



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

1575 Sherman St.
Denver CO 80203
6th Floor Conference Room--CDHS
March 16, 2016
10:00 a.m. – 12:00 p.m.

On the Phone

The phone was not working during this meeting.

ATTENDEES

Arlene Miles--AM	Vista View
Heather Terhark--HT	Vivage
Kellen Roth--KR	Colorado Access
Daniella Johnson--DJ	Malley Health Care
Martha Meyer--MM	CU
Larry Fortier--LF	Rock Canyon
Kathy Capell--KC	Colorado Access
Ed Arnold--EA	eQhealth
Dr. Deb Parsons--DP	eQhealth
Heather Fladmark--HF	HCPF/LTSS
Randie Deherrera--RD	HCPF/Rates
Erik Holt--EH	HCPF/LTSS
Cathy Fielder--CF	HCPF/LTSS

Unfortunately, the phone and internet was down during this meeting. Only members in the room were able to participate.

Randie Deherrera gives her update on the cost out/rate sheets:

- *There was no formal feedback from any of the providers. There was feedback during the meeting; Randie will go back and make changes and updates.*
- *Randie will be sending out the second round of the sheets with the updated numbers for each facility.*
- *Once the second round of reviews are complete, we will then establish dates for when new clients need to be on the new forms and then, when the existing clients need to be added.*
- *Randie will update the indirect and direct care numbers.*

February meeting minutes are approved.

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Dr. Deb Parsons reviews the CSR communication that eQhealth put together for NF and the SURC. This document is intended to describe the communications between the SURC and NF prior to every CSR review (90 day and annual). All the information within the packet has been vetted by all 4 NF and the SURC.

The communication includes:

- *Contact lists for the employees of the SURC*
- *Address and main numbers for all four HBU facilities and regular contacts.*

STEPS OF COMMUNICATION FOR THE CSR:

- *The SURC Nurse Manager will send out a notification 2 weeks prior to the CSR giving notice to the NF to begin gathering all necessary documentation in preparation for the visit.*
- *A reminder will be sent one week prior about the visit.*
- *The day before the visit, a phone call will be made by the visiting nurse to a specific contact and relay the time of arrival. And the contact person needs to have packet ready and to meet and allow visiting nurse to gain access to the building.*
- *On the day of the visit, SURC nurse will review prepared packet, visit the patient, and complete the technology dependent medically complex (TDMC) nursing assessment form.*
- *After the visit all the documents will be reviewed for accuracy. Eligibility will be verified with a clarifying narrative.*
- *If a client does not reach HBU criteria, the SURC will call the NF to verify accuracy of diagnosis and information collected by the visiting nurse.*
- *If no new information is obtained, a denial will go to the Chief Medical Officer of HCPF for review.*
- *SURC nurse manager will write final determination letter and sends the letter to HBU administrator and notifies the NF. HBU administrator will disseminated the SURC's information to all relevant parties.*
- *There is a checklist attached to make sure no relevant information is missed.*

HF: there is no need for this document to be made public. This is a flow for the NF and the SURC to maintain a smooth working relationship.

Heather relays to stakeholders that the HBU email is up and running and requests that the providers relay that information to their coworkers.

PROCESS, REGULATIONS AND RULES

A review of the current spreadsheet of the rules and regulations, created by the project team, which could change as a result of the HBU redesign is presented to the group. This sheet is intended to track all of the potential changes to current rules and regulations as they are now.

Staff stability is the first topic. In our rule, it says we need staff stability but it does not give a definition of what that is. Various departments could define that in their own way and we could end up with inconsistent results when it comes to helping and monitoring our providers.

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Heather presents the topic to the group for discussion. What does that look like? How do we define that? If the department says a provider has staff stability and then CDPHE does a survey and decides that a provider does not have staff stability we will run into problems.

HF: what does staff stability look like for the facilities?

LF: the services we provide from a staffing rate? Or turnover rates?

HF: not the turnover rates. Rather, how it looks in your facility to have the HBU program. What are your patient to caretaker ratios?

LF: from a repertory stand point, we have more intense than any ICU in the area. A lot of our clients are mobile and participate in the community, and it takes a lot of one on one time with an RT.

Staffing is a huge piece of the Rock Canyon facility. They currently provide about 4 hours a day contact and have about 30 respiratory clients total.

Most of the providers have a higher nursing staff compared to a traditional facility mainly due to the different type of clientele however.

The Department is looking for better, more defined information to get a sense of what CDPHE looks for in staffing stability when they survey a NF. The HBU aspect needs more clarity and we are hoping to get more information from our providers.

AM: have you looked at the definitions of when you would remove a provider from the program?

HF: we have not. I don't believe we have anything in rule either; we should look into that for the future.

Dr. Deb Parsons reviewed the recommendations from all of their site visits with HBU providers:

- *Bariatric patients*
- *MS or ALS conditions*
- *Trach patients*
- *A broad category of patients that have disease processes that are “on and off”*
- *Cancer*
- *HIV positive*
- *Complex COPD patients.*

Heather made the request of the providers to come back with some numbers and concrete data around certain populations that facilities are struggling with.

Other recommendations:

- *Study the process of financial eligibility and try to break down those road blocks.*
- *Patients that are discharged to the hospital and will not be back to the facility; a case study of this problem has been requested.*
- *Advance care planning--more consistency is necessary in this area.*

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All of the points brought to the committee's attention will be covered in the care coordination umbrella.

MA Sites—there are 7-9 sites in the state. Heather and Saori visited with the staff to find out some information. What holds up a case? Circumstances around that? The staff were reluctant to agree to a typical case; so much information was missing or unknown, and for a client's family to get POA becomes very difficult because the information is just missing.

One caveat about MA sites, if a client originally applies to a county office, MA sites cannot step in and take over to expedite the process.

Another problem that is very hard to solve, getting to the hospital before a Medicaid application is sent in to let the hospitals know the MA site would process it faster is next to impossible. We would have to provide training and education to the hospitals to get them on the same page regarding where to send Medicaid application.

Some disagreement arises within the group about the time it takes for a client to get on Medicaid between the providers and SEPs.

Clients need to have SSI in place before Medicaid is able to be approved.

