

Commission to Study Difficult-to-place Patients
November 5, 2015
Meeting Summary

Convened 10:00 a.m., Room 216, Cross State Office Building, Augusta

Present:

Sen. Anne Haskell
Rep. Drew Gattine
Rep. Peter Stuckey
Jeff Austin
Melvin Clarrage
Richard Erb
Brenda Gallant
Simonne Maline
Kim Moody

Absent:

Sen. Roger Katz
Rep. Richard Malaby
Michael Lemieux
Ricker Hamilton

Staff:

Natalie Haynes
Dan Tartakoff

Introductions

Commission Chair Drew Gattine called the meeting to order and the members introduced themselves. Commission members reviewed the agenda for the day and Commission staff described for members the various handouts and documents on their desks.

Panel discussion on geropsychiatric facilities

The Commission received a panel presentation on the approval process for admission to the 3 geropsychiatric facilities in Maine, an explanation of the rate structure for these geropsychiatric units and a discussion of their operational capacity and turnover rates. The presenters on this panel were Richard Erb (Maine Health Care Association), Michelle Bellhumeur (Gorham House, Gorham) and Larry Davis (Hawthorne House, Freeport).

To open up the panel, Mr. Erb provided a brief overview of the State's 3 geropsychiatric facility units. He noted that these facilities are not always operating at full capacity, although he also recognized that there is a demand for more geropsych beds statewide. Mr. Erb explained that there is a set fee for geropsychiatric units that typically includes a private room differential (most nursing rooms are semi-private) and that these units usually receive reimbursement for their actual costs for services, provided they are determined to be reasonable. Mr. Erb, however, was not aware of any complaints from these facilities regarding the issue of payment for services.

Michelle Bellhumeur stated that Gorham House has 17 geropsych nursing facility beds. Patients at Gorham House are heavily monitored and generally treated successfully at the facility. This sometimes means that because a patient is doing so well, a GOOLD assessment may indicate they are ready to transfer to a traditional nursing home setting, which often does not work well because of the lack of support in those facilities for patients with mental illness. Ms. Bellhumeur noted that in order for a patient to receive placement at a geropsych facility, their psychiatric diagnosis must be the primary diagnosis. If a reassessment is done and it demonstrates that a

different diagnosis, such as dementia, has become the primary diagnosis, that patient typically must be transferred to a traditional nursing facility.

In follow-up by Commission members, the issue of the limited number of dementia beds in the State was discussed, and panelists agreed that the current number of dementia beds does not match the level of need from the increasing population of dementia patients in Maine. Panelists also raised their concerns that nurses and not licensed mental health clinicians (APRNs, PMH-NPs, etc.) are conducting these GOOLD assessments, and that their more limited knowledge of mental health issues and disorders affects the assessment, often to the detriment of geropsychiatric patients. Additionally, panelists questioned whether PNMI level 4 facilities need to be considered for providing geropsych services and whether the Preadmission Screening and Resident Review (PASRR) process can be amended to better focus on psychiatric behavior.

Larry Davis stated that Hawthorne House has 18 geropsychiatric beds and that the average length of stay at his facility is 4.25 years. He noted, however, that his facility has 3 residents who have been there more than 10 years, 4 residents that have been there between 5 and 10 years and 11 residents that have been there for less than 5 years. Mr. Davis also stated that Hawthorne House has discharged over 30 patients since 2008.

Ms. Bellhumeur noted that Gorham House has 2 empty beds at present and that they can go 6 months at times without filling an empty bed. Much of this delay, according to the panelists, is due to the complex nature of the placement/referral process conducted by DHHS. Because of the unique behavioral and other related issues that are present in mental health units like geropsych units, there is not as much of a cycle of movement in such units as there is in the traditional nursing facility context. Additionally, because of these patient concerns, PNMI and traditional nursing facilities are nervous to take residents from a geropsychiatric facility.

Panelists recognized that ensuring regular provision of behavioral health services can be challenging for geropsych facilities. Ms. Bellhumeur noted that Gorham House is fortunate to finally have a PA and psychiatrist to manage residents at their facility and that because of this, they no longer need to call the police as frequently to assist with physically violent patients. However, as a result, DHHS' utilization review (UR) nurse wants to discharge some residents because they are doing so well, which the facility believes is a result of how well their needs are managed, and not a result of any substantive change in the underlying diagnoses or patient needs. The panelists also explained that there is pressure on the UR nurse to discharge people from geropsychiatric facilities to free up beds for patients stuck in community hospitals.

Representative Stuckey stated that perhaps there is a need for a new facility or process that focuses more on mental health and dementia to find the safest residence for people. Brenda Gallant stated there are 16 residential care geropsych units at Mount Saint Joseph in Waterville and that it would be helpful to have more of these types of beds. Ms. Gallant asked panelists how long it takes to place a patient in a geropsych bed once a referral has been made to the UR nurse, to which they responded that it is a very different process than for referring to a traditional nursing facility bed. For placement in a geropsych bed, a LCSW performs an assessment, which requires documentation of long-term treatment for mental illness and behavioral problems, and a GOOLD nursing level of assessment and then a referral is made to the facility for a referral review. The geropsych facility then meets the patient to assess their needs, determine if they will be a good fit for the facility and review Medicare or MaineCare eligibility. Once all this is completed – a process that can take a number of weeks or more – the patient can be placed.

Jeff Austin next raised the question as to how the State is able to determine the cost of adding new additional private, for-profit geropsych facilities, to which the panelists responded that this information is in the cost reports and would involve looking at the room differential (private rooms) and the reimbursement for actual costs. Kim Moody stated that the State has relied upon the 3 existing geropsych facilities to fill the need for decades and have not looked at enhancing specialized services for these patients in regular nursing facilities. In fact, it was noted that the number of geropsych beds in the State has remained unchanged over the last 20 years. Ms. Moody also recognized that even if the State opens up more geropsych beds, they still will find it challenging to secure the psychiatric services necessary to manage those populations.

Panelists next raised the issue that there is a population of nursing facility patients that might be better served in a geropsych unit, but who lack required documentation of a long history of mental illness, often because they never received any treatment despite the need. Representative Gattine suggested that because geropsych beds are a scarce resource in Maine, determining priority for placement into an open bed is the primary contributor to the lengthy referral process. Ms. Gallant recommended the Commission look into improving the referral process, starting with a review at DHHS from the top down. Ms. Moody believed the group should also consider improving specialized services for these patients in traditional nursing facilities.

Panelists also suggested the Commission address the need for mature, trained staff in geropsych facilities. Ms. Moody noted that staffing deficiencies are a problem across the board and recommended the Commission focus efforts with the Department of Labor to train people for community support jobs, which pay a good wage, and increase efforts for public/private partnerships in this area.

Mr. Erb next addressed PNMI capacity issues, noting that appendix C PNMIs are generally fully occupied (90-95%), while Mainecare beds in such facilities are closer to 100% occupied and private pay rooms are almost never vacant. The reimbursement rate for these PNMIs is nearly half of the nursing facility rate and their staff generally have less than a third of the training as those in geropsych facilities. As such, patients may not be best served by expansion of geropsych services in the appendix C PNMI context. Mr. Erb noted, however, that he was surprised to hear that Mount Saint Josephs has a successful geropsych PNMI unit and recommended further exploration of this option. The Commission requested that Mr. Erb determine the actual rate paid by the State to the 3 geropsych facilities to hold open a bed for a patient requiring hospitalization and for how long they are eligible to receive this rate.

Representative Gattine stated that perhaps some of these issues could be better addressed if the State provides increased support services, including psychiatric support, to better assist facilities with managing the challenges that arise with specific patient populations. Ms. Moody added that more work needs to be done to get the PNMI system to work better for Maine.

Additional presentations

The Commission also received brief presentations from Jeff Austin and Brenda Gallant. Mr. Austin summarized a list of proposed recommendations and proposals for discussion that he had provided for the meeting. Ms. Gallant provided the Commission with a summary of the role of the Office of the Long-term Care Ombudsman. She described their outreach efforts with hospitals across the State and their efforts with the federal Homeward Bound program. Representative Gattine suggested that perhaps federal grant funds could be expanded under the Homeward Bound program to serve more people and requested that DHHS provide information on whether the State can request additional federal grant funds to support the program.

Commission discussion

The Commission next opened up the floor to discussion. First, Mr. Austin provided additional information on his list of draft proposals. His first proposal addressed the need for hospitals to receive payment for days that a patient is awaiting placement to a long-term care facility. Hospitals care for these patients in a manner that is similar to a nursing facility and, per Mr. Austin's recommendation, should be paid a daily rate similar to that currently received by critical access hospitals. This rate will not cover a hospital's costs of care (e.g., staff salaries, use of bed/services, cost of services, etc.). MaineCare approval and geropsych placement processes are complex and lengthy and if these delays cannot be remedied, then hospitals should be provided with some form of reimbursement for these costs, as they are currently operating at a loss with these patients. Senator Haskell requested that Mr. Austin identify, if possible, what is being done in other states in regards to hospital reimbursement for these types of patients, while Representative Gattine asked for more specific information on this proposal (e.g., what specific rate would be paid, when would the rate kick in, would there be a cap, etc.).

Ms. Moody expressed concern that paying a daily rate to hospitals for these patients would reduce incentives for the hospitals or the State to get these patients placed in a proper facility. Mr. Austin responded that hospitals are paying on average a significant amount per day for patients awaiting placement and they are only proposing to receive \$100-200/day, so they would still be operating at a loss. As such the incentive would still be there for the hospitals. In terms of the State's incentive, he hoped that the existence of a new fiscal cost (i.e., the days awaiting placement reimbursement) would spur action by the State to address barriers to placement.

There was additional Commission discussion regarding the costs and benefits associated with the nurse education consultant position at DHHS and their role in performing patient assessment at hospitals and informing placement facilities of that individual's needs. A number of Commission members agreed this position helps facilitate the referral process to a proper facility.

Another proposal discussed by the Commission concerned the addition of staff to the Long-term Care Ombudsman's office. Commission members generally agreed that the Ombudsman's Office has done great work helping to place individual patients, which is time-intensive, and the Office could use more staff to expand assistance provided to patients in hospitals. Per Ms. Gallant's recommendation, changes to the statutory provisions governing the authority of the Ombudsman may be necessary. Commission members agreed to develop this proposal further.

The Commission next turned to capacity issues relating to geropsych facilities, noting that the number of these beds has not grown with demand and that there is a specific lack of these services in Northern Maine. Members agreed to further discuss the proposal to direct DHHS to issue a Request for Proposals (RFP) for the establishment of a geropsych unit in Northern Maine.

The fourth proposal addressed concerns raised by Disability Rights Maine (DRM) regarding contract compliance and enforcement issues. Commission members were interested in reviewing specific proposals and Ms. Moody, on behalf of DRM, stated that she would provide specific recommendations for the next meeting.

The fifth proposal addressed concerns raised with placements other complex patient populations, including ventilator-dependent and bariatric patients, and the lack of facilities that provide services necessary for these patients. The vent rate rules that allow for negotiated rates for facilities that serve these patients may be sufficient to address the need, but the question was

raised as to cost neutrality for special populations and the need for additional geropsych beds to be MaineCare neutral.

The final proposals discussed by the Commission was whether hospitals should be able to waive the 60 mile rule (i.e., patient can refuse placement at facility greater than 60 miles from their residence) in the event that an appropriate facility greater than 60 miles away is available to take the patient, and whether facilities should be allowed to presumptively determine MaineCare eligibility for patients. Both proposals were flagged for future discussion.

Public comment

The Commission next opened up the floor for public comment. Sheila Pechinski testified first regarding her own experiences caring for family members with Huntington's Disease (HD). She noted that there is a pilot program in New York for HD patients and that there are at least 150 HD patients in Maine who would be interested in similar care as there is at present no specific facility in Maine to treat these patients. Ms. Pechinski noted that the primary barrier to treating HD patients is staffing costs (need specialized skilled staff often around the clock).

Lisa Harvey-McPherson testified next on behalf of EMHS. She noted that retirement facilities in Maine are increasing their staffing and other services for specific patient populations, which is affecting nursing facility enrollment in Maine. Ms. Harvey-McPherson stated there is a need for increased home care services and increased skilled staff working in the field for specialty populations. She recognized that Northern Maine does not have sufficient facilities to meet the demand of specialized patient populations. Geropsych patients in particular need secure units and there are some that cannot be commingled in a long-term care setting. Ms. Harvey-McPherson noted the problems caused by delays in MaineCare application processing that must be addressed; on average, it currently takes DHHS 45 days to process a MaineCare application. She also stated that there needs to be a streamlined process to help people transition back into the community and there need to be more beds to incentivize this transition. To assist in addressing these many issues, she believes that we need more data to identify areas where the capacity for special patient populations is lacking. A State reporting requirement for nursing and long-term care facilities refusing placement of a patient would, in Ms. Harvey-McPherson's opinion, provide us with critical data on these issues. The Commission requested that she draft up her suggestions and proposals in a written document for consideration at the next meeting.

Lastly, the Commission heard testimony from Eric Pooler, who manages Southridge Rehabilitation in Biddeford. He noted that some of the biggest issues he faces are staff burn-out and the lack of mental health providers. In Mr. Pooler's opinion, he can presently work with the State in terms of reimbursement and costs. For example, he described caring for a bariatric patient recently, where he worked with DHHS to secure an adequate reimbursement rate and to provide the resources necessary to outfit the facility with appropriate equipment to address the patient's needs. Mr. Pooler also suggested the Commission look at the possibility of allowing a medical facility, under certain conditions, to offer medical certifications, such as for a certified nursing assistant (CNA), in-house to address staffing deficiencies and barriers to education.

Information requests

As a result of its discussions at the second meeting, the Commission requested that Commission staff develop a spreadsheet with the proposed recommendations identified to date for consideration at the next meeting. In addition, a number of information requests were made of different parties, as described below.

Maine Health Care Association was asked to provide the following information:

- Can MHCA provide any information on the rates (i.e., what are the actual rates) that the 3 geropsych facilities are receiving from the State through SAMHS for holding open beds for geropsych patients beyond the 7 day federal limit when they decompensate and have to be hospitalized?
- What suggestions does MHCA have for expanding or improving/reconfiguring Appendix C PNMI facilities to better serve these patient populations (i.e., expanding capacity, staff training/availability/skill levels, etc.)?
- What is MHCA's position on the feasibility of implementing a presumptive eligibility standard/option, as described by Jeff Austin/MHA at the meeting (i.e., provider would have ability to presume Medicaid eligibility for a patient with later DHHS follow-up)? Is this a good idea; is it something that could work in Maine?
- What is MHCA's position on the proposal to implement a basic reporting requirement for facilities refusing patient placement (i.e., facility refusing placement of patient would be required to fill out and submit to DHHS a short form outlining reasons for refusal, such as lack of available bed, appropriate staff, necessary resources/equipment, etc.)?

Maine Hospital Association was asked to provide the following information:

- What additional specifics can you provide on the proposed "days awaiting placement" rate for hospital patients awaiting placement, including, what rate would the MHA consider appropriate for reimbursement (dollar figure?), when would the rate kick in; would there be a cap on the rate (# days, total reimbursement cap per patient) etc.?
- What approaches have other states taken in terms of reimbursement for this patient population (i.e., do other states reimburse hospitals in a similar fashion)?

DHHS was asked to provide the following information:

- At the second meeting, Commission members discussed the Department's process for referral of a patient to a geropsych facility. It is our understanding that a team of individuals at DHHS make decisions regarding whether a patient meets the criteria for placement and which patient meeting the criteria will ultimately be placed in an available bed (i.e., a discussion of "placement priority"). It was suggested that this process, from the time a bed at a geropsych facility becomes available, to the time a patient is placed, can often take a number of weeks, despite the fact there may be a number of patients who meet the criteria and would benefit from immediate placement. Could you outline for the Commission how this process is conducted at DHHS and what improvements, if any, could be made to facilitate quicker placement of patients?
- At the first meeting, it was suggested during public comment that when the State places a Mainecare patient for treatment out-of-state, the State is only obligated to reimburse that patient's care for the first two years of placement out-of-state and then no longer has a financial obligation. As you may recall, this assertion surprised most Commission members, and given that we have received no clarification from the individual who made

the comment, can DHHS comment on whether or not this is an accurate description of the State's financial obligation to patients placed for care out-of-state?

- At the second meeting, members discussed the Homeward Bound program, specifically the federal grant monies made available to support the program in Maine. It was suggested that one possible recommendation the Commission might make would be to support the expansion of this program, perhaps with the assistance of the Long-term Care Ombudsman, to place more than the current program goal of 26 placements per year. Can the Department comment on the feasibility of expanding the Homeward Bound program in Maine, specifically addressing the possibility of securing additional federal grant monies to support this expansion?
- At the second meeting, there was additional discussion about negotiated rates. Members have asked us to get the Department's perspective on the negotiated rate process and whether it believes that this process is working to adequately and effectively serve these populations of patients with complex medical conditions, including whether expansion of the negotiated rate process for these populations is feasible or would prove effective?

Disability Rights Maine was asked to provide the following information:

- What specific proposals does Disability Rights Maine suggest to address contract compliance and enforcement issues, including any statutory or regulatory changes that would assist DHHS in ensuring facility contract compliance as well as in enforcement when there are violations?

Future Meetings

The third meeting of the Commission will be held on November 20th. The final meeting will be held on Wednesday, December 2, at 10:00 am. Unless otherwise noted, all meetings will be held in Room 216 of the Cross State Office Building.

The meeting was adjourned at 3:00 p.m.

G:\STUDIES 2015\Difficult-to-place Patients\Summaries\Final November 5 Meeting Notes Summary.docx