN. If no resolution obtained, follow the next step as recommended by Anthem Blue Cross such as peer-to-peer review within 30 days of receiving the denial or appeal the denial.

x. When the patient is discharged either to the acute hospital or to the community, the UM Nurse notifies Anthem Blue Cross.

b. SNF

i. The UM Nurse shall ensure that pre-authorization is received from A & E.

ii. The UM Nurse notifies Anthem Blue Cross UM RN of patient's admission on the day of admission or soon thereafter by sending via fax the Facesheet and admission orders.

iii. The UM Nurse sends a notification on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under Anthem Blue Cross Medi-Cal Managed Care. Sends updates to the group as needed.

iv. The UM Nurse enters the patient information in the Anthem Blue Cross Medi-Cal Managed Care Patient List and updates as needed (refer to Appendix L6). The UM Nurse reviews the medical records if patient meets the levels of care by Anthem Blue Cross.

v. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

vi. The UM Nurse sends copies of medical records to Anthem Blue Cross UM weekly via fax to obtain authorization for continued stay. When approved the UM Nurse shall receive the authorization for continued stay via fax and make sure the approved level of care is appropriate. If not, the UM Nurse shall discuss the case with Anthem Blue Cross UM RN.

vii. If the patient is still meeting the levels of care by Anthem Blue Cross and denial for continued stay was received, the UM Nurse shall discuss case with Anthem Blue Cross UM RN. If no resolution obtained, follow the next steps recommended by Anthem Blue Cross such peer-to-peer within 30 days of receiving the denial or appeal the denial according to required time frames.

viii. The UM Nurse notifies Anthem Blue Cross about patient's disposition. When the patient is discharged to the Acute Hospital, UM Nurse obtains authorization for bedhold.

ix. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

x. The UM Nurse shall complete a Utilization Review note in EHR.

8. Procedure F – Other Payor Coverage

a. A & E sends Letter of Agreement (LOE) and any other information related to this case to UM Department.

b. The UM Nurse notifies payor/insurance of this admission on the day of admission or soon thereafter and obtain information from the payor of the requirements to obtain coverage for this admission.

c. The UM Nurse enters patient information in the Other Payor List and updates the list as needed (refer to Appendix L7).

d. For any issues, obtain assistance from OMC as necessary.

e. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

f. The UM Nurse shall complete a Utilization Review note in EHR.

ATTACHMENT:
Appendix A2: Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN/HINN 1)
Appendix A3: HINN Noncovered Continued Stay (HINN 12)
Appendix L2: SFHP Patient List
Appendix L3: Acute Rehab Patient List
~~Appendix L4: Log of PMA Admission~~
~~Appendix L5: Log of PMR Admission~~
Appendix L6: Anthem Blue Cross Medi-Cal Managed Care
Appendix L7: Other Payor List
Appendix L8: Utilization Review Daily Analysis
Appendix L9: Medi-Cal SNF Log
Appendix M1: SNF Advance Beneficiary Notice of Non-coverage (SNFABN)

Appendix M2a: Benefit Exhaust Letter
Appendix M2b: No Qualifying 3-day Inpatient Hospital Stay
Appendix M3: SNF Physician Certification
Appendix M4A: Notice of Medicare Non-Coverage (NOMNC)
Appendix M4B: The Detailed Notice (Detailed Explanation of Non-Coverage)
Appendix M5: Medicare Information Summary
Appendix M6: Medicare Part A SNF List
Appendix M7: Skilled Nursing Facility Reinstatement
Appendix M8: Delayed Physician Certification

REFERENCE:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
LHHPP 55-02 Processing of Long Term Care TARs
LHHPP 55-03 PASRR

Revised: 11/21/19, 05/08/18, 08/04/17, 10/08/19, 11/09/27, 14/01/28, 14/03/25, 14/07/29, 16/11/08, 20/01/14, 21/04/19, 21/09/14 (Year/Month/Day)
Original Adoption: Est. 1993

Laguna Honda Hospital and Rehabilitation Center

Security Management Plan ~~2020-2021~~2022-2023

REFERENCES

California Code of Regulations, Title 8, Sections 8 CCR 3203 *et seq.*
~~California Code of Regulations, Title 22, Sections 22 CCR 70738~~
Health & Safety Code, Section 1257.1, 1257.8, 1257.7

I. PROGRAM OBJECTIVES, INTENT and CORE VALUES

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe, secure, accessible, and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to residents/patients, staff, and visitors.

It is the overall intent of this plan is to establish the framework, organization, and processes for the development, implementation, maintenance, and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology, and environmental controls.

The objectives of the Security Management program include:

- Continuous review, survey, and auditing of the physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess, and control security risks, and vulnerabilities
- Ensure timely and effective response to security emergencies
- Ensure effective responses to service requests
- Report and investigate security related incidents
- Promote security awareness and education
- Enforce various hospital rules and policies
- Establish and implement critical program elements that safeguard people, equipment, supplies, medications, and control traffic in and around the hospital campus.
- Establish policy and procedures for addressing illicit drugs on the hospital campus.

~~Laguna Honda Hospital and Rehabilitation Center (LHH) is a system of care within the San Francisco Department of Public Health (DPH) and the San Francisco Health Network (SFHN) that is committed to providing a safe, secure, accessible, and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients/residents, served, staff, volunteers, contractors, and visitors.~~

~~It is the overall intent of this plan is to establish the framework, organization, and processes for the development, implementation, maintenance, and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology, and environmental controls.~~

~~The objectives of the Security Management program include:~~

- ~~Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess, and control security risks, and vulnerabilities~~

- Ensure timely and effective response to security emergencies
- Ensure effective responses to service requests
- Report and investigate security related incidents
- Promote security awareness and education
- Enforce various hospital rules and policies
- Establish and implement critical program elements that safeguard people, equipment, supplies, medications, and control traffic in and around the hospital and the outlying buildings.

II. SCOPE and APPLICATION

The Security Management Plan comprises standards applicable to addressing and facilitating the protection, welfare, safety, and security of the environment. Included is a full range of protective services for persons, property, and assets at the hospital. The Security Management plan requires compliance with all policies and procedures. The management plan calls for best in class customer service for resident/patients, visitors, volunteers, contractors, and staff as well as the protection of property and assets.

The scope of the plan addresses all program elements required to provide a safe and secure environment. Key aspects include:

- Program planning, design, and implementation
- The measurement of outcomes and performance improvement
- Risk identification, analysis, and control
- Reporting and investigating of incidents, accidents, and failures
- Security Awareness, education, and training
- Emergency response
- Addressing legal and criminal matters
- Use and maintenance of equipment, locks, physical barriers, security surveillance systems, alarms, etc.
- Security of medications
- Traffic control
- Security of sensitive areas
- Visitors Screening and Property Searches

The Security Management Plan comprises standards applicable to addressing and facilitating the protection, welfare, safety, and security of the environment. Included is a full range of protective services for persons, property, and assets at the hospital and outlying medical offices. The Security Management Plan requires compliance with all policies and procedures. The management plan calls for best in class customer service for patients/residents, visitors, volunteers, contractors, and staff as well as the protection of property and assets.

The scope of the plan addresses all program elements required to provide a safe and secure environment. Key aspects include:

- Program planning, design, and implementation
- The measurement of outcomes and performance improvement
- Risk identification, analysis, and control
- Reporting and investigating of incidents, accidents, and failures
- Security Awareness, education, and training
- Emergency response

- ~~Addressing legal and criminal matters~~
- ~~Use and maintenance of equipment, locks, physical barriers, CCTV systems, alarms, etc.~~
- ~~Security of medications;~~
- ~~Traffic control~~
- ~~Security of sensitive areas~~

III. AUTHORITY

The SF Health Network provides the program's vision, leadership, and support. The Director of Health appoints a Director of Security who is responsible for the oversight of security program development, and implementation. The Director of Security reports directly to the Department of Public Health Chief Operating Officer and will collaborate with and maintain communication with the LHH Chief Executive Officer to ensure that the healthcare security program reflects an alignment with the LHH mission, vision and strategic objectives.

IV. RISK ASSESSMENT

Security risks, vulnerabilities, and sensitive areas are identified and assessed through ongoing campus-wide processes that are coordinated by Facility Services, San Francisco Sheriff's Office, and the DPH Director of Security. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics, and physical systems. Considerations include:
~~Security risks, vulnerabilities, and sensitive areas are identified and assessed through ongoing facility-wide processes that are coordinated by the Director of Quality Management, Chief Operations Officer, the Director of Security, and the contract security provider. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics, and physical systems. Considerations include:~~

- Routine Environmental of Care Rounds
- Root Cause Analysis of significant events
- Failure Mode and Effects Analysis (FMEA)
- Sentinel Event Alerts
- Security Patrols
- Unusual Occurrence Reports- Review of pertinent data/information, incident reports, evaluations and risk assessments
- Community crime statistical data or CAPRISK Reports
- Facility crime, incident and property loss statistics, workplace violence, and crime statistics
- Customer and benchmarking surveys
- "At Risk" residents/patients (such as clinically indicated restraints, medical holds, and stand-by services)
- Hours of operation
- Hospital operations and processes
- Employee, resident and visitor identification
- Hospital and Rehabilitation Center operations and processes

The profile of potential risks results in an integrated approach to risk control and management. Identified "Sensitive Areas" include all areas with protected health information (PHI), Administrative Offices, Human Resources, Pharmacy, Nutritional Services, and Psychiatry, Information Technology, and Central Plant areas.

V. PROGRAM ORGANIZATION AND RESPONSIBILITIES

The Director of Security is responsible for the quality oversight of the security program. The Director of Security in partnership with the San Francisco Sheriff's Office is responsible for the overall management of the security program. This includes the program design, implementation, identification, control of risks, staff education, training, and consultation.

The Director of Security manages the work order with the San Francisco Sheriff's Office (SFSO) by participating in the development and approval of standard operating procedures, ensuring the appropriate resources are available to accomplish the objectives and goals of the Security Management Plan.

The SFSO Unit Commander manages the public safety and law enforcement services, including providing law enforcement personnel, management of SFSO operations, and compiling data from incident reports to form the Environment of Care Security Report.

The Unit Commander assures that SFSO assigned staff receive hospital related training, including racial humility and trauma informed care training; participate in safety and security, and threat management committees, and assures that all SFSO staff follow LHH security operating procedures.

The Director of Security and the SFSO Unit Commander will collaboratively establish and maintain communication and mutual ownership for outcomes by identifying and troubleshooting emergent safety and security concerns.

The Director of Security reports to the Environment of Care Committee about the implementation of new procedures and operations, as well as installation of new electronic security systems.

The Environment of Care Committee (EOC) comprised of clinical, administrative, operations support services, and labor representatives to ensure that the security management program is aligned with the core values and goals of the organization by providing direction, setting strategic goals, determining priority, and assessing the need for change.

The EOC is the central hub of the information collection and evaluation system and acts as a clearinghouse for action items, recommendations, and ensuring that risks are controlled in a timely fashion. The committee also ensures coordination, communication and integration of performance improvement, strategic planning, and injury prevention activities in committee activities.

In the context of security management, the Environment of Care Committee is designed to:

- Develop strategic goals and annual performance targets, relative to Security and the Environment of Care (EOC) programs.
- Carry out analysis and seek timely, effective, and sustainable resolution to security related issues
- Prioritize goals and resources.

~~The Director of Security is responsible for the quality oversight of the security program. The Director of Security in partnership with the contract security provider is responsible for the overall management of the security program. This includes the program design, implementation, identification, control of risks, staff education, and training, and consultation.~~

~~The Director of Security manages the work order with the San Francisco Sheriff's Office (SFSO) by participating in the development and approval of standard operating procedures, ensuring the appropriate resources are available to accomplish the objectives and goals of the Security Management Plan. The Director of Security reports to the LHH Campus Safety and Security Committee (CSS), and Executive Committee about the implementation of new procedures and operations, as well as installation of new electronic security systems.~~

~~The SFSO Unit Commander manages the public safety and law enforcement services, including providing law enforcement personnel, management of security and law enforcement operations, and compiling data from incident reports to form the Laguna Honda Campus Safety and Security and Executive Committee Security Reports. The Unit Commander assures that security and law enforcement staff receive hospital related training, participate in appropriate workplace violence prevention, safety and security, and threat management committees; and assures that all SFSO staff, follow LHH security operation procedures.~~

~~The Director of Security Services and the SFSO Unit Commander will collaboratively establish and maintain communication and mutual ownership for outcomes by identifying and troubleshooting emergent safety and security concerns.~~

~~The Laguna Honda Campus Safety and Security Committee (CSS) is comprised of clinical, administrative, operations support services, and labor representatives who ensure that the security management program is aligned with the core values and goals of the organization by providing direction, setting strategic goals, determining priority and assessing the need for change.~~

~~The LHH CSS Committee is the central hub of the Information Collection and Evaluation System and acts as a clearinghouse for action items, recommendations, and ensuring that risks are controlled in a timely fashion. The committee also ensures coordination, communication and integration of performance improvement, strategic planning and injury prevention activities in committee activities.~~

~~In the context of security management, the LHH CSS Committee is designed to:~~

- ~~Develop strategic goals and annual performance targets, relative to Security and Safety Program.~~
- ~~Carry out analysis and seek timely, effective, and sustainable resolution to security related issues~~
- ~~Prioritize goals and resources~~

Department managers are responsible for the provision of a safe and secure work environment for staff through full implementation of established Environment of Care programs. This includes the identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting, and the protection of residents/patients and their belongings.

~~Department managers are responsible for the provision of a safe and secure work environment for staff through full implementation of established LHH CSS Committee programs. This includes the identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting, and the protection of patients and their belongings.~~

Employees are responsible for following security policies and practices about personal protection and reporting of security incidents, risks and threats. Employees include contract employees, volunteers, students, registry personnel and anyone working under the facility's auspices.

VI. PROGRAM IMPLEMENTATION AND PROCESSES

Successful implementation of the Security Management Plan involves ~~the~~ incorporating the principles of the plan into the culture and operations of LHH. Implementation of the security program is the responsibility of the Director of Security and SFSO Unit Commander. The performance is monitored quarterly by the Environment of Care Committee, Campus Safety and Security Committee, and the Performance Improvement & Resident/Patient Safety Committee. They include:

1. The designation of a person to be responsible for program development and oversight. The Director of Security as the person responsible for the quality oversight of the security program's development, implementation, and monitoring.

2. The Security Services Department and the San Francisco Sheriff's Office conduct investigations and complete written reports about security incidents involving residents, staff, visitors, domestic related incidents that impact LHH, and property. Investigations are documented and reviewed by the SFSO Unit Commander and the DPH Director of Security. Corrective actions are developed and implemented to mitigate risks. The Director of Security in collaboration with the SFSO Unit Commander ensures that incident reports are distributed to the appropriate departments (i.e., Quality, Risk Management, etc.) Significant events are reported to the Administrator-on-Duty, Nursing Ops, Executive Leaders, and the Environment of Care Committee.

3. Security in collaboration with Facility Services will ensure that employees, vendors, and contractors wear personnel identification badges to facilitate the creation of a safe and secure environment. Badges are issued to all employees, physicians, volunteers, and vendors.

4. Access to the hospital's perimeter and buildings are maintained by appropriate security safeguards, including security surveillance cameras, routine checks on all perimeter doors, and the securing of individual departments after normal business hours. All employees are responsible for ensures that access to the facility is restricted to residents, employees, visitors by providing an appropriate greeting and wayfinding. Unauthorized individuals, suspicious persons and activity are reported to the SFSO/contract security supplier—**race, gender, and religious affiliation are NOT considered suspicious**.

5. Security controls access to and egress from security sensitive areas by means of direct observation, locks and other physical barriers, signage, alarm systems and access control systems.

Successful implementation of the Security Management Plan involves the incorporation of the principles of the plan into the culture and operations of the organization. Implementation of the security program is the responsibility of the Director of Security, and SFSO Unit Commander. The performance is monitored quarterly by the Campus Safety and Security Committee and the Executive Committee. They include:

1. The designation of a person to be responsible for program development and oversight. The Health Director has designated the Director of Security as the person responsible for the quality oversight of the security program's development, implementation and monitoring.

2. The Security Services Department and the San Francisco Sheriff's Office conduct investigations and completes written reports about security incidents involving residents/patients, staff, visitors, volunteers, and property. Investigations are documented and

reviewed by the SFSO Unit Commander and the DPH Director of Security. Corrective actions are developed and implemented to mitigate risks. The Director of Security in collaboration with the SFSO Unit Commander ensures that incident reports are distributed to the appropriate departments (Quality, Risk Management, etc.) Significant events are reported to the Chief Executive Officer, LHH Chief Operating Officer and to the Director of Workplace Safety and Emergency Management.

3. Security will ensure that employees, vendors, and contractors wear personnel identification badges to facilitate the creation of a safe and secure environment. Badges are issued to all employees, consultant physicians, volunteers, and vendors.

4. Access to the hospital's perimeter and buildings is maintained by a lock down of unoccupied areas, routine checks on all perimeter doors, and the securing of individual departments after normal business hours. The contract security provider ensures that access to the facility is restricted by confirming unauthorized personnel and escorting them off the premises.

5. Security controls access to and egress from security sensitive areas by means of direct observation, locks and other physical barriers, signage, alarm systems and access control systems.

6. SFSO and the contract security provider conduct regular foot and vehicular patrols to identify potential security risks and assess the status of physical conditions within the buildings and on the hospital campus. Regular patrols, security checks of the campus interior and exterior, and parking areas, and maintaining fixed positions are conducted to deter theft, vandalism, and other criminal activity, including use or possession of contraband, and prohibited items.
7.
8. The Director of Security and the SFSO Unit Commander are actively involved in the Campus Safety and Security Committee and Threat Management Workplace Violence Prevention Committee, providing investigative and protective services for LHH Hospital Administration, Human Resources, and Resident.
9.
10. The Security Operations Center provides call-taking and dispatch services, monitors alarms and surveillance cameras to augment patrol staff and ensure an appropriate and timely response to security-related incidents and service request.
11.
12. The Security Services Department, and SFSO maintains records of all incident reports, service calls and crime statistics. Incident reports that involve safety, residents and environmental issues will be forwarded to the Executive Committee, Risk Manager, and Facilities Director.
13.
14. The collaborative efforts of Security Services and Facilities Services maintains and coordinates the badge access program. The Access Card Request Form is reviewed by the Facilities Department to determine the need for the requestor to have card access. Approved Card Request are processed by the Facilities Department. Records of all issued access cards are maintained with Human Resources and Facilities.

15. The SFSO and the contract security provider will respond to hospital emergencies, including:

~~6. The contract security provider conducts regular foot and vehicular patrols to identify potential security risks and assess the status of physical conditions within the buildings and on the hospital grounds. Regular patrols and security checks of stairwells, campus interior and exterior, and parking areas are conducted to deter theft, vandalism and other criminal activity. Security and Law Enforcement presence includes foot patrols, vehicle patrols and recording of security surveillance cameras in the Security Operations Center and maintaining fixed positions.~~

~~7. The Director of Security is actively involved in a multidisciplinary, hospital wide Threat Management Team, and provides both investigative and protective services. The Director of Security in collaboration with the SFSO work closely with Administration, Human Resources, the Department of Public Health, and other law enforcement agencies on matters concerning criminal cases, threat management investigations, and other non-criminal cases.~~

~~8. The Security Operations Center monitors all alarms, radio, and security telephone transmissions to ensure that the appropriate actions are initiated and communicated.~~

~~9. The Security Services Department, and SFSO maintains records of all incident reports, service calls and crime statistics. Incident reports that involve safety, resident/patients, and environmental issues will be forwarded to the Safety Manager and the Risk Manager.~~

~~10. The Security and Facilities Department maintains and coordinates the card access program. The requestor submits an Access Card Request form signed by the requestor's manager. The Access Card Request form is reviewed by the Facilities Department to determine the need for the requestor to have card access. Approved Card Requests are processed by Facilities. Records of all issued access cards are maintained with Human Resources and Facilities.~~

~~11. The SFSO provides emergency response for the following:~~

- **Code Red** – Respond to the alarm point of origin to assist in implementing initial fire plan, aid local fire department and Facilities.
- **Internal / External disasters** - Control access, crowd management, and activate mutual-aid responses as required.
- **Code Green** - Deploy security personnel to designated locations to establish a perimeter and begin the search for missing residents.
- **Media and VIP Response** - Managing situations involving media or VIPs by aiding the Information Office and safeguarding info of any VIP on premises.
- **Lockdown Procedure** - Heightening existing security measures as needed during civil unrest, disturbances, demonstrations, or acts of terrorism.
- **Resident Assist** – SFSO will provide emergency assistance to address resident-initiated attacks on medical staff, including resident stand-by services. The contract security provider's assistance will be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a resident.
- **Resident Standby** – the contract security provider's assistance will be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a resident/patient, including following the resident/patient that is attempting to leave and radioing the exterior security units the elopement attempt.
- **Patient Abuse Reporting** – Investigation and document all incidents of resident/patient abuse as required by SOC-341.

- ~~Code Blue – Upon notification, to providing crowd control as needed~~
- ~~Code Red – Upon notification, respond to the alarm point of origin to assist in implementing initial fire plan, provide assistance to local fire department and Facilities.~~
- ~~Internal / external disasters - providing staff to control access to the facility and provide assistance to/from local emergency response agencies~~
- ~~Code Green - deploy security personnel to designated locations to establish a perimeter and begin the search for the missing resident/patient.~~
- ~~Managing situations involving media or VIPs by providing assistance to the Information Office and/or Administration and safeguarding info of any VIP on premises.~~
- ~~Lockdown Procedure - Heightening existing security measures as needed during civil unrest, disturbances, or acts of terrorism.~~
- ~~Security also provides emergency assistance to medical/clinical staff, including but not limited to stand-by services, resident/patient restraints, searching for missing persons, crowd control, response to duress alarms, etc.~~

~~12.~~16. All new employees, at the time of hire, will attend a New Employee Orientation Program. All employees will receive basic information related to the Security Department and its Security Management Plan. During the security portion of the orientation, employees will receive information about the following:

- Security Department Services
- Prudent security practices
- ID Policy
- Threat Management and Workplace Violence Prevention
- Reporting a security incidents or suspicious activity
- Security locations and phone numbers, etc.

17. Additional training will be provided to all Clinical and Ancillary Departments in Non-Violent Crisis Intervention (CPI), Management of Aggressive Behavior, and Threat Management and Workplace Violence Prevention, and Active Shooter.
18.
19. The SFSO Unit Commander and the contract security provider's Account Manager will verify that LHH assigned SFSO and contract security employees, complete all required trainings. Training records will be retained by the Department of Education and Training for Security Services and SFSO assigned staff.
20.
21. Security refresher in-services will be based on the assessment of the department's need, change in roles or regulatory requirements, and EOC findings.
13. ~~Additional training will be administered as needed to assure competency in federal, state, local laws, and regulations: Crisis Prevention and Intervention, Management of Aggressive Behavior and Threat and Workplace Violence response.~~

14. ~~The SFSO Unit Commander will verify that each SFSO employees assigned to Laguna Honda Hospital and Rehabilitation Center complete the required LHH New Employee Orientation,~~

~~LHH Security Standard Operating Procedures, Non-Violent Crisis Intervention (CPI) and LHH annual core competencies refresher training.~~

~~15. Documentation will be retained by the Department of Education and Training and/or the SFSO Training Representative. Security refresher in-services will be based on the assessment of the department's need, change in roles or regulatory requirements and/or findings of the Campus Safety and Security Committee.~~

VII. PROGRAM EFFECTIVENESS

Through the Environment of Care Committee, the effectiveness of the security program is monitored and assessed on an ongoing basis. Identified risks are used to develop performance metrics to create a safe and secure environment for staff, residents, and visitors to the hospital. A quarterly report is submitted to the Environment of Care Committee. Recommendations are made, as needed, to facilitate improvements in performance. Action plans are developed and implemented to improve performance.
~~Through the LHH Safety and Security Committee, the effectiveness of the security program is monitored and assessed on an ongoing basis. Identified risks are used to develop performance measures to create a safe and secure environment for staff, patients and visitors to the hospital. Performance is reported to the LHH Safety and Security, and Executive Committee on a quarterly basis. Recommendations are made as needed to facilitate improvements in performance. Action plans are developed and implemented as needed to improve performance.~~

VIII. PERFORMANCE

The hospital has developed and implemented a systematic, campus-wide approach for performance improvement. It is intended to assist the hospital in developing and maintaining improvement programs that are meaningful, realistic, and adjustable based upon relevant data and customer feedback. The standards and metrics by which the performance of this plan will be measured are based on hospital and department experiences, 2021-2022 Security Risk Assessment/Survey, 2021-2022 Annual Security Report, exercise evaluation results, observed work practices, customer expectations/satisfaction, and Environment of Care Committee recommendations.
~~The hospital has developed and implemented a systematic, department-wide approach for performance improvement. It is intended to assist the hospital in developing and maintaining improvement programs that are meaningful, realistic, and adjustable based upon relevant data and customer feedback. The standards and metrics by which the performance of this plan will be measured are based on hospital and department experiences, 2019-2020 Security Risk Assessment, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or LHH Safety and Security, and Executive Committee recommendations.~~

During 2022-2023, the measures that will be collected, tracked, and analyzed by the Environment of Care Committee on a quarterly basis include:

Performance Metric #1 – Code Green, SFSO Resident Elopement Response Incidents and Drills:
During actual Code Green incidents/drills, the effectiveness of the contract security provider will be measured to determine their response in the following areas:

- Initial Perimeter and Search
- Notification of SF~~PD~~SO, BART, and MUNI

- Documentation of Search Activity
- Locate/Not Located Procedure

1. The contract security provider will be measured on their ability to effectively respond i.e., initial perimeter search, and notification of SF~~PD~~SO, BART, and MUNI as applicable, and document the search activity:

Response-rate Threshold – 80%
Response-rate Target – 90%
Response-rate Stretch – 100%

2. The contract security provider, in collaboration with the hospital will be measured on its ability to make contact i.e., determine the location, and deem safe, an “At Risk” resident/patient, and when they are not located, follow the Not Located Procedure.

Locate/Return-rate Threshold –90%
Locate/Return-rate Target – 98%
Locate/Return-rate Stretch – 100
~~During 2020-21, the measures that will be collected, tracked and analyzed by the Safety, and Executive Committee on a quarterly basis include:~~

~~**Performance Metric #1 – Code Green, “At Risk” SFSD Patient Alert Response Incidents and Drills:**~~

~~During actual Code Green incidents/drills, the effectiveness of the contract security provider will be measured to determine their response in the following areas:~~

- ~~Initial Perimeter and Search~~
- ~~Notification of SFPD, BART, and MUNI~~
- ~~Documentation of Search Activity~~
- ~~Locate/Not Located Procedure~~

1. ~~The contract security provider will be measured on their ability to effectively respond i.e. initial perimeter search, and notification of SFPD, BART, and MUNI as applicable, and document the search activity:~~

   ~~**Response-rate Threshold – 80%**~~
   ~~**Response-rate Target – 90%**~~
   ~~**Response-rate Stretch – 100%**~~

2. ~~The contract security provider will be measured on its ability to locate an “At Risk” resident/patient, and when they are not located, follow the *Not Located Procedure*.~~

   ~~**Locate/Return-rate Threshold –90%**~~
   ~~**Locate/Return-rate Target – 98%**~~
   ~~**Locate/Return-rate Stretch – 100**~~

Performance Metric#2 – Employee Security Awareness:

During EOC rounds, hospital staff will be tested on 5 questions regarding their full knowledge of:

- Code Green Response
- Unauthorized Person
- Workplace Violence
- Disruptive Resident
- Contacting Security

Threshold - 80% Somewhat Satisfied

Target - 90% Satisfied

Stretch – 98% Very Satisfied

~~**Performance Metric#2 – Customer Satisfaction:**~~

~~In accordance with the scope of the security management plan, the management plan calls for best in class customer service for patients, visitors, volunteers, contracts and staff. On a quarterly basis, customers that consist of patients/residents, visitors, employees, and physicians that had a recent contact with Security Services, will be surveyed on their experience.~~

~~Customers will respond as either, Very Satisfied, Satisfied, Somewhat Satisfied, Dissatisfied, and Very Dissatisfied in the following areas:~~

- ~~Responsive~~
- ~~Treated with dignity and respect~~
- ~~Courteous~~
- ~~Effective~~
- ~~Overall Experience~~

~~**Threshold -** 80% Somewhat Satisfied~~
~~**Target -** 90% Satisfied~~
~~**Stretch –** 98% Very Satisfied~~

Performance Metric#3 – Electronic Security System Performance:

On a monthly basis the Security Operations Center will inspect the electronic security system for functionality. The Facilities Department will monitor all service call/work-orders to ensure timely response. The Security Director and SFS~~D~~O Unit Commander will develop a plan to mitigate risk, resulting from system malfunctions. The action plan will be documented in Campus Safety and Security Report.

The monthly target is for 100% of the system to be inspected and will be 98% functional.

Performance Metric#4 – Contraband and Prohibited Item Reductions: