



COLORADO

Department of Health Care
Policy & Financing

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

303 E. 17th Ave.
11th Floor Conference Room 11A
Denver, CO 80203
January 6, 2016
10:00 a.m. – 12:00 p.m.

On the Phone

Joyce Humiston--JH	CG Health Care Management
Abigail Walda--AW	Rocky Mountain Options Long Term Care
Dan Larsen--DL	Meridian Care
Cindy Lubiard--CL	Meridian Care
Tanya Gallery--TG	Pueblo County
Josh Fant--JF	Colorado Healthcare Association
Dr. Eric Yeager--EY	Kindred/Avamere Malley
Dr. Adolf Edwards--AE	Kindred
Martha Meyer--MM	Colorado University
Sandra Whitley--SW	Ensign
Daniella Johnson--DJ	Vivage
Stephanie Williamson--SW	El Paso County

ATTENDEES

Larry Fortier--LF	Rock Canyon
Megan Roberto--MR	HCPF/Data
Louis Jaime--LJ	Colorado Access
Lori Woods--LW	Jefferson County
Kellen Roth--KR	Colorado Access
Kathy Capell--KC	Colorado Access
Dawn Mowat--DM	eQhealth
Mike Modiz--MM	eQhealth
Ed Arnold--EA	eQhealth
Dr. Deb Parsons--DP	eQhealth
Heather Fladmark--HF	HCPF/LTSS
Laura Russell--LR	HCPF/LTSS
Randie Deherrera--RD	HCPF/Rates
Erik Holt--EH	HCPF/LTSS
Joanna Vasquez--JV	HCPF/LTSS
Heather Terhark--HT	Vivage Communities
Jay Moskowitz--JM	Vivage Communities
Marie Stern--JM	Vivage

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

Room introductions and phone introduction take place.

No questions or comments about prior meeting minutes, they are approved and will be posted on HCPF website.

Heather Fladmark relays to the stakeholders that without Department documents going through our internal eClearance process we cannot send or hand out and information with the external stakeholders. The exception to this would be agendas and meeting minutes with a draft watermark.

HBU APPLICATION REVIEW

Laura Russell begins presenting the changes made to the HBU Application since the last meeting starting with the admission page and then moving through the application page by page.

Admission page:

All the spaces are bigger if handwriting is necessary.

Any number or letter fields are required to be entered as either numbers or letter and then will be formatted after entered; i.e., the “dashes” are entered automatically when you enter the numbers. There are a couple of fields that do not (or cannot) require a specific field.

Legal Representative is not a required field, if there is contact information to add do so but if not it, leaving the section blank will not hinder the application submission.

Additional Document Checklist:

LR: any objections?

LF: a lot of patients that are on repertory programs that are not vent dependent that are in the HBU confusing. We don't want to miss any information that pertains to the difference between the two.

LJ: if you click on the ADL list does it break it down into the actual ADLs and the clients score?

LR: no this is just a check box. We can include the ADLs under checkbox.

LJ: I don't think people will need it. All the ADLs are in the PT notes.

LR: I know the SURC uses the ADLs would you be okay with removing the ADL checkbox?

DP: are some of the ADLs on the ULTC?

HF: they are on the ULTC assessment. The ULTC referral will have marked boxes with the areas they need assistance in but not how much assistance they require. We could add the assessment and send to

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the SURC with the application, it's up to you. It does identify in rule the SURC should be receiving the ULTC 100.2 anyways.

Agreement within the SURC that wherever the ADLs are listed, they need to include not only what they need assistance with, but the amount of care they need on a daily basis.

HF: when a nurse does a face to face, does an ADL assessment take place or is it taken from the chart?

DM: they confirm the chart information.

HF: so if the ADLs are included in all the other notes, it's really up to you guys (SURC) what you want to do.

DM: I can't answer which form is better for inclusion within the application without seeing the notes that come with it first; at least not at this point. Also, I would like to add to our checklist any radiology information, chest x-rays for vent people, jpeg insertions and things like that.

LW: when you say you want to see the rating of the ADLs, are you exploring on your own or are you referring to the 100.2?

The rating of the ADLs is agreed upon again as very necessary. Several stakeholders respond the same; the group agrees that the ADLs and the ULTC 100.2 referral will be deleted and the ULTC 100.2 assessment will be added in its place.

Wound care notes will be added to the application; a request more recent H and P notes, notes PT and overall health care (the last 3-5 notes recorded) was added to the checklist as well.

HF: do we want the "yes" or "no" boxes for the criteria or do we want it listed separately?

The Medical Necessity Criteria section discussion ends with the group determining the each criteria for vent dependent needs to list separately with their own check boxes to state more clearly what the client needs. The prior paragraph format made it confusing with just a yes or no answer.

A lot of discussion occurs around how to list the criteria and how to make the forms easy to fill out. When getting into the criteria it could become redundant and complex.

The agreed upon format: we will have a single "yes/no" box at the top of a page that states if the client meets criteria for vent-dependencies or complex wound. Then under that, each criteria will have a check box next to it for more specific information for whomever needs it.

Laura Russell proposes, in the next section of wound care and medically complex, would the group like list out the criteria in a similar way like the vent dependent, if the criteria is met then check the box that says they meet the criteria for medically complex and/or vent dependent. Or, if the existing checklist of documents will provide that information do we need the check list specific to wound care and medically complex?



LF: the more instruction that says “if you say yes here, we’ll need X Y Z.”

HF: if that’s what the group agrees on then we need to meet with some of you to determine what forms need to be under what. We don’t want to miss anything that is medically necessary.

LR: we will contact those stakeholders we think will be able to help. We’ll move that “meet wound criteria” to the top. We’ll have the sub section of the checkbox, and at the end we’ll have a check box that says “if they meet criteria then please include XY&Z forms.”

HF: so the checklist for medically complex and wound care will be in addition to the larger checklist at the front of the application.

MR: I would put “meets criteria” at the top, and then say something like “if it does meet the criteria please see the checklist below” so it doesn’t get missed.

The question of whether or not we can require sub section checkboxes to be marked if the yes/no box was checked needs to be researched.

Next is the signature section. We have provided an electronic signature and if you have that capability please use it. If you do not have this software, fill it out, print, and sign. Then scan and email back.

DP: is there any value in having a hospital contact in the application?

HF: the evaluator typically is the hospital contact filling it out.

No questions regarding the eSignature.

COST OUT AND CARE PLAN

Randie Deherrera reviews the new form she has built to regulate the HBU rates. Some rates for HBU clients have not been updated in over 10 years. Each facility has their own form, and needs to fill out the form each time they get a new client. The need for the new form and the standardization, there poses a huge audit risk. The process is outdated, current facility documents are scattered and all over the place. We will address the entire rate process as a whole, first, we need to get our compliance on track, to make sure our reimbursement and we have documentation for that reimbursement. We also need to maintain compliance with rule and statute.

The form includes:

- *Direct care (labor hours)*
- *Medical expenses*
- *Facility expenses*
- *Administrative*
- *Indirect care*



RH: I want to point out; because your rules are different, even when I suggest we use what exists (the maximums) none of that stuff applies. We do not have rules in place to allow us to do that. I don't want anyone to get too concerned, we have flexibility when it comes to the rates.

The first section of the form is the labor section which includes:

- *Wage paying*
- *Hours per day or per week*
- *Total cost wage x hours =total costs.*

There will not be a lot of scrutiny around this form. Randie will check wages against the BLS (?) wage and get the mean. The hours of care will be used to determine if the client needs to be in HBU or do they need to be moved to a program that suits their needs better. We will not question why they have this many just the appropriateness of the hours.

The rate Excel workbooks includes forms for

- *RN*
- *LPN*
- *CNA*
- *Respiratory therapist*
- *Physical therapist*
- *Speech therapist*
- *Occupational therapist*
- *Restorative aid*
- *Other*

Depending on need, more other boxes can be added for labor tracking. These are what have been identified by Randie DeHerrera from reviewing rates and labor cost in the past. If there are more we can add them.

Direct care/medical expenses for the client. This section has itemized worksheets for audit purposes. The larger cost consist of 4 categories with itemized tabs, total cost is filled out, it will auto populate the main worksheet.

Specialty service and special equipment is big for cost tracking.

RH: all that is necessary for the rental and specialty services is an invoice. The reason for just an invoice, is the amortizations has been incorrect in the past. The rental needs to be split between the days it was used not for the year. This goes back to the auditing factors and being able to justify our expenditures. Next, I will need stakeholder guidance in this section. There are no hard and fast rules similar to a SNF, there are no rules to follow or guide, we need to cover all the costs according to the rules we do have.

Medical supplies include but are not limited to:

- *G-tube*
- *Diabetic supplies*
- *Intervals*

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- *Respiratory supplies*

The form will auto populate and I separate these out just because I see these items a lot. Randie is not 100% sure of all the supplies that are necessary. Randie will send this out for the stakeholders to review. We need to review the supply list for accuracy. Randie will send this out to the group.

Randie requests for the stakeholders to use the form for a testing period to capture the items that she hasn't thought of or the items the will change on a more regular basis.

RD: with this form we need to think about a lot. How often do you reassess a client, and does the form need to come back with them? When the costs goes up, your rate goes up and vice versa. We need to figure that out as a group.

To some extent, facilities will need to drill down pretty far into their medical expenses, however once the form is complete for a lot of daily items the cost will remain the same. The work will be a lot up front, however, once those daily expenses are entered it is done. And the audit implications will be much more time consuming and expensive than the rate form.

RD: we have to follow the federal guidelines, and in the state plan it states, it will be a negotiated price based on the cost of care of the client. The form will not be a daunting process where you have to count band aids, it is just a general picture of the cost of care the client will need.

JM: in terms of the form, the main thing on a cost estimate sheet, it has to say "estimate."

RD: exactly. Just a general expectation.

JM: band aids don't change but, hours and nursing staff is what is going to change.

RD: I will put on the form the expectations, and make sure the expectations are clear.

Stakeholders familiar with the form, reiterate the fact that the work is primarily up front on the rate form. But once you get the beginning information entered, it will only take about 15 minutes to enter information for a new client.

Implementation of the new rate form, everyone will have to be on board and supporting it. A stakeholder review will take place, the Department will take feedback, and we will then revise the form to improve it. Instructions and a guide will be developed to go along with the final product. When do we want to implement this? I have cost outs from ten years ago; with the implementation we get everyone on the same page. So given all the time it will take to get your current clients and existing clients on the form.

Heather Fladmark suggest that a subcommittee be formed to iron out the wrinkles.

Aligning the rates with the Med-13 would be help to monitor and make fair the rate methodology. Keeping in mind that this would help the facilities and the Department get on the same page and stay there.



Randie begins to review the new rate form and go over the ins and outs of the sheet. The departments portion is explained; this is new for the rate negotiations due to the Department has never said “no.” up until now the facility has always sent in their request without any pushback.

CARE PLAN

HF: we always ask for the care plan at the same time as the care plan, and I need a consistent care plan from the facilities. All facilities have a care plan, some are the actual plans, and some are word documents created from those plans, others just list medications and diagnoses and a cost out from that. That does not help me. However I need the plans to be more consistent and I need the following:

- Date
- Medical problem(s)
- Treatment/intervention
- Expected outcomes
- Expected outcome dates.

This should match up with the cost out for the most part. If we can start consistently sending standard formatted care plan that would help me and my processes.

Dr. Deb Parson requested to clarify; the criteria on the HBU application will be reviewed and could potentially change. The HBU application will not be formalized or sent through eClearance until the intake referral process is finished. Heather relays to the group that the project team wants to show progress and that the Department is “working.”

Clarity regarding the vent dependent patients, specifically how weaning occurs and the difference in hours for such patients. The issues around that subject will be addressed during the criterion section of the redesign project.

No further comments or questions from the group, meeting adjourned.

