DIFFICULT-TO-PLACE BEHAVIORAL HEALTH PATIENTS MEETING

September 30, 2009

FOCUS OF MEETING

There are an increasing number of complaints from member hospitals about delays in discharging patients to post-acute care settings, such as residential and skilled nursing facilities and intermediate care facilities for individuals with mental retardation or developmental disabilities (MR/DD). Some of these delays have resulted in avoidable hospital days extending into weeks, sometimes months, which ties up beds and increases costs for providers and payers. Similar concerns were expressed in 2001.

BACKGROUND

Lori L. Popejoy, Ph.D., Interdisciplinary Center on Aging at MU Sinclair School of Aging, presenting preliminary results of a 74-item survey she conducted to determine the frequency and specific types of problems related to post-hospital discharge to SNFs, RCFs, home health and long-term care hospitals.

The methodology used was a statewide snowball sample of 369 participants: 16.4 percent staff nurses, 23 percent were physicians, 21.6 percent were social workers, 15.3 percent were case managers, 17 percent were management or administrators and 6.7 percent were other. Forty-three percent of all respondents were nurses.

Preliminary results indicate that significant placement problems occur with ventilator, mentally ill, chemotherapy, radiation therapy, isolation, wound vacuum and tracheotomy patients. Reasons given for delays include issues related to insurance/reimbursement, medically complex patients, expensive medications, mental illness or behavioral problems. The survey indicated that two-thirds of all discharges to SNFs are delayed more than 24 hours because of placement problems. Urban areas report having more problems than rural communities.

A difficult-to-place study done by MHA in 2001 identified the following patients as the most difficult-to-place.

- major mental illness with chronic illness
- ventilator-dependent
- requiring costly medications
- organic brain disorder or dementia with behavior problems

TMC Experience

Truman Medical Centers, Inc. presented an overview of 18 difficult-to-place patients in 2008 and 2009. These 18 patients represented 22 inpatient admissions and four emergency department

examples. The 22 inpatient admissions accounted for 518 avoidable days and $698,316 in lost revenue. All but one received payment from Medicaid. Three were dual eligible.

Three of the ED visits were Medicaid patients under the age of 50 from the same nursing home who, after getting in a fight, were transported to the ED for evaluation. The hospital evaluated and treated them in the ED, but the nursing home refused to take them back. The ED had to find other facilities to admit these residents. Appeals to the Missouri Department of Health and Senior Services were filed.

A similar incident occurred with another 51-year old Medicaid nursing home resident who the facility refused to readmit until the hospital threatened to call DHSS' hot line.

Problem: Finding discharge placement for individuals with nonacute medical problems but still needing a skilled nursing home environment with their concurrent conditions, such as:

A. dangerousness for reasons other than psychiatric (e.g., criminal or sexual predator history, neurological disorders such as traumatic brain injury, conditions like encephalitis or progressive dementias like Huntington's), much of which is secondary to episodic agitation accompanying delirium and/or dementia or history of instrumental violence associated with past criminality

B. psychiatric disorders with behavior problems (e.g., elopement, para-suicidal behavior, substance abuse) requiring a locked environment but not actively dangerous to self or substance abuse

Individuals classified under (A) have a neurologic disorder that affects their behavior but is not a psychiatric disorder. These individuals often pass the Preadmission Screening and Resident Review (PASRR) screening but are a danger to themselves and others. Missouri Department of Mental Health MR/DD facilities will not take them because they do not meet criteria (head injury after age 22 or not MR/DD). You cannot involuntary commit them because 632.380 RSMo excludes mentally retarded, developmentally disabled, senile or those impaired by alcoholism or drug abuse unless they also are mentally ill. SNFs are the least restrictive environment for these patients. According to Missouri Health Care Association, there are facilities that are able to manage them. However, because of fear of citation, lawsuit under Olmstead or Institution for Mental Disease (IMD) threat, they are reluctant or will not take them. MHCA reported there are several facilities in the state that are able and willing to take behavioral patients with skilled nursing needs under a behavioral rehabilitation model if the Central Office Medical Review Unit (COMRU) would allow placement in these facilities. COMRU's general position is that if the patients have had a history of being dangerous to themselves or others, they are not appropriate to a nursing facility environment.

Possible Solutions

- Develop new or identify less restrictive environments that meet regulatory requirements than a hospital environment for these populations.

- Identify appropriate skilled nursing/behavioral rehabilitation facilities and remove barriers to placement for these special needs patients.
- Change the regulations/laws/payment models to permit current types of post-acute care facilities to safely and effectively care for these populations in the least restrictive environment possible.

Problem: A resident has behavioral issues or a change in behavior, and the resident's needs cannot be met in an ALF. Currently the resident does not have a need for skilled nursing care, but ALFs are not able to provide 24-hour protected oversight.

Inappropriate placements are made because we are trying to fit a nongeriatric patient into a geriatric model. There is no continuity of care for these types of patients. The current model does not allow patients to move up and down through levels of care as needed because of "siloed" payments.

Possible Solution: Develop a level of care between ALF and SNF for these residents. LTC facilities need to have a plan other than sending them to the ED when they cannot manage their behavior.

Problem: LTC residents are sent to EDs with an emergency involuntary discharge from the LTC facility because of an episodic inappropriate or violent behavior or when the resident has become progressively more difficult to manage. LTC facilities that are struggling often will take all patients but then send the residents to the ED when they find they cannot control them. If the resident does not have a medical reason, the hospital, by regulation, cannot admit the resident. Alternatively, if a resident has a medical reason and is admitted and the medical reason and the subsequent behavior are resolved, the hospital must make the arrangements to relocate the patient upon discharge. While awaiting placement, the resident is staying in the highest and most costly level of care.

SNFs/RCFs emergently discharge patients and transport to EDs or refuse to accept patients back from the hospital under 19 CSR 30-82.050 (5)(A-D). However, this rule states under (11) that the burden of showing that the facility has complied with all requirements for appropriate discharge of the resident shall be on the facility. Under (14), the rule says if the decision is in the facility's favor, the resident shall be granted an additional ten days after the decision is received for the purpose of relocation, and the facility must assist the resident in making suitable arrangements for relocation. LTC facilities are shifting their burden of finding appropriate placement to hospitals through ED transfers. Although (6) in the same regulation does provide for an appeal process, hospitals are reluctant to do that because of fear of jeopardizing their relationship with the LTC facilities.

Lawyers are advising assisted living facilities not take these residents back because surveyors will cite them. The language in the new ALF law is too broad and may need to be amended to exclude dementia and delirium. On DHSS' ALF assessment form, the question related to danger to self or others is too broad.

Possible Solutions

- Hospitals could call the facility and tell them that the resident is being sent back because an emergency or medical condition no longer exists.
- Hospitals can file an appeal under 19 CSR 30-82.50. This takes too long and is too costly. Avoidable days and uncompensated care costs are still occurring for both hospital and nursing home during an appeal.
- DHSS should develop an alternate dispute resolution process rather than depending solely on the appeal process afforded in state regulations.
- A change could be made in the regulations to require the LTC facilities, when a resident does not have an acute medical condition needing hospitalization, to work with state regulators, ombudsman and other LTC facilities to make suitable arrangements for relocating the resident.
- Workgroup needs to review the ALF law to determine if there is a need to exclude dementia and delirium.
- The state needs to revise the question related to danger to self or others on the DHSS ALF assessment form.
- For Medicaid patients, should nursing facilities be required to give them an advance notice of appeal rights upon admission and before discharge notifying them of their rights, similar to the Important Message from Medicare given to SNFs?

Problem: SNFs and ALFs transfer most difficult patients Friday evenings and Saturdays when staffing is down. Admission data show this is not true. Data actually show that these are the lowest days for admissions from these facilities.

Problem: SNFs limit the time and days when they will accept patients from hospitals.

Possible Solutions

- Extended Care Information Network (ECIN) software used in St. Louis enables a hospital to send out a request to nursing homes or rehabilitation facilities in St. Louis per patient/family specifications. The system tracks how long it takes SNFs to respond to a request and when patient is transferred. Hospitals and SNFs are able to send required transfer documents via the system. Hospital members include BJC Healthcare hospitals, St. Louis University Hospitals, St. John's Mercy Health Care hospitals and others. Any LTC facility can be a receiving member.
- SNFs will accept weekend transfers if they are notified by 3 p.m. Friday.

Problem: PASRR screening take too long, and there is an observed increase in the number of patients who have failed Level II screening.

DHSS receives many DA 124 forms that are incomplete, not signed, filled out wrong or the documentation is not supported. As a result, they have to send them back or wait for additional information. The DMH Comprehensive Psychiatric Services contracts with Bock Associates to complete the Level II evaluations for individuals suspected of having serious mental illness. Bock Associates employs registered nurses to complete these Level II evaluations. DMH, Division of Developmental Disabilities uses their 11 regional offices to perform the Level II

evaluations for individuals suspected of having DD. Each regional office employs R.N.'s who conduct these evaluations. Last quarter, Bock Associates completed their evaluations at an average rate of 4.77 days. For regional offices, the average rate was nine days.

Are Missouri's PASRR regulations more restrictive than federal requirements? COMRU has not changed the criteria but are reviewing the regulations to ensure that facilities have ruled in or out of danger to self or others (need a statement from treating physician) and that the 21 points required are being met for reasons other than only psychiatric. Determination is absolute rather than contextual because once approved, individuals can be moved from one setting to another without any rescreening. Joseph Parks, M.D. suggested that the question should be asked within the context of the environment in which they are residing, as well as conducting educational sessions on how to interpret suicidality, because many consumers who are suicidal can be effectively managed in many nonhospital environments, including SNFs.

Possible Solutions

- Compare Missouri's PASRR regulations to federal requirements and make revisions to state regulations if appropriate. (DMH has completed a self-assessment, but results have not yet been shared internally.)
- MHA and PASRR staff to hold regional training workshops for hospitals on the PASRR process and application.
- Provide education to reviewers and/or physicians required to offer statements about dangerousness to self or others specific to the setting in which the patient is residing and levels of dangerousness requiring hospitalization.
- Provide additional training to nursing facility staff on meeting needs of individuals who have a mental illness on behavioral problems and interventions.

Problem: A few nursing homes may be near the 50 percent limit for patients with a diagnosis of mental illness and may be at risk of disallowance as IMDs.

Possible Solution

Missouri Health Care Association in conjunction with DHSS is to research the criteria care and compliance standards necessary to allow placement in skilled nursing facilities with behavioral rehabilitation programs without risking violation of the IMD standards. Consideration should also be given for more Home and Community Based Waivers to serve patients with MI as an alternative to nursing home placement if the lower level of care is safe and appropriate.

Problem: Under the Centers for Medicare & Medicaid Services' regulations, residents on two or more psychotropic drugs must have a psychiatrist justify the need or have a plan to taper them off the medications. You cannot bill Medicare for a psychiatrist visit in a nursing home. Under Medicaid, no psychiatrist will see a Medicaid patient at the current payment rates. There are not enough psychiatrists in the state. Few will see nursing home patients in the facility, and many will not even see them in their offices.

Possible Solution: Allow more telepsychiatry services in nursing homes and allow psychiatrists to bill separately for service.

Problem: Surveyors will cite facilities that use drugs such as Haldol to treat delirium as a restraint.

Possible Solution: Educate surveyors that delirium is a medical condition that is appropriately treated with Haldol and is therefore not a restraint.

NEXT STEPS AND ACTION ITEMS

Data Needs

- Identify the number of patients in hospital who have been labeled as difficult-to-place.
- What is the magnitude of the discharge problem for hospitals because of violent behavior with and without nursing care needs?
- What is the cost to hospitals and payers, such as Medicaid, for avoidable days?

Action Items

- Identify extent of problem, number of individuals affected by using a hospital survey, tracking tool or review of administrative data. This will be done by MHA.
- Identify facilities that currently accept individuals with neurologic or behavior problems with concurrent skilled or assisted living needs. This will be done by LTC associations.
- Review current laws and regulations to identify current barriers and possible revisions. This will be done by MHA and LTC associations.
- Review and revise the question related to danger to self or others on DHSS' ALF assessment form and change to "currently in danger."
- Compare federal requirements for PASRR to Missouri's rules and other states' regulations.
- Review other state's regulations for emergency transfers from LTC.
- Review the ALF law to determine if there is a need to exclude dementia and delirium.
- Ask DHSS to share with hospitals their guidance and policies on emergency involuntary discharge, which was prepared for LTC facilities.

Next Meeting: Add LTC providers. Add Tracy Niekamp and/or Danette Beeson from DHSS to meeting list.