



MEETING MINUTES
Hospital Back up Redesign Advisory Council
Department of Health Care Policy and Financing

303 E. 17th Ave.
7th Floor Conference Room 7B
Denver, CO 80203

December 16, 2015
9:00 a.m. – 11:00 a.m.

On the Phone

Joyce Humiston--JH	CG Health Care Management
Abigail Walda--AW	Rocky Mountain Options Long Term Care
Heather Terhark--HT	Vivage Communities
Julie Reed--JR	HCPF/LTSS
Dan Larsen--DL	Meridian Care
Cindy Lubiard--CL	Meridian Care
Tanya Gallery--TG	Pueblo County
Kathy Capell--KC	Colorado Access
Megan Roberto--MR	HCPF/Data
Josh Fant--JF	Colorado Healthcare Association

ATTENDEES

Larry Fortier--LF	Rock Canyon
John Adams--JA	Vibra Healthcare
Louis Jaime--LJ	Colorado Access
Lori Woods--LW	Jefferson County
Kellen Roth--KR	Colorado Access
Dr. Eric Yeager--EY	Kindred/Avamere Malley
Dr. Adolphe Edwards--AE	Kindred
Dawn Mowat--DM	eQhealth
Mike Modiz--MM	eQhealth
Dr. Deb Parsons--DP	eQhealth

Heather Fladmark--HF	HCPF/LTSS
Laura Russell--LR	HCPF/LTSS
Erik Holt--EH	HCPF/LTSS
Jason Takaki--JT	HCPF/LTSS
Saori Kimura--SK	HCPF/LTSS
Eric Stricca--ES	HCPF/Eligibility
Cathy Fielder--CF	HCPF/LTSS
Joana Vasquez--JV	HCPF/LTSS

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HF: Welcome to the HBU redesign committee. Today our focus is on the HBU application. We will start with meeting minutes.

LR: Any objections to the minutes? Questions?

No comments or questions from the attendees.

Phone call-ins introduce themselves.

HBU ROLES OF EACH ENTITY INVOLVED WITH HBU CLIENTS

HF: First, we will go over the roles. Within the report, some of the roles need clarification. If anyone has clarifications for let me know.

Hospital—determines if the client is eligible for the HBU program, they find the accepting Nursing Facility (NF), they reach out to the HBU providers to see if they can provide care, they fill out the application which includes a history and physical and a med list, they send application to the Department and sometimes to the SEP as well. They fill out the ULTC 100.2 which is sent to the SEP to trigger the long term care Medicaid functional assessment.

SEP—the SEP will receive the 100.2 from the hospital, they occasionally receive the application, they complete the intake assessment and send into the Department and wait for our determination letter.

Nursing Facility (NF)—they meet with the client to see if they care provide the appropriate level of care for the client, a tentative acceptance or deny the client, they wait for financial approval and check through their systems or will call the county to see if they are financially eligible, they create a cost out and care plan and provide to Department to determine per diem rate and wait for their letter from the Department. Once the documentation has been completed they admit the client to their NF.

SURC—they receive completed HBU form from Department and complete clinical assessment. They have 2 nurses who perform the assessment and have a physician that reviews the assessments. Then the nurse and physician review together and then send a letter of program participation to the Department.

Department—we receive HBU application from the hospital, what we need included is the 100.2, if I don't see that I check the BUS for that information and print it. We then need an accepting NF to move forward. I review the application and once it is completed, I upload it to SharePoint and share it with eQhealth. They upload their documents as well. I receive a determination letter from the SURC, and then the cost out and care plan from the NF. It's hard to determine which piece comes first, I just collect all the documents and then send out an acceptance or denial letter to the NF.

Is there anything that needs to be added, taken away that isn't done?

AE: One key point, and I'll categorize this as a failure of the system, the first hospital that reviews the client has to start the process when the client is identified. A lot of the time, the client has been in the system 120 days and no one has stopped to ask if we can start the HBU process? If they have done that initially, upon determination, then it is a much more simplistic way to place the client and not prolong the stay, as I am seeing. Our physicians are frustrated because they want to discharge the patient but have to wait for the financial approval. We need to talk to the acute hospitals in the market and let them know the case managers need to act as soon as they are identified and not wait until they get to the acute care setting or any other level after that.

HF: That makes sense. But what happens is that they start out at the hospital and then move to an LTAC, unfortunately the client needs to be assessed where the client currently is. For example, we can't have

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and assessment from University if the client is in a Kindred NF and admit the client to the HBU program. The client's condition may have changed significantly. The assessment needs to be done in the current environment. If the client appears to be HBU level of care when they enter a new NF then the process can start immediately. Does that make sense?

AE: No not really. When we talked about doing that at the HBU level, the idea behind it, at every NF the assessment would be initiated and carried over clinical information, you might create something new, but we shouldn't drop an assessment from an acute setting. We have had these conversations from across the country. Why can't we activate the process early on? Where is the initial assessment? Changing conditions will be captured. Is there a more progressive way to capture this?

HF: Our first determination letter is only good for 90 days. It's a great idea, and we can talk about it, but we could be wasting resources by sending nurses out twice from where the clients start and then to where they end up. That would significantly increase the amount of assessments by the SURC.

AE: An electronic assessment should be handled somehow, to be able to enter information early so you don't have to physically send a nurse out until a certain point. 90% of the client information is loaded up and the nurse just looks at the client and talks to them, and then talks to the case manager and that should only take about 10-15 minutes. But your assessors are saying it takes 55 minutes and we have to copy a ton of pages to get our information. Is there a way to activate an electronic method for basic data, like we do with "all-scripts" and look at the case prior to sending anyone out?

HF: It is a great idea. We would have to work with the SURC to set up a secure portal. That would cost money and we can look into it. I'm not saying it's not possible but we would have to look into that.

AE: Look at Korea and look at the grant they get from federal as well as state resources.

HF: I want to make it clear that the intake process takes 10 days for all players to complete their work. What holds up the process is the financial process, and that's the county, we don't have any control over the county. Eric Stricca and I have identified some potential things that are holding us up financial eligibility, and we could potentially fix those hang ups with a tentative date. I hear what you are saying, we could do some background work for that assessment to move things along.

MR: I appreciate the comments you made and I think what you're talking about it an important point that needs to be addressed.

HBU ADMINISTRATOR PROCESS (VISIO MAP)

LR: This is a visual map of the HBU intake process and all the entities involved with the process. It starts here.....*visual representation of the process that Heather goes through, all the people she talks to and the handoffs within the department.*

LR: We wanted to clear up the overlap of the SEP and the SURC. I want to highlight the hospital is notifying 3 different people. The receiving NF, the county and the SEP are all doing things at once.

JH: Are the hospitals in Colorado going to have a list of which NF are licensed HBU units?

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HF: That is what we are going to talk about next.

JH: The process on how to become an HBU NF?

HF: Yes.

LR: That is the overview, each of the main players are doing their processes at the same time. Arrows between to different players shows they are communicating.

HBU APPLICATION REVISION

HF: We are lucky enough to have the SURC here today. The SURC are who I send out to do the assessments. Would you like to talk about your process and how things work?

DW: Yes. My name is Dawn Mowat and I am the clinical nurse manager for eQhealth Solutions. We receive an HBU application from the Department, I assign it to a couple nurses who respond to it to perform a hands on assessment, they acquire the data and then they deliver it to the physician reviewer Dep Parsons. Deb reviews the assessment and then I review all of the reviews for a final determination, and then I send a determination letter to the Department. I agree with Adolph Edwards that the process for receiving information is difficult for us upon arrival to the hospital. We have generated a list of the information we would like from the hospitals in advance of arriving.

HF: That's a great lead in to our next topic, the actual HBU application and what we can revise to make it more effective for the SURC. Does the SEP get the application? If the NF gets it? We have questions about that. Do these application go to the SEP and the NF? Speaking from my SEP experience, some hospital would send us the HBU application which was nice because then I knew it was an HBU client. But, sometimes they don't know until the end when they find out they are going to a HBU facility. Can some of the SEPs and NF speak to that? Do you receive the HBU application?

LW: I have not seen an application. I work with Stacy Menardie and she tells me when there is an HBU client. She just lets us know, we don't get the paperwork.

TG (phone): We don't see the application. We get a referral from the hospital and it states they are looking at the HBU program.

HT (phone): We don't see the application typically, there is discussion and we've been informed but we do not receive the actual piece of paper.

LJ: One thing I have seen, new social workers at facilities, not aware of HBU or the requirement of HBU. New social workers administrators will send it to us without notifying the Department.

HF: would it be helpful if we created 1 packet that is sent to all entities? Such as the SEP, Department, and the NF?

Collective group all agree to this idea. Several of the people in the room reply with "yes" and "sure."



JA: Is there an opportunity to do this electronically?

HF/LR: Yes.

HF: Thank you for bringing that up. We have been working on that. The goal is to make the application on an outward facing web site. I get a phone call once a day for the application. It will be a fillable document online. This is directed to the SURC, do you use all 9 pages of this application? I know you have a list of what you would like to see, so what does that list look like and what pieces of the application are used?

DM: I'll let Deb (Parsons) speak about the list. What we really see on these applications is "see notes." There are a few hospitals that give us good notes, labs, progress notes, and an H & P. What we really need in order first to make a determination, we need the documents behind our assessment. Deb can speak to the list of our needs.

DP: Thank you. If you look at the last 2 pages of application, "medical necessity criteria" a separate issue is there any criteria what do we want going forward? Anything that we want to add or subtract? Right now this is our criteria for medically complex, vent dependent, complex wound. Those 3 areas, we get stuff that does not help us make a determination if the patient is medically complex as defined the criteria or the wound care or defined by the vent dependence. For instance, if you have a pressure ulcer, it must be staged as stage 4. I would say 1 out of 50 since we took the reins, has had that stage listed. A big educational piece is warranted to the hospital on putting forth a request. Things that help, what's interesting, patients not coming from a hospital, but that are up for 90 day or annual, there is frequently a lack of progress notes. Another conversation, is what kind of communication is going on in some hospitals when medical progress notes aren't available to rest of the team? We see things completely contradicting each other even done on the same day. I have a check list of about half dozen items of things that are needed. We need to look at some physician documentation, and that differs from a 90 day and an annual. The physician documentation really needs to look at status of patient, progress toward goals and prognosis from a very high level. Again, more than half the time, there is no care plan available to our nurses in the field. We need therapy notes with goals and prognosis, and PT/OT and speech, respiratory is key because that is an eligibility criteria for many of these. It needs to be good in documentation, there is a requirement in the application that respiratory services need to exceed 3.5 hours a day which is above and beyond every 4 hours that an RT might spend with a client. We need documentation that that is beyond that. We don't see that the 3.5 hours has evidence behind it. As of now if patients are only seen 2-3 times a day, that doesn't meet criteria. Respiratory is key, and we need more. The wounds are strict about the criteria, treatment of nutritional deficiencies. There is a whole litany of things that may not be evident in reviewing the records. Medication list, only one set of labs. All of these things help in our review.

HF: Perfect.

JA: Do your reviewers, when they go to NF, do they ask for that information?

DP: Yes. What's interesting, what is effective communication with the NF, the nurses are arriving and the documents are ready ahead of time. So they call, and they show up and the director is not even available. Staff nurses try to help, or regular staff, some things are paper, some things are electronic it is



very challenging. The typical barrier is that the correct people who can provide that information are not available.

Joyce Humiston raised concerns around the application, the length being the primary concern. NF have a lot of paperwork to do to begin with and adding something like this is problematic for her and the other facilities. Heather Fladmark just reiterated to Joyce shortening the application and making it more user friendly in a checklist format is one of the goals of the redesign project.

JA: Under the current system the hospital case managers aren't filling out the current format correctly. They don't have skin in the game and just want to discharge the patient.

DP: Not every document is useful for every patient, not every document is useful for an initial evaluation, a 90 day or an annual evaluation. I agree with you on the initial evaluation. It should be easy and streamlined to get the patient out of the hospital. There should be more scrutiny at the 90 day evaluation—are services still necessary for that patient or if a different level of care is more appropriate. Getting out of the hospital should be simple.

JH: It should be simple for the facilities as well. We are very highly regulated and NF will not get on board if it's difficult.

JA: From my perspective it's not that bad. We teach hospital case managers what the criteria are (for HBU program) we even give them the application to fill out and fax in. The NF responsibility is to provide the care plans and provide that to the SURC. Then there is a cost out and negotiation. So it's not a difficult process. The length is the difficulty of the process, that's the challenge and talking to the right people. The process is very simple

HT: The actual process is not difficult, just like John said. It's the time frame we have been talking about. It's having to save a bed for that HBU client, which puts the facility at risk financially. If we have to wait 3-4 weeks for a patient to go through the process we lose money.

JA: If you agree to take a patient we've never held a bed knowing we typically would have one. The hospitals need to understand that if a NF agrees to take a patient but is full when that patient is ready to move, the hospital may need to hang on to that patient longer. I would never hold a bed waiting for a patient that just wouldn't make sense.

HT: We have held a bed when we knew they were close to the end of the process, maybe 2-3 weeks out. If we're full and the hospital is full. Where are they going to go? I only have one NF in our network, and so it is a delicate balance on what we need to do.

HF: If we created a packet that went to all three entities, what would be useful for the SEPs? I know the 100.2 would need to be in there but what else? Deb said a lot of clinical stuff.

LJ: 100.2, PASRR, PMIP, H&P, that's probably what we would need.

HF: What would you (John Adams) like to see as a NF in this packet?



JA: Well you talked about, what case managers send the “see attached” and it’s a quick breeze over by the hospitals. The primary criteria for the program isn’t being discussed. There is nothing for vent dependent or wound criteria. More expansion of criteria in the application for the hospital case managers.

HF: Would you like to see that as a checklist?

JA: Whether it’s a checklist or not, the ideal is to make a case to meet criteria. So the backup medical chart needs to be in there, and the application process backs up the criteria. So the three criteria are simple, do they meet criteria for vent defendant, or for stage 4 wounds or are they medically complex. The first six pages should talk about the criteria versus the ADL care and things like that.

MR: What assessment does the hospital do in house to help determine that a client is appropriate for the HBU program?

HF: They don’t have an assessment. They go with HBU when they know they can’t do the level of care that a NF provides and when they know they can’t send them home. Their care is too high, so there is not really an assessment, it’s just a conversation between the care teams.

JA: The hospital case managers are looking for a discharge plan. When they have ruled out skilled nursing facility level of care, ruled out LTAC and ruled out home. HBU is the only option left. The hospital will request our clinical liaisons if the client will meet HBU criteria. We review the records and then determination will be made. If they are not sure then they need to fill out the application.

HF: It sounds like we should go through the application page by page and what we need to take out, expand on or just leave it in there. Laura Russell is the one rewriting the application so please send her your ideas and comments.

LR: We are going to put this on the external HCPF website as a PDF. You will be able to print it out or make comments electronically. We will put stuff like “this field is required” and submitting the application without it being complete will not be allowed.

HF: This first page is the demographic of the client, this helps me at the Department. I would like to see this stay and expand it to allow more room for easier completion.

DM: We use it a lot. It’s the best information we get sometimes on the application.

HF: Okay. Let’s jump to the second box. Past medical history, illnesses, past hospitalizations, do we want to keep this or take it out?

LW: I don’t think for SEPs it would be.

LR: Does anyone use the second box?

DP: The only time I do is in the context of the H&P. The single H&P done either to the hospital of NF should include this and that document is already done, nobody needs to recopy, a medical person has

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already done that. Having that H&P attached gives you tons of context, history, past and present illnesses it includes a good assessment and plan.

HF: Page 2—current diagnosis, treatments, medications. We see the “see attached” written in this box a lot. Any opinions on this box.

EY: A lot of the same things, this should be part of the H&P.

LW: For the SEP, the PMIP would have that information

LJ: Which usually says see attached, with the 30 list of meds.

DP: Since medication reconciliation is required, if a client is at a facility for a few month the H&P could be outdated. So a recent progress note or recent med list should have the active things in it, plus more, it gives it context. Just listing stuff isn't enough and there is stuff that doesn't talk about the active problems of the patient. An H&P and the last two progress notes.

EY: The hospital should be required to put in the medications that would help you folks. Some of that should be adopted by hospitals that's a whole different argument. We don't have that. NF have an indication of meds, your mostly going to SNF they should know the implication of the meds. A sheet of paper should be included that lists the implications of the meds.

HF: How about other treatments, therapies, other treatments?

DP: The attachments are appropriate. We should have the most recent notes for: PT, OT, the speech, the RT and the nurses care plans. Just having someone recopy that doesn't add value for anyone.

EY: I think we need to replace the entire list of things with a list of what information you want. Hospitals can print a better version than what someone can write. I wouldn't even know what to write here, “other treatments, therapies, and medical procedures.” I could spend a few hours writing you a 20 page response or I could just write a few lines. What you really want, is “please include last 5 days of PT notes, last 5 days of speech therapy notes.” This should be a list not documentations.

LF: All of our systems are built to do a select and print of the clients records.

EY: Right. I'm gonna get by on this is incomplete. Ask the hospitals for a complete list. A full H&P, an interim summary, complete notes from PTO to speech. Be specific about what information you are requiring.

LF: One of our biggest complaints from NF is that the application takes so much time to fill out and we have to walk them through it. Every piece of information requested on the application I already have on my referral. So it like making two referrals, and redundant.

DM: This is typically what we get from an initial application. When we do a 90 day or annual assessment, we do not see recent PT notes, recent OT notes, dietary notes and the like. I think as we go through the process of improving the application, identifying the different type of needs is important so

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we can streamline things. It's important they get their HBU status renewed. Those documents are the worst for us.

LF: The way the system is set up, at least in my facility, if given a list of 4-5 parameters you need to see, it takes about 10 minutes to create. If we get better as a team communicating that, the pack will be useful. It's not difficult to do, sometimes we just don't know what to do.

HF: Something as simple as a check list is what we need. A lot of documents and info is received but it is not useful. We need to narrow down what we need to get clients into facilities faster.

DP: Has there ever been a patient in a hospital with a wound or vent that was denied access to an HBU service center?

HF: I don't know.

DP: Because if not, is there value in the delay of having a nurse go out on site and say "yes" this patient is on a vent? Okay, are there steps for the initial for the steps be cut back? Is it a slam-dunk the client needs to get out of the hospital and then use the HBU as the stage where you can further assess their needs?

LF: That leads to the conversation of the onsite certification outside the hospital. That might be an overarching goal, I understand the need for oversight to make sure we all have faithful players in the program. But you're right, if there was a checklist that told us if someone was on a vent that would develop my relationship with the guys at HBU to see if this patient will qualify.

HF: I think a lot of times NF take clients pending, the NF do not get paid. So that's a reason to keep them at the hospital. It's a huge financial burden for the NF.

LF: It has happened to us. If we set that type of program up, we would need a semi-guarantee that we would get our money and the patient is covered. We would have to be reimbursed.

DP: I don't believe the SURC does any of the financial determination.

HF: No. That's being done in the hospital.

DP: Our piece is a clinical piece.

HF: Correct.

Heather reviews the ideas discussed with the Eric Stricca about a tentative discharge date with the group. There seems to be a consensus around the tentative date being a good idea. Sometimes the financial approval can take weeks or months. Why it takes that long is still unknown, some possible ideas are that the family has yet to be convinced by the medical staff that Medicaid is even necessary, the process of filling out the paperwork is very long and drawn out, and it could also be the spenddown time a potential client needs to qualify.

CL: Is there an average time it takes for the financial?

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HF: I can't speak to a specific time-line, it depends on a particular case. A lot of times we are waiting for the county.

DP: And there could be a spend down time.

JH: Are we gonna go to the part of what facilities are required to do to become a HBU member?

HF: We will talk about expanding the HBU provider base.

HF: I believe we have come to the conclusion that we can take out most of the clinical information of the application and make it a checklist.

Collective Group agrees with Heather's statement.

HF: Moving to the ADL portion of the application, the SEP does this.

LW: You could take most of this out.

HF: So we can make this just another checklist.

ES: If you have specific cases, and specific questions and you're waiting for specific financial document get a hold of Heather and she can get a hold of me and we can intervene.

DP: Are there any navigation tools to help families get the documents you need for financial approval?

There are several people and facilities that can help families fill out the paperwork for Medicaid eligibility.

HF: Back to the dietary, labs, x-rays, nursing notes and everything can all be turned into a checklist?

GROUP: Yes

HF: Next page is the ADLs.

LJ: This is all on the 100.2, they can attach the 100.2 to the application.

HF: Does the SURC use the ADLs at all?

DP: Yes, it's one of the criteria.

HF: I never send the actual assessments. That's done by the SEP to the SURC. Do you guys do the assessments yourself?

DP: The nurses do it, it's part of their checklist.



HF: This piece can be removed from the application.

DP: There is a form you mentioned that might help them.

MM: If you have something already, I would prefer if you attach it and then we don't have to do the leg work.

LF: You can add a 100.2 and then you can check it off and see if you agree with it.

DP: The nurses just verify the information, you don't want them doing the complete assessment, and there is no time for that.

HF: Right. My concern is that the SEP would have this done within two days. But sometimes they are not even aware this is going on. So I have to call the hospital to verify they sent the referral. I don't want to hold anything up on you guys getting your referral done. If this is being used by you guys I don't want to take it out of the application and have to wait several days to get the referral myself.

DM: I think if we require the ADL information to be attached, that a detail, that would be fine enough if it's from the SEP or whomever it's from. Instead of having the hospital going through all this.

DP: Maybe I'm confused, but if you have the hospital request the referral.

HF: Right. But what I run into a lot is that I get my documentation like the application, the notes needed I move forward and send it to the SURC. Sometimes the SEP doesn't know they need to go do an assessment. That's why I'm looking for the 100.2 to make sure the SEP is aware they have an assessment to do. I also don't want to hold up the SURC's assessment because we are waiting for the SEP to finish their input of the assessment. So if you guys use the ADL section I don't want to take it out of the application. But if the nurse goes out for a chart review of the ADL's, is that sufficient enough?

DP: I would love to have our nurses input on this.

HF: Talk to your nurses and get back to us. The next page is what John was talking about. This is the medical necessitated criteria, this is the vent dependent section. How do we want this to look in the application? Do we want to break it down into pieces and the hospital can check it off or do we want a detailed explanation of the of what the criteria is for the hospital to be aware and keep the check box at the top where is states "vent dependent?"

LF: When you look at that definition, it's a pretty easy check box to determine. If the sending and receiving facility have their ducks in a row we are likely to know if this patients will be qualified. I don't think that needs to be expounded on, that'll be done during the assessment.

HF: Do you feel the same way about wound care or medically complex documents?

DP: Is there a way to gauge this as we are for the rest of the documents toward the initial assessment and it is the 90/annual assessments? For example, under medically complex and it is an initial assessment so number 2 should be taken out.



MM: This application is only for an initial assessment. It sounds like we need a partner form for a 90 day assessment. Maybe that's where we add that in.

NF: Okay. Being that we have the majority of, that puts a responsibility on the NF for the 90 day and the annual and the CSR. Thoughts?

LF: We have been working on that process. We don't have it ironed out yet, but we are close. If we had an agreed upon set of documents, and we are all in agreement or we just say the client has a 90 day, if we are in agreement that means this packet will be waived or these are the 5 criteria of days we need information on. I think we're on our way of getting that done, and that will make it easier for the third or fourth assessments.

HF: Vivage, vista view, and thoughts?

JA: Pretty easy to do.

DP: Just looking at the criteria, I would love to hear Eric and Larry's take on ventilator dependence that might be a later conversation.

HF: It is a latter conversation.

HF: Would we be okay with taking out all of the listed items? We can keep the A, B, C and D boxes along with the demographic page and include a checklist with that of what's needed and consider that the packet for now. We will touch on the criteria at a latter point but that should be something we change in rule and we can edit the application down the road.

