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EARLY DATA FROM THE MAINE OMBUDSMAN’S HOSPITAL ADVOCACY PROGRAM: A DEEPER LOOK AT DIFFICULT-TO-PLACE PATIENTS

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Abstract
There is little data available on the complex cause and effect of delayed hospital discharge; however, some evidence suggests that long-stay patients tend to be complex, older, and sicker. In Maine, a 2014 Maine Health Association report found complex hospital patients were waiting weeks, months and sometimes over a year in Maine Hospitals before accessing long-term services and supports. In response to these concerns around delayed discharge from hospitals, the First Regular Session of the 127th Maine Legislature created the Commission to study Difficult-to-Place Patients. The Commission ultimately passed Legislation that gave the Maine Long-Term Care Ombudsman Program the ability to assist with delayed discharges to decrease these delays and free up hospital beds. This paper will share and analyze preliminary data from this innovative program (approx. 1.5 fiscal years).

Background
A British study defined “delayed discharges (also called long-stays, delayed transfers, or bed blockers) as a situation where a patient is deemed to be medical well enough for discharge but where they are unable to leave hospital because arrangements for continuing care have not been finalized.”¹ According to author Karen Bryan, these situations are associated with patients who are “older… with complex needs.”¹ Other scholars have argued that “a widely accepted, valid, and reliable definition for delayed discharge is lacking,” exacerbating the problem of understanding the issue completely.² Large studies on this population and problem are indeed rare.² Studies that have explored the issue often had small sample sizes, or were looking at a particular hospital or minimal region.³ “Very few studies have comprehensively addressed the multifaceted problems of discharge delays in a heterogeneous acute patient population.”³
Measuring delayed discharge is also difficult because there is not a reliable assessment tool for these situations. Although some authors have suggested that identification of the barriers to discharge, rather than tool development, will reduce the problem. Studies that have been done recently, suggest that long-stay patients are disproportionately represented by those 65 and above and that is where efforts should be focused.

Finally, delayed discharge is not just burdensome to hospitals, as extended stays have been associated with increased “non-socomial infections, immobility, pressure sores, deep vein thrombosis (DVT) and deconditioning, thus worsening the patient’s life.” Therefore remedying delayed discharges would not only reduce hospital losses but improve patient outcomes and quality.

**History**

In 2014, a Maine Hospital Association (MHA) study estimated that there were up to 120 hospital patients around the state ready for discharge from the hospital, but without anywhere to go. A majority of these patients required a long-term care healthcare facility or willing homecare provider but were not being accepted by service agencies. At the time of the study, 40 of these patients had met discharge criteria for over 40 days. This presented a pressing issue for hospitals as they are not reimbursed for patients once they have met criteria for discharge.

A MHA survey in 2015, again indicated a statewide problem with difficult hospital discharges—particularly elders and adults with disabilities. Preliminary evidence suggested that the barriers in accessing long-term services and supports for these patients was caused by: dementia with

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1 There are currently “36 hospitals in Maine, including 33 non-profit general acute care hospitals, two private psychiatric hospitals, and one acute rehabilitation hospital”. In addition, there are several government-run hospitals in Maine—the Dorothea Dix Psychiatric Center in Bangor and Riverview Psychiatric Center in Augusta—and one federal facility, the Veterans Administration Medical Center in Togus.
behavioral challenges, mental illness, age (under the age of 60), high acuity & bariatric care, lack of a decision-maker, and issues with Medicaid. MHA found that complex patients waited weeks, months and sometimes over a year, in accessing long-term services and supports.

As a response, the First Regular Session of the 127th Legislature created the Commission to study Difficult-to-Place Patients, to address “the challenge of ensuring the availability of appropriate treatment option to the State for patients with complex medical conditions and the feasibility of making policy changes to the long-term care system for those patients.” The Commission’s duties, were ultimately set under Resolve 2015, Chapter 44, and included:

- Identification of categories of patients with complex medical and mental health conditions unable to be discharged from hospitals because no facilities or providers are able to care for them or accept them for care;
- Determination of how these patients are placed currently and primary barriers to placement of these patients;
- Review of the facilities in which these patients are currently placed, including the location of these facilities and the facility costs associated with these patients’ care;
- Identification of options for increasing availability of residential and long-term care facilities for specialized populations that are difficult to place for care, such as ventilator-dependent patients, geropsychiatric patients and bariatric patients; and
- Determination of rate of reimbursement necessary to operate facilities to manage patients with complex medical conditions.

Legislative changes were recommended by a majority (11 of 12) of the Commission, including, most notably “expanding the State’s Long-Term Care Ombudsman Program.”

LD 1617 was later introduced and passed by the Legislature on April 29, 2016, (overriding a Governor’s Veto). The language amended the Long-Term Care Ombudsman Program’s state-enabling statute under Sec.1. 22 MRSA 5107-A, and bill gave LTCOP “the authority to act as a resource during the hospital discharge process to assist patients with
complex medical needs who experience significant barriers to admission in a residential care facility, nursing facility or assisted living facility or program." Because of LTCOP’s expertise and relationships in long-term care, it was assumed that they could assist with these long-stay patients.

The specific changes Sec.1. 22 MRSA 5107-A include:

*The Ombudsman may provide advocacy during the hospital discharge process to assist patients with complex medical needs who experience significant barriers in accessing long-term services and supports.*

*If the Ombudsman provides advocacy, the Ombudsman shall ensure that the patient has information regarding available options including, but not limited to:*

- home and community-based services provided under MaineCare or funded by the State;
- admission to a residential care facility as defined in section 7852, subsection 14 and licensed according to section 7801;
- admission to a nursing facility licensed according to section 1817;
- and admission to an assisted living facility or program licensed pursuant to chapter 1663 or 1664.
- The Ombudsman also may provide assistance to the patient after discharge from the hospital.  

Supporters of the bill included the Maine Hospital Association, Legal Services for the Elderly, Maine Health Care Association, AARP, the Office of Aging and Disability Services and Disability Rights Maine.

**Current Program Structure & Scope**

As a result, the Hospital Advocacy Program is currently housed within the Maine Long-Term Care Ombudsman Program and currently has 4.5 staffed positions with a budget around $300,000.00 (one 1.0 FTE for management, 3 FTEs for Patient Advocates and .5 FTE for
intake). All cases are commenced through a telephone intake process. Intake gathers basic demographic and clinical information including:
Following intake, the Program Manager reviews materials and assigns cases based on 3 designated regions (North, Central, South). Patient advocates are expected to meet with hospital staff and the patient within two business days. Upon first meeting, advocates are expected to: visit with the patient, discuss their goals and care needs, review the patient’s history, share LTCOP’s role, review medical records, and educate the patient and/or families on long-term care system. In educating patients and families, Advocates should review the status of any Long-Term Care MaineCare application that has been submitted or needs to be submitted, and review any assessments that have been or should be completed, (including the MED Assessment, the PASRR level 1 screen and if triggered, a PASRR level 2 completed- which are required for placement in a facility).

**Collecting Data**

One of the difficulties with data collection is that the bulk of information is gathered at intake, and information at this stage can be unreliable. The program has weekly meetings to review all open cases and information could be updated at that point, however, this is still not a failsafe way of capturing exact information. The program has collects demographic data, current clinical information, assessments and perceived barriers to placement. In terms of the perceived barriers
to placement, this data was originally collected by LTCOP based on the MHA survey in 2015, which included:

- dementia with behavioral challenges
- mental illness, age (under the age of 60)
- high acuity & bariatric care
- lack of a decision-maker
- issues with Medicaid

The program decided to collect more specific data in FY2018 (year two), ultimately tracking barriers based on:

- behavioral issues
- substance abuse
- mental health
- cognition
- homeless
- age
- weight/ bariatric
- complex medical needs
- medication costs

**Number of Referrals**

Referrals to the program began with FY2016 (called year one), as the program officially commenced opening cases under the title of Hospital Program. Referrals remained somewhat constant through year one and slightly increased in the first 6 months of year two. In year two, there appears to be a trend of around 20 referrals per month, which is an increase from the average of 15.5 referrals in year one. This rate of referral seems to indicate that assistance is needed for about 100-200 patients per year. While the Hospital Advocacy Program has no way of knowing how many patients are not being referred (and are delayed discharges), that number appears close to the snapshot provided by the 2014 Maine Hospital Survey that found between 100-200 patients were ready for discharge without a bed.
Referral Sources
Referral sources have remained stable between year one and the beginning of year two with three quarters of referrals are coming from hospitals and one quarter coming from outside sources, i.e. family members or government agencies. Interestingly, the program does not actively advertise this service outside of hospital staff, therefore referrals from non-hospital sources could be the result of word-of-mouth.

Basic Demographics
As stated above, basic demographic information is collected regarding a patient with each intake. Rather than analyze all the demographic data here, selected data will be discussed. For example, gender in referrals has remained stable, with a slight majority of male patients over female patients. Since males historically have fewer beds available in long-term care facilities, more males waiting seems appropriate. However, why males make up a slight majority should be studied further.

Age. In regards to age, patients below the age of 70 and above the age of 50 make the up the largest percentage. This is logical considering most long-term care facilities are resistant to younger patients, and ages 50-70 would be considered younger to a nursing home or assisted living facility, but this may not be in line with data that shows long-stay patients are categorically “older”. The current average age of a referral is approximately 63.

Prior Residence. There has been an assumption that complex hospital patients are the result of patient dumping (where a facility sends a patient to the hospital and refuses to take them back). However, data appears to indicate that the majority is coming from the community. About a
quarter is coming from another facility, which may indicate some patient dumping, however this could also indicate a change in the level of care the patient requires. For example, a patient who cannot return to residential care because they are assessed at a nursing home or higher level of care.

**MaineCare & Medical Assessments.** Another data set that has been collected is whether the patient’s Long-Term Maine Care is active at the time of the referral. The Long-Term MaineCare process can take weeks if not months to process, so this can be really important to the amount of time it takes to place the individual outside the hospital. Most long-term care facilities and home care agencies will require that MaineCare is active before starting services. (Private pay would not require this process however; the majority of referrals are overwhelmingly MaineCare eligible individuals). In year one, more than half of referrals did not identify what the MaineCare status of the individual was, or had not filed for MaineCare. In year two, that was cut in half. Likewise, intake tracks whether a Medical Assessment is active at the time of the referral. Medical assessments are required under MaineCare for accurate level of placement or for how many hours of homecare the patient would qualify for. Both a long-term care facility or a homecare company would likely require a completed assessment before providing services. (A long-stay patient without an active Medical Assessment or open Long-Term MaineCare seems to indicate that hospitals have not completed the basic requirements to access the long-term care system). LTCOP’s hospital advocacy program data illustrates that open MaineCare and active Med Assessments have steadily increased since the program began. This could again, reflect that education and outreach has been successful, but there is no way to verify this data.
**Level of Care Needed.** While at the hospital, patients qualify for a particular level of care, for example, nursing home level. As noted above, the level of care (determined by a Medical Assessment) required for patients may not have been assessed at the time of intake, however, usually there is an indication in the patient’s chart about what level of care they would be assessed at. This data is updated when the case is closed for an accurate picture of the level of care required. The clear majority of long-stay patients were needing nursing home level of care, with slightly more than half. Residential care is more than a quarter with others included (assisted living, group homes, etc.)

![Figure 1](image1.png)

**MaineCare 2017 (Medicaid Application active at referral)**

- Long-Term Medicaid
- Unknown/Not completed

![Figure 2](image2.png)

**2018**

- Long-Term Medicaid
- Unknown/Not completed

One of the more striking changes between FY2017 and the first 6 months of FY2018 was the amount of referrals coming into the program, where a MaineCare application had not yet been filed or a status of MaineCare was unknown. In FY2017, more than half of the referrals had an unknown MaineCare status or unfiled MaineCare. In FY2018, almost three quarters was readily identified and/or started. This could indicate that hospitals are making sure MaineCare is worked on sooner than later.
Similar to figure 1&2 above, another change from FY2017 and the first 6 months of FY2018 was whether the medical eligibility determination (medical assessment) was completed at the time of intake. In FY2017, less than half of the referrals had an assessment completed. In FY2018, more than three quarters were readily identified. This could indicate that hospitals are making sure medical eligibility is determined sooner than later.

**Barriers to Placement.** (See Figure 5&6 below) In year one, age was the largest barrier to placement, identified in 65% of referrals. That ratio dropped dramatically in year two, when it was identified in only 15% of cases, a 50% drop. All other categories (highlighted in yellow in Figure 2) increased. The largest increase was substance abuse concerns, which saw a 70%

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2 In year two, the Hospital Advocacy Program decided that aggression and criminal history should no longer be requested, as aggression was difficult to define and likely fell under behavioral challenges, and criminal history was difficult to determine accurately.
increase in year two. Homelessness, behavioral challenges, and bariatric also more than doubled in year two.

<table>
<thead>
<tr>
<th>Hospital Identified Barriers to Placement</th>
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<tbody>
<tr>
<td><strong>Total Referrals 199</strong></td>
</tr>
<tr>
<td>Age 96/147</td>
</tr>
<tr>
<td>Advanced Dementia 36/147</td>
</tr>
<tr>
<td>Aggression 31/147</td>
</tr>
<tr>
<td>Weight &amp; Bariatric 6/147</td>
</tr>
</tbody>
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Figure 5
With such little data gathered, it is difficult to recognize any kind of widespread trend, and make any conclusion. However, a couple of characteristics of this data are interesting through an initial glimpse:

- Referral rates seem to remain constant per month with a slight increase as the program progresses.
- The gender ratio seems to remain constant with slightly more males referred than females.
- There appears to be a bell curve for age, trending towards 50-70 year olds with tails of the curve under age 50 and over age 80.
• Medical assessments and MaineCare applications are more likely to be completed by the time a case is referred to the Program as time goes on.
• The level of care needed upon leaving the hospital appears to remain constant with mostly nursing home level of care, and less residential/assisted living level of care.
• Prior residence before hospitalization is majority from the community. This seems to indicate most long-stay patients are not a result of “patient-dumping” from facilities.
• Identified barriers increased in almost every category in FY2018 over FY2017, most dramatically in the category of substance abuse, while age as a barrier dropped dramatically (50%).

**Conclusion**

It appears from preliminary data collected by LTCOP’s Patient Advocacy Program that the Maine Hospital Association’s 2014 estimate (up to 120 hospital patients around the state are ready for discharge from the hospital and about 40 patients are over 40 days past discharge criteria), was a reasonable estimate. Early figures collected by LTCOP appear to support a state-wide patient overstay problem involving more than 100 patients during the year. Preliminary figures collected by the program, while limited, indicated stability among some data while minor fluctuations regarding others. Assuming LTCOP’s Hospital Advocacy Program reduces these long-stay patient days, we may realize more hospital beds days, better patient outcomes, and reduced overall costs (hospital losses) across the state. Collected figures might also lead to a better understanding of long-stay patients and how to remedy the problem.


