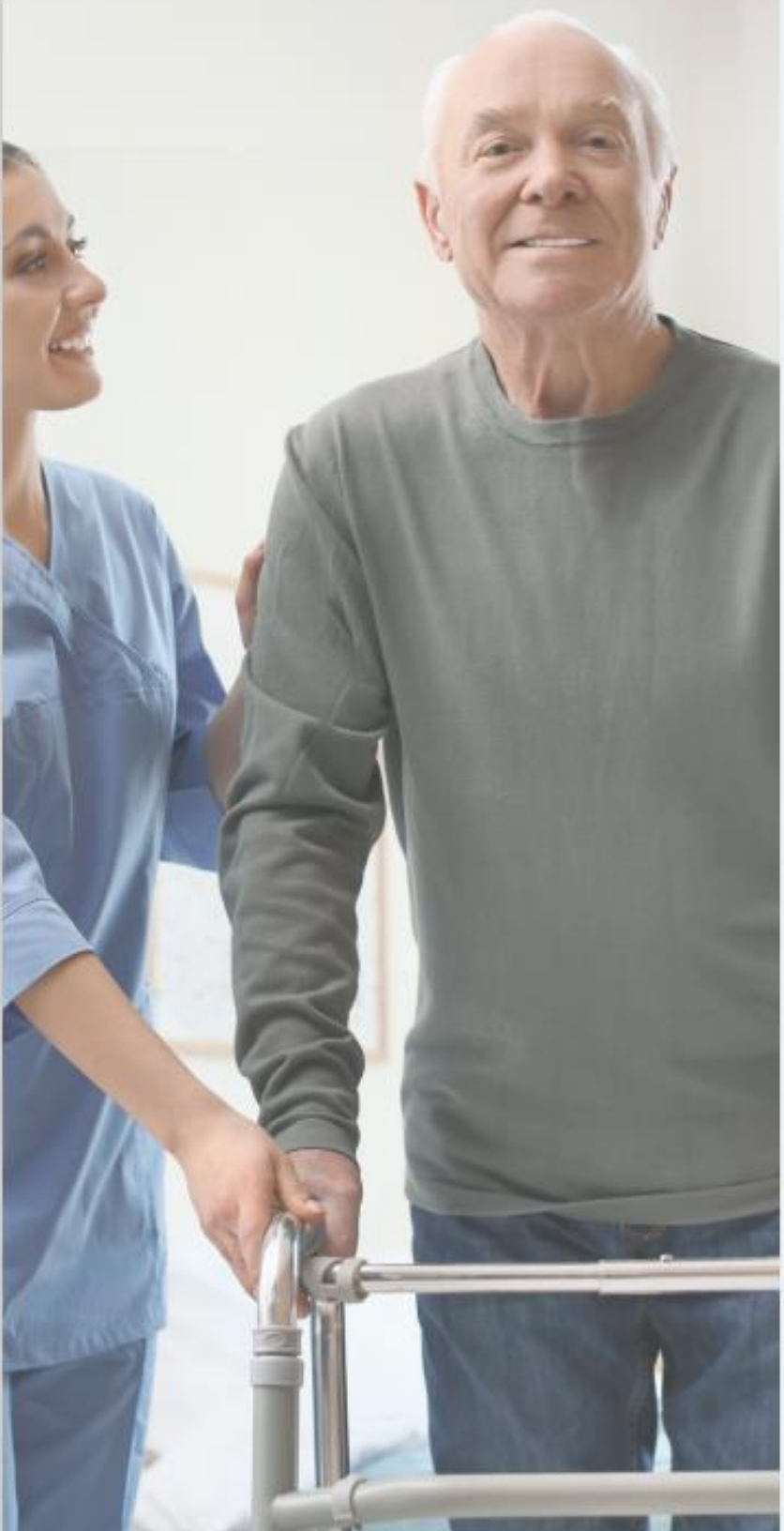


Healthcare Coalition of Maine

Post Acute Care Patient Placement Playbook

A document to provide resources to help ensure comprehension of the discharge process and support successful transitions from hospital to post-acute care settings.

Contents

Acknowledgements

The U.S. Department of Health and Human Services (DHHS) Administration for Strategic Preparedness and Response (ASPR) provided a total of $350 million in emergency supplemental funding to support the preparedness and response activities and needs of hospitals, health systems, and healthcare providers on the front lines of the Coronavirus Disease (COVID) pandemic.

This publication was supported by Maine's Supplemental COVID Funding provided by ASPR. All Clear Emergency Management Group was contracted by the Maine Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC) to develop this publication's content.

This publication draws from the contributions and expertise of the workshop participants and the Hospital to Home Advisory Group. Workshop participants helped to identify barriers and potential strategies to address the challenges of post-acute care placement of patients. While it was identified during workshops that there is needed policy change and reimbursement strategies, we want to recognize these changes are outside of the prevue of this project. Identified barriers and possible strategies were documented in each workshop report and shared with the Hospital to Home Advisory Group for situational awareness and possible elevation to the right agencies.

We would like to thank the following organizations/agencies for participation in the Hospital to Home Advisory Group:

- Maine Medical Center
- Mt. Desert Island Hospital
- Maine DHHS, CDC Public Health Emergency Preparedness (PHEP)
- Maine DHHS, Office of Aging and Disability Services (OADS)
- Maine Emergency Medical Services (EMS)
- Maine DHHS, Division of Licensing and Certification
- Maine DHHS, Office of Behavioral Health

Maine OADS staff reviewed and provided guidance for the development of this Playbook.

Introduction

This project highlighted the unique challenges hospitals face regarding decompression efforts, identify strategies to mitigate the challenges and barriers, and provide lessons learned from rural states, and at a national level.

This playbook is a result of the workshops and research into hospital decompression strategies within Maine and national best practices.

Overview

During COVID and even still now Maine acute care hospitals are experiencing unprecedented patient placement challenges resulting in hospital surge capacity issues.

Hospitals are seeking innovative ways to help make certain that patients are discharged to the appropriate care setting, be that the patient's home or another community health care setting, with the goal of improving quality across the continuum of care.

Safe and effective decompression at the hospital level requires a medical surge back into the "community setting". Community settings such as skilled nursing facilities, long-term care facilities, and home health play a vital role in the healthcare ecosystem but are rarely engaged or partnered with outside of acute circumstances. The term "community setting" does not include only agencies/facilities licensed to provide medical care. Considerations should also include residential type locations and home care dependent on the level of care required for the individual patient.

Purpose

This playbook is designed to be a resource for providers to help improve the hospital discharge process for both patients and family members. The playbook will provide centralized resources to help ensure comprehension of the discharge process and support successful transitions from hospital to post-acute care settings. It will also provide links to additional resources and help enable a positive experience for everyone involved. Additionally, this playbook will emphasize the importance of communication and collaboration between patients, family members, and other healthcare professionals.

This list is not exhaustive, and every attempt has been made to provide accurate resources. The inclusion of any organization, agency, business, or service in this playbook does not imply or constitute an endorsement or

recommendation, nor does exclusion imply disapproval. To the best of our knowledge, the information contained in this playbook was accurate and current at the time of publication. Playbook users are encouraged to contact Office of Aging and Disability Services (OADS) or other healthcare providers for additional information or resources.

Scope

This resource playbook will provide resources and detailed steps that cover the discharge process, from preparation for discharge to transitioning from hospital to community settings or home. It will include information on who is involved in the discharge process, steps to promote a successful transition, and resources for adequate support. Additionally, this playbook will include information on how to effectively communicate with other healthcare professionals and family members. It will also provide links to additional resources to ensure a positive experience for all.

How to Use this Playbook

This Playbook was designed to flow along with the patient discharge process.

Prior to preparing to discharge a patient please review the Quick Guide to Referral for Long Term Services and Supports (LTSS) Community Services.

A patient placement/discharge algorithm was developed to assist in the workflow of patient placement into community settings. A full page version of the flow chart is available in here.

This playbook is divided into four categories (Coordination, Complexity, Compensation and Capacity) which were developed based on the outcomes of the workshops focusing on barriers to patient flow.

Image 1: Barriers to Patient Placement

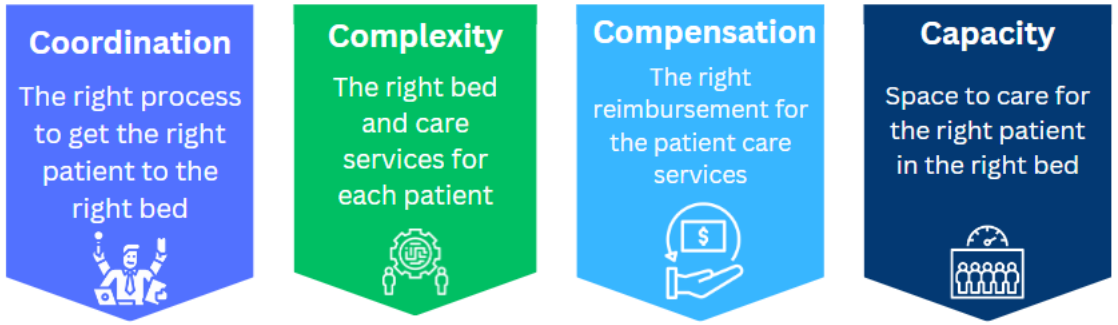
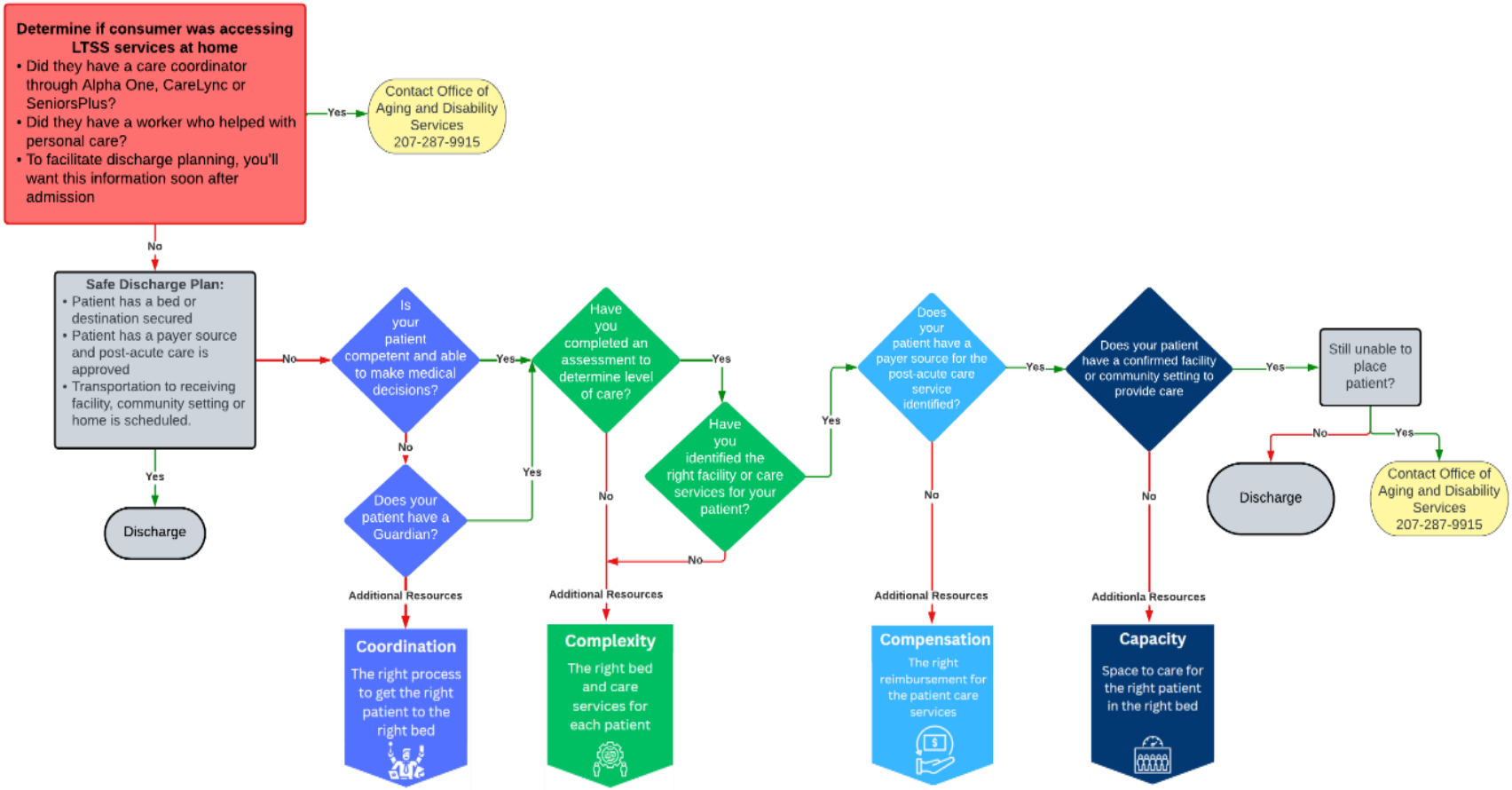


Image 2: Patient Placement Workflow



Each category includes:

- **Description**: Explanation of the category
- **Desired Outcome:** The desired end state
- **Objective(s):** A component of achieving the outcome
- **Activity**: Steps that can be taken to reach an objective
- **Resources**: Information supporting the activities
- **Level:** The level at which the objective/activity likely occurs for each category, which is denoted by any of the six icons in the left hand column. Those denoted by icons include:

Table 1: Level Description

Icon	Description of Level
	**Acute Care Provider/Case Management**- Acute care is a level of healthcare wherein a patient needs immediate yet brief treatment. Acute care is typically provided in a hospital setting by a variety of experienced clinicians. Case Management is a dynamic process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value.
	**Patient and Family or Support System-** A support system can include a patient's family and/or their friends.
	**Healthcare Workforce (Acute and Post-Acute)-** The health workforce refers to all of the people who deliver or assist in the delivery of health services or help operate health care facilities.
	**Healthcare Coalition (HCC)-** HCCs are groups of local health care and responder organizations that work together on challenges and find solutions that improve emergency preparedness and the health and safety of their communities
	**Home Care Agencies or in home caregiver-** Home care includes any professional support services that allow a person to live safely in their home. In-home care services can help someone who needs assistance to live independently; is managing chronic health issues; is recovering from a medical setback; or has special needs or a disability. Professional caregivers such as nurses, aides, and therapists provide short-term or long-term care in the home, depending on a person's needs. Caregivers can also be a family member or paid helper who regularly looks after a sick, elderly, or disabled person.
	**Emergency Medical Services (EMS)-** EMS agencies that provide transport of patients between two healthcare facilities or healthcare facilities to residential care or home (Acute to Post-acute).

Quick Guide to Referrals for LTSS Community Services[1]

Determine if consumer was accessing LTSS services at home

- Did they have a care coordinator through Alpha One, CareLync or SeniorsPlus?
- Did they have a worker who helped with personal care?
- To facilitate discharge planning, you'll want this information soon after admission,

Have they been assessed by Maximus related to their stay at your facility?

- Is the consumer's primary pay source Mainecare?
- Did they need to apply for Mainecare for their copay?
- If Maximus has assessed, and consumer was previously receiving services through a community program, their services have been terminated. Do not call Alpha One/ CareLync/SeniorsPlus in these cases.

If a consumer had services prior to admission and has been away from home less than 60 days, and has not been reassessed, call the Service Coordination Agency (SCA) that has been working with them (Alpha One/ CareLync/SeniorsPlus). ***Services will not resume unless you notify the SCA.*** This includes consumers who are self-directing their care, even if caregiver is a family member.

If a MaineCare member has been terminated from community services due to end of suspension or assessment while in facility/hospital, OADS can facilitate transition back to community services.

OADS will:

- Inform you of the services on consumers plan of care so you will know how many hours you are looking for providers to cover
- Notify Maximus of discharge date so community plan can be made active *
- Provide interim billing authorizations so PSS providers may start upon discharge
- Alert the appropriate SCA (Alpha One/EIM) of pending discharge

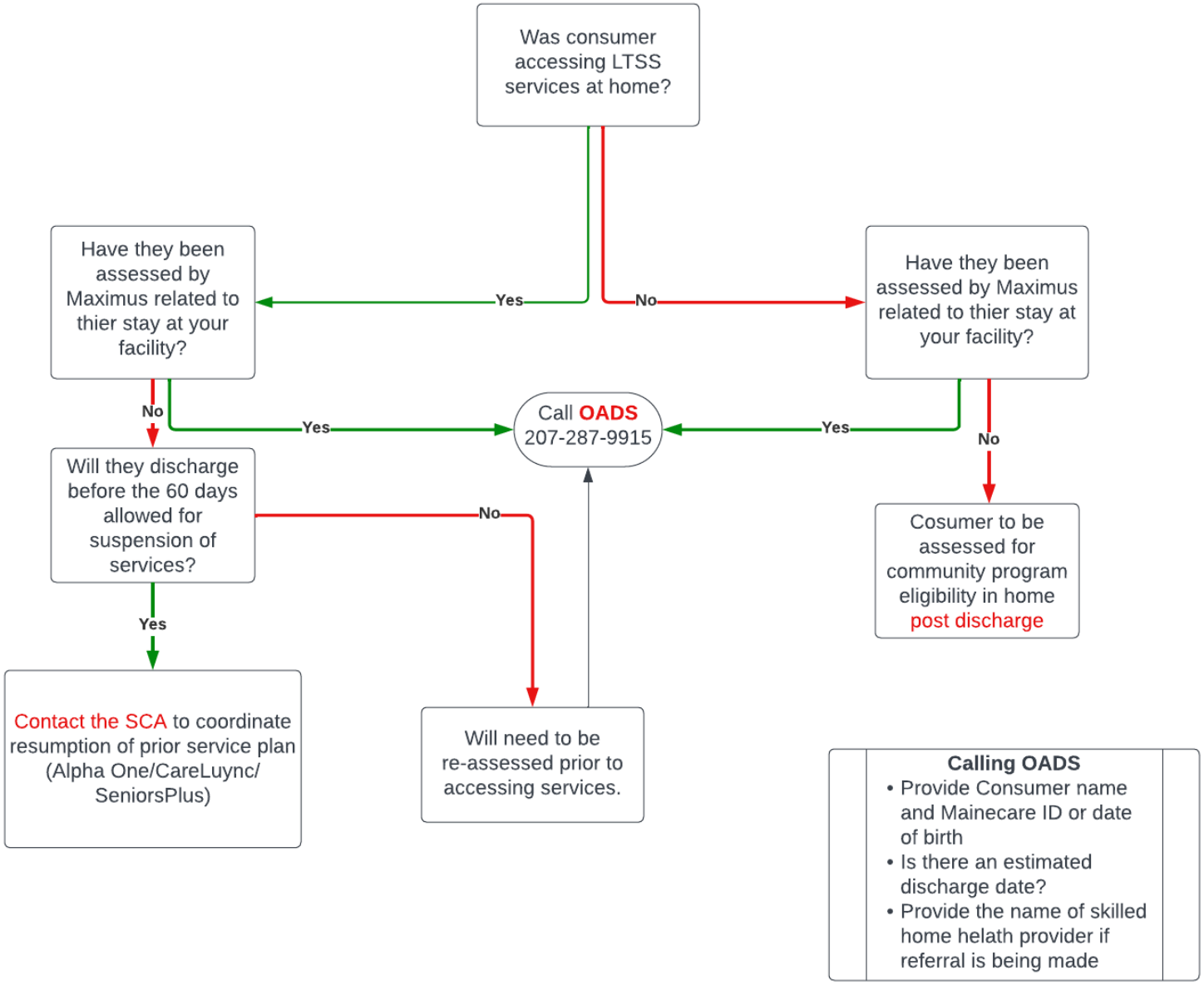
You will:

- Search for agency to staff consumer's plan of care
- Provide OADS with name of agency agreeing to provide services
- Provide updated discharge date, ideally 3 days in advance

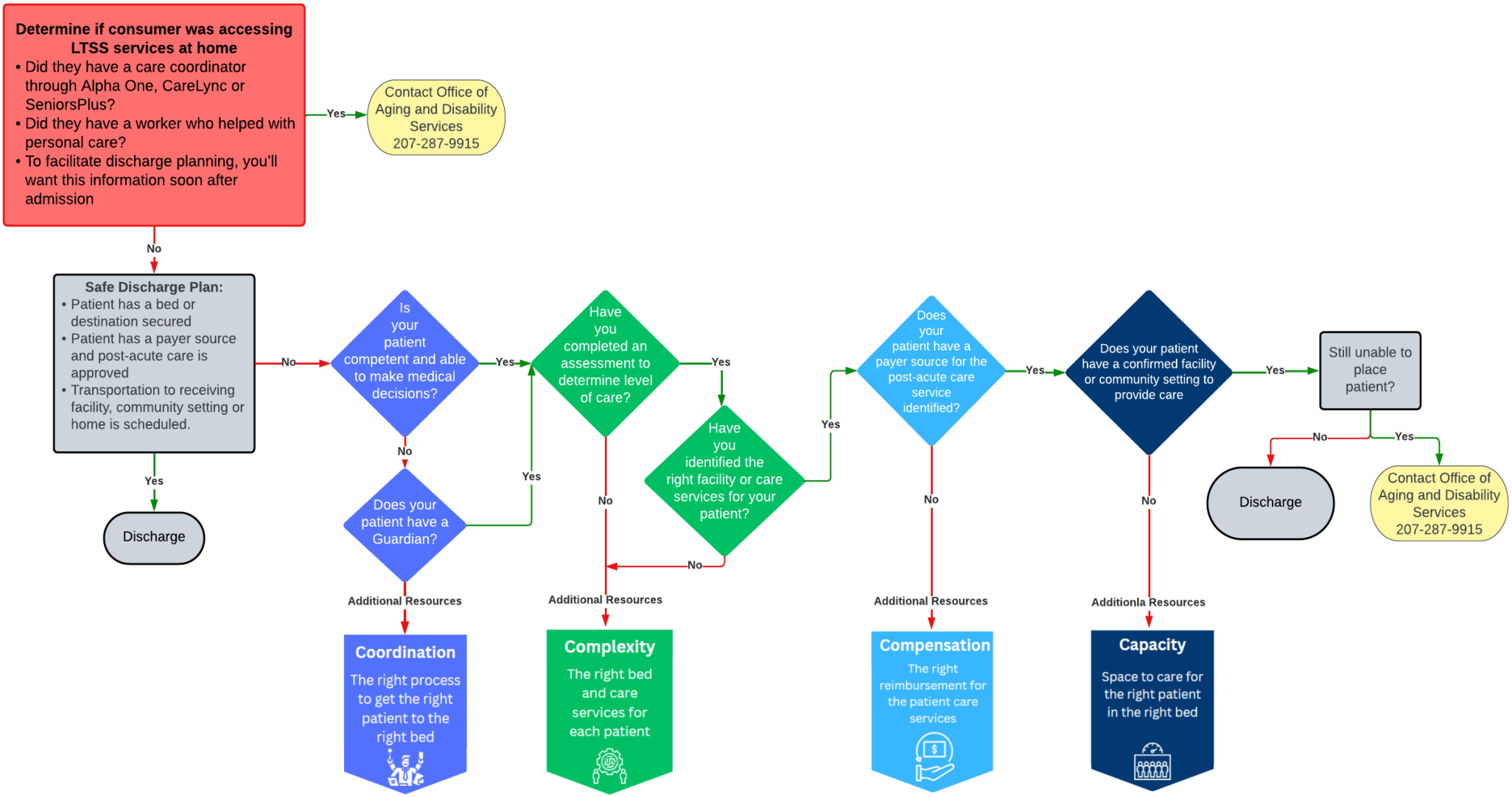
*Consumers suspended for more than 60 days from State-funded programs are subject to waitlist.

[1]Adopted from Maine Department of Health and Human Services Aging and Disability Services Quick Guide to Referrals for LTSS Community Services 6/23/2023 (available upon request)

COMPLETE THIS PROCESS FIRST Referral to LTSS Community Services for Discharge Planners



Patient Placement/Discharge Planning Process Flow



Coordination

The process of finding the right patient for the right bed should be a coordinated process that incorporates accurate transportation availability, bed availability, and the needs of the patient to ensure that all patients are receiving the best possible care and the inefficient use of beds and resources is minimized.

Desired Outcome

A process that involves a multidisciplinary team of healthcare professionals that takes into consideration the individual needs of the patient, the resources available, and the needs of the organization. A system should be put in place to ensure that the patient is placed in the right bed in the right facility.

Level	Objective	Activity	Resources
 	Increase the accuracy of bed availability coordination	• The Healthcare Coalition of Maine should promote the need for consistent and accurate reporting of real time bed availability (staffed beds) into appropriate reporting systems. • Healthcare facilities should participate in information gathering and/or information sharing within local response structure(s) when requested. • Promote effective communication among healthcare organizations, clinicians, home care liaisons, patients, and family members/caregivers for optimal discharge planning	Healthcare Coalition of Maine EMResource Hospital Bed Availability **Emergency Communication Systems Coordinator** Nate Riethmann nathaniel.riethmann@maine.gov

Level	Objective	Activity	Resources
	Determine if a patient is able to make and communicate informed decisions or meet essential requirements for physical health, safety or self-care.	• Identify the need for guardianship or alternative. • Get support additional support	Adult Guardianship and Alternatives DHHS Rule on Public Guardianship/Conservatorship OADS@maine.gov
  	Coordinate the post-acute care placement for patients, ensuring that each patient is placed in the most suitable facility or service for their individual needs.	• Coordinate with HCCME to identify resources available or to stand up a workgroup of organizations involved in post-acute care placement. • Involve the patient and their family/caregiver in the discharge planning process • Ensure that the patient and their family/caregiver are included in all discussions and decisions related to their discharge. • Coordinate with community resources: Work with community resources, such as home health agencies, to ensure that the patient has the necessary support in place after they are discharged. This may include arranging for home health care, meal delivery, or transportation services. • Schedule follow-up appointments: Schedule follow-up appointments with the patient's primary care provider or any specialists as needed. This will ensure that the	Healthcare Coalition of Maine Home Health Agencies in Maine

Level	Objective	Activity	Resources
		patient continues to receive appropriate care after they leave the hospital. • Assist the patient and their family/other support systems to identify individualized discharge needs while also verifying the accessibility of services and the affordability of the discharge plan.	
 	Maximize post-acute care placement efficiency and minimize extended admissions in acute care facilities.	• Coordinate transportation needs with EMS • Coordinate with HCCME to identify resources available or to stand up a workgroup of organizations involved in post-acute care placement.	Maine EMS Regions Healthcare Coalition of Maine
  	Develop community partnerships to address equity in discharge planning	• Collaborate with the healthcare coalition in your region • Hospital Association • Healthcare Association (LTC) • Home Health Agencies	Healthcare Coalition of Maine Maine Hospital Association Maine Healthcare Association Home Health Agencies

Level	Objective	Activity	Resources
   	Regularly assess inequities in access to care, access to countermeasures, and health outcomes and use findings to guide community partnerships and address needs	• Collaborate with other healthcare and community health services through the healthcare coalition in your state/region.	Join the Healthcare Coalition of Maine

Complexity

Aim to improve post-acute care placement of complex patients and ultimately load balance acute care facilities by finding the right bed or services for the right patient in a timely manner.

Complexity is referring to:

- Behavioral health diagnosis
- Social complexity, such as housing instability, incarcerations, or insurance complexity
- Medical complexity, such as chronic medical conditions or discharge to post-acute care (e.g., dialysis care and/or transportation, isolation, bariatric care, TBI)

Desired Outcome:

Improved patient outcomes, increased satisfaction among patients and their families, and reduced costs, time, and resources wasted due to the inefficient use of beds and resources. Additionally, acute care facilities will benefit from improved efficiency due to the better alignment of patient needs with available resources.

Level	Objective	Activity	Resources
  	Assess the patient's specialty needs and create a plan of care that outlines the necessary steps for a safe and successful discharge.	• Conduct a comprehensive assessment of the patient's needs ○ Identify appropriate specialized facility for patient care needs ○ Identify the patient's specialty needs and create a plan of care. ○ Discuss plan of care with patient and family members. ○ Educate patients and family members on the plan of care.	Discharge Needs Assessment Factors[2] (list of actual and potential discharge planning needs of the patient/family)

[2] University of Texas Medical Branch -https://www.utmb.edu/

Level	Objective	Activity	Resources
		○ Arrange for necessary follow-up appointments and referrals. ○ Arrange for specialty transportation	
  	Provide training and support to caregivers and family members of patients requiring complex post-acute care placement or support.	● Support the family and caregivers of complex patients. ○ Share available resources. ○ Provide training and support services to family caregivers. ○ Share available providers and services with family and caregivers. ● Identify Specialty Equipment needs for each patient and facilitate the ordering process for family and caregivers. ● Provide patients and family with resources to support their decision making of appropriate facility selection. ● Provide resources to caregivers and family members on the basics of post-acute care, including the different levels of care, payment options, and the process for placement. ● Train Providers in Evidence Based Practices for Behavioral Health and Substance Use Disorder	Training for Family Caregivers of Members Initiative Benefits of ePrescribing DME Training for Family Caregivers of Members How to choose a residential mental health facility Family Checklist The Caregiver's Handbook NIH Caregiving resources Family Caregiver Alliance Resources

Level	Objective	Activity	Resources
   	Increase partnerships to improve the process for identifying resources for patients with complex care needs and enhancing their access to a continuum of care.	• Coordinate with healthcare partners through the HCCME to identify specialty facilities and services. • Coordinate with healthcare coalitions in neighboring states to identify the closest LTAC or other specialty facilities. • Coordinate with EMS to secure transportation including specialty transport (i.e., bariatric capability) prior to discharge date. • Identify available programs that provide supportive community and facility-based services to older adults and adults with physical disability.	Healthcare Coalition of Maine Maine EMS Regions Maine Long-term Care Services

Compensation

Determine patient eligibility for the right patient care services by assessing the patient's financial situation to ensure that they receive the care and services they need and work to ensure that the appropriate reimbursement for those services is found.

Desired Outcome:

Ensure that the patients are receiving the right care and services they need, and that facilities and caregivers are being reimbursed properly for those services. Additionally, ensure that the patient is receiving the best care possible for their financial situation and that they are not unduly burdened by the cost of treatment.

Level	Objective	Activity	Resources
	Determine placement eligibility by referring patients for assessment to determine Medical Eligibility.	• Complete a Medical Eligibility Determination (MED) assessment referral ○ Ensure that all necessary paperwork is completed, including discharge instructions, medication lists, and any other relevant documents. • Complete a patient assessment for eligibility through Maine's Statewide Assessing Services.	Maximus Tools MAXIMUS
	Train the workforce on eligibility standards to avoid delay and enhance timely access to post-acute care services.	• Train case management staff on the eligibility assessment referral process.	LTC Assessment Referral Training

Level	Objective	Activity	Resources

 	Provide Family/Caregivers with financial eligibility information	• Assist patient, family or caregivers with application for healthcare financial support services
		• Educate patients and family members on MaineCare
		  ○ **Services include**: State Funded In Home and Community Home Based Care; and Medicaid Waiver for Elderly and Adults with Physical Disabilities; MaineCare Home Health Services, MaineCare Private Duty Nursing Services, Nursing Facility and Residential Care Services.
		  ○ Gain a working knowledge of eligibility standards
			MaineCare Information
			MaineCare Application
			Application for Long Term Care Maine Care
			MaineCare Regulations

Capacity

Post-acute care resources are available to ensure that patients have the necessary placement options, support, and resources to meet their needs for placement or assignment of caregivers.

Desired Outcome:

Patients will receive the necessary support and resources to meet their needs for post-acute care placement or caregivers, have access to quality post-acute care services, effectively transition from acute care to post-acute care, reduce health disparities and ensure equitable access to care for all patients.

Level	Objective	Activity	Resources

	Ensure equitable access to post-acute community based healthcare, public health , and social services resources.	• Assess available post-acute placement options for each patient in an acute care setting.
		• Assess eligibility for placement for each patient in an acute care setting.
		  ○ Long-Term Care (LTC) Advisory
		  ○ Pre-Admission Screening and Resident Review (PASRR)
		• Additional resources for PASRR and Medical Eligibility Determination MED Assessment (webinars, how to guides and additional resources.
			Find a Facility
			
			Office of Aging and Disability Provider Directory.
			
			Maine Medical Eligibility Determination Forms and Protocols
			
			PASRR and MED Assessment

Level	Objective	Activity	Resources
  	Plan for a timely transition of patients from inpatient to outpatient or home care.	• Begin hospital discharge planning when a patient is admitted. • Begin the determination of financial eligibility (See Compensation) • Involve the patient and family in discharge planning to improve patient outcomes, reduce unplanned readmissions, and increase patient satisfaction. • This plan should include any necessary medications, treatments, and follow-up appointments.	Example Discharge Planning Checklist for Patients IDEAL Discharge Planning Overview, Process, and Checklist Residential and Nursing Care Services Maine Medical Facilities
 	Empower the patient and family with placement and care decisions.	• Focus on the patient's goals and treatment preferences and include the patient (and/or the patient's representative) and his or her caregivers/support persons as active partners in the discharge planning for post-discharge care. • Inform the patient and/or representative of their freedom of choice in selecting their Post-Acute Provider/Service. • Engage patients and family members in the transition from hospital to home	CMS 3317-F and CMS 3295-F Final Rule IDEAL Discharge Planning

Level	Objective	Activity	Resources
	Recruit and retain a healthcare workforce that is fully staffed for daily needs.	• Provide resources for providers of health care, behavioral health, and long-term services and support recruiting and retaining workers.	Maine DHHS Recruitment and Retention Toolkit
	Develop a resilient, adequately resourced, trained, and supported health care workforce to improve timely access to services.	• Inform leadership of Office of Aging and Disability Services Home and Community Based Services (HCBS) Projects: Timely Access to Services • Train the workforce, market to potential workforce	Engage and Empower Direct Support/ Direct Care Staff Initiative Home and Community Based Services Workforce Marketing
	Share Hospital, LTC, home health bed capacity status.	• Access bed reporting systems to identify placement options. • Report bed availability at least daily in available systems. • The Healthcare Coalition (HCC) can share bed availability data as requested to help with discharge decisions and load balance acute care facilities. • Request assistance from the HCC to identify specialty facilities outside of Maine.	Hospital Bed Reporting (login page)

Appendix A: Family Checklist to Identify Specialty Care

	Family Checklist to Identify Specialty Care
☐	Research the different types of specialty healthcare facilities and agencies that can provide the complex care your family member requires. Key words: ☐ post-acute care ☐ long-term care ☐ rehabilitation ☐ skilled nursing facility ☐ assisted living facility ☐ subacute care ☐ hospice care ☐ home health care ☐ geriatric care ☐ palliative care ☐ post hospitalization care ☐ long-term acute care
☐	Determine your family member's healthcare needs and medical condition: ☐ Is your family member in need of surgery or other complex medical procedures? ☐ Does your family member have a chronic condition that requires ongoing care? ☐ What type of specialty care does your family member need?
☐	Contact facilities or agencies to discuss your needs and the services that they offer. ☐ What is the cost of care? ☐ Is there a waitlist for appointments or admissions? ☐ Does the facility offer any support services for family members?
☐	Determine the location of the specialty healthcare facility: ☐ Is the facility close to home or work? ☐ Are there any transportation options available?
☐	Ask for referrals from local healthcare providers, such as doctors or hospitals, to determine the best facility for your needs.
☐	Research the facility or agency thoroughly, including reading reviews from previous patients and their families.

	Family Checklist to Identify Specialty Care
☐	Visit the facility in person to get a better sense of its quality and to ensure that it will provide the level of care that you need.
☐	Ask about the facility or organization's treatment plans and protocols and ask about the experience and qualifications of the staff.
☐	Ensure that the facility or agency is licensed and accredited by the appropriate state and federal agencies.
☐	Check the credentials of the facility, agency, and physicians: ☐ Is the facility accredited? ☐ Are the physicians board-certified?
☐	Identify the types of insurance coverage your family member has: ☐ Does the patient have private or public insurance? ☐ Are there any restrictions or limitations on the type of care the patient can receive?
☐	Check the facility's insurance coverage to make sure that it accepts your family members insurance.