



MEETING MINUTES
Hospital Back Up Redesign Steering Committee
Department of Health Care Policy and Financing

February 17, 2016
10:00 a.m. – 12:00 p.m.
1575 Sherman St.
Denver CO 80203
6th Floor Conference Room--CDHS

On the Phone

Lori Woods--LW	Jefferson County
Abigail Waldo--AW	Rocky Mountain Options Long Term Care
Cindy Lubiarez	Care Meridian
Mike Modiz--MM	eQhealth
Joanna Vasquez--JV	HCPF/LTSS
Jackie Mycelia	Ensign Services
Josh Fant--JF	Colorado Healthcare Association

ATTENDEES

Arlene Miles--AM	Vista View
Donna Zwierzynski	Vivage
Heather Terhark	Vivage
Kristen Victor—KV	Malley Health Care
Daniella Johnson—DJ	Malley Health Care
Martha Meyer—MM	CU
Larry Fortier--LF	Rock Canyon
Kathy Capell--KC	Colorado Access
Louis Jaime--LJ	Colorado Access
Ed Arnold--EA	eQhealth
Dawn Mowat--DM	eQhealth
Dr. Deb Parsons--DP	eQhealth
Heather Fladmark--HF	HCPF/LTSS
Randie Deherrera--RD	HCPF/Rates
Jay Moskowitz	Vivage
Erik Holt--EH	HCPF/LTSS
Cathy Fielder—CF	HCPF/LTSS
Megan Roberto--MR	HCPF/Data

Italic font is summary of conversations and ideas presented by steering committee.
Regular font is actual dialogue.

January minutes are approved.

Reasonable accommodations will be provided upon request for individuals with disabilities. Please notify the 504/ADA Coordinator John Barry at 303-866-3173 or john.r.barry@state.co.us at least one week prior to the HBU Redesign meeting. www.colorado.gov/hcpf



Application in eClearance and should be approved soon.

Rate sheet has been sent out and is currently being tested by the providers.

HBU email is up and running; hospitalbackup@hcpf.state.co.us

Populations and providers:

*Today's discussion is centered on populations that could enter into a NF but the cost is very high. Some of the clients could cost as much as \$400 dollars a day. We would like to hear what types of clients you have requests for but do not end up taking them. For example a **bariatric patient**. What are the costs around clients such as these? A lot of it has to do with staffing and the extra people needed just to move them. Door sizes, bathroom services, wheelchairs, and beds. Individuals can be over 500 pounds.*

There seems to be about a \$200 dollar gap that NF end up eating the cost on. The therapies around such patients, and medications can be very cost prohibitive. Bariatric patients are some of the hardest and most expensive to place when they no longer need hospital level of care.

***Behavioral patients/mental health patients** are hard, anytime there needs to be a 1 on 1 sitter that is a huge cost if the patient is dangerous to the doctors and other patients. These patients are on a case by case basis, a 30 day trial "without incident" is standard. But if there is another problem, then they will be sent back to the hospital. There is a huge issue of facilities getting a demerit on their survey taking these patients because if a patient hits another patient then the NF is held accountable. There are 2 categories cost prohibitive, and behavior health.*

Medically complex usually means more readmissions to the hospitals that also becomes a grading tool from CDPHE and how a facility is assessed.

***Children:** per our rule the department cannot admit children into the HBU program. There is a huge liability for taking children into NF. There are issues with mixed populations. Utah, Nevada, Florida, and New York has a HBU children's program. With the existing programs for children there is the possibility of a program getting established in CO. there are no current facilities that can take children but there providers interested and ready to help. Cindy Lubiarz is responsible for the Nevada center and spearheaded the effort in Las Vegas and Reno.*

CL: is there a designation for the bariatric patients or amputees?

HF: no not under HBU.

CL: that might be a consideration.

JM: amputees fall under the complex wounds.

Brain Injury: *it is a 1 to 1 staffing with specialized equipment and specialized rooms. Very expensive.*

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Equipment costs have been the biggest hurdle for facilities to get over so they can provide the best level of care.

RD: we can look at the amortization of that through the rate sheet. We need to agree as a group and have a discussion around that.

A lot of NF do not buy the equipment because they may only use it for a short period of time or a limited number of patients. DME does not cover equipment for clients in a NF but it will cover it for a patient who is home. Most equipment is a single use item, and once a patient is better than the NF has no use for it and is still being paid for.

The idea of incentives for NF to alter their facilities for the bariatric patients is brought up. If NF knew they would get a good reimbursement for bariatric patients then the cost of constructions for those patients would be more appealing.

Burn victims: *a lot of NF don't even have that type of patient on their radar. The cost and needs of a patient are so high that the majority of facilities couldn't take them. Rate of infections, structural considerations, and the around the clock need is very high.*

Difficult to discharge: *patients is brought up to the group. What challenges do hospitals face with patients that have been there for 50-100 days? Hospitals do have their own length of stay reports of patients that have had extended stays. All the providers get the calls for patients that have extended stays. How do these patients get the help they need? One problem now is that there is no communication with the Department about potential extended stay patients. Some facilities encourage hospitals to start paperwork if they think a client could be an extended stay patient. Another problem is that there just isn't the training and education about the HBU program in the hospitals.*

Spinal cord: *we do have the waiver for this type of injury, however, the waiver does not help someone who cannot go back into the community. And the waiver is only within 2 counties.*

Provider expansion: *we only have 4 NF that are HBU providers, and we are starting to build waiting lists. So, what does it take to become a HBU provider? Not everybody has to take all 3 HBU populations and we need to let everyone know that. Life safety ties into this type of expansion. The last time we tried to expand the HBU provider base, we ran into all sorts of life safety issues. We need to know what the life safety requirements are and what Rob Sontag wants. There needs to be clear definitions and guidelines around each category of HBU programs. This portion of the redesign will most likely need a subcommittee.*

Parking lot issue: *patient centered care, team based care, and outcome focused way are areas of focus as we move forward.*

