BHP Operations Sub-committee - Minutes

DATE AND TIME OF MEETING: Date: March 5, 2021 Time: 2:30 - 4:00 Location: via zoom	Internal	External	Recorder: Lynne Ringer, Beacon Health Options	Draft	Final
		x		X	

TOPIC	DISCUSSION/RECOMMENDATION
1. Review of Level of Service Guidelines for Acuity Add On Rate OpsComm6-16-21DraftLOCGuidelinesA(	•Dr. Sandrine Pirard (Beacon) explained language change to "Service Level" criteria instead of "Level of Care" as the youth is already being authorized for inpatient psychiatric level of care and this is an added service. Denial process will not be a medical necessity denial since the level of care is not being denied. Administrative denial will be issued if youth is not meeting criteria. This is intended for youth who exceed needs seen of typical youth presentation on the inpatient unit. •Dr. Pirard reviewed the eligibility criteria. Section A111 is related to behavioral challenges, youth must meet 2 criteria. Section A112 is related to medical needs or developmental disabilities. •Dr. Frank Fortunati (Yale) recommends wording be changed from "physician ordered" to "ordered by a credentialed provider" which would include PA or APRN staff. The 1st set of criteria seem restrictive and he does not believe any youth would meet the criteria as they are outlined. At Yale they do not utilize 5 minute checks and often use line of sight supervision. •Laura Nesta (St. Vincent's) discussed transitioned within their facility to preventative care. Restraint rates are low, IM medications are used as a last resort. Wondering if there is a way to look at this in terms of preventative responses. Could the youth's presentation in the 7 days prior to admission be taken into account? What does mitigating circumstances mean and how is it defined? •Dr. Fortunati- All youth in ED are on some level of constant obs by protocol not by physician order. At Yale they also try to avoid restraints. They may at times use physical holds but not for long durations. He can't recall any holds longer than 2 hrs. •Heather Gates asked for specific wording the meeting attendees would recommend in substitution of some of the language. •Laura- Consider behaviors and symptoms leading up to hospitalization, perhaps within past 7 days while in community. •Dr. Fortunati- It may be difficult to measure what is happening prior to admission and behaviors at home or in community are in a different context. Dr. Fortunati suggests the language of A1112 be modified and that A1111 be eliminated. •Dr. Pirard discussed often hearing that the youth is too acute or the unit is too acute when we hear of declines from ED's. Where do we set the line since we have to focus on youth who are requiring a higher intensity level of service. •Dr. Mara DeMaio (Hartford – IOL) asked if something could be added in about time spent deescalating patient. Ex: Worked on de-escalation for 3 hours for a specific case over the weekend. This required extensive staffing. •Dr. Fortunati feels like criteria are outdated based on interventions used previously but not currently how inpatient units operate given the extensive training of staff around de-escalation and utilization of individualized behavior plans.

	• Stacy Cruess (Natchaug) suggested there could be different criteria on admission versus continued stay. Could the focus be on how the youth impacts the unit? Many admissions require additional staffing support/resources and intervention to prevent harm to others. Is there a way to be more open to how we assess criteria? Extra staffing usually occurs rather than 1:1. Could the admission timeframe be more open ended to assess for how are they responding in first days of admission and are they stabilizing. Making sure the units have the resources/supports they need. • Dr. Fortunati agrees with Stacy's comments. Often 'too acute youth' or 'too acute unit' is based on a combination of factors including how would that youth impact milieu or be able to be managed. • Stacy asked for clarity on the authorization process. Lynne Ringer (Beacon) explained this will be separate authorization and shorter authorization. And with the ability to submit request on-line. • Dr. Pirard reviewed next section around medical complexity and gave examples of youth with eating disorders or youth with ASD or other developmental disorders that require additional support on the unit. • Dr. Fortunati feels the 3x/day nursing care section should be looked at further. There are youth with underlying conditions that are severe but may not require 3x/day care. • Laura asked for clarification on "assistive devices." Does that include interpreter services? Hearing aids? Wheelchair? Dr. Pirard clarified this was more focused on non-verbal youth or youth with developmental delays. She asked that the group take a closer look at discharge delay youth and whether they would be able to get increased acuity rate. She believes they should be eligible for this add-on. Rod stated he will take this back to state partners for review. • Discussion around whether criteria should be taken back for further discussion by Beacon/state partners as revisions will need to be made. Determined providers will have 1 week to make their own edits and then will send the edited versions to Lynne Ringer and Dr. Pirard for review. Beacon will integrate the versions with state partners and then they will be brought back to committee meeting. Dr. Fortunati and some staff at Hartford Healthcare have already begun making edits. Terri will outreach to other providers who were not present at this meeting. All hospitals need to respond with their edits by 7/16/21 close of business. •
x **Attendance** Stephney Springer Heather Gates, Co-chair Sandrine Pirard Rodrick Winstead Terri DiPietro, Co-chair Colleen Harrington Kelly Phenix Kerri Lloyd Erica Carr Donyale Pina Frank Fortunati Stacy Cruess Mark Vanacore	• x

Mara DeMaio Laura Nesta Joy Pendola Paul Guerrero Carmen Teresa Rosario Amy DiMauro **2.** Ann Turkington	
3. x	• x
4. x	• x
5. New Business and Announcements / Adjourn	• Meeting adjourned at 3:38 p.m.
6. Upcoming Meetings	• TBD