Challenges in Throughput and Post-Acute Care

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Transitions of Care and COVID

- Planning for the downstream effects of COVID were established on the fly
- What happens when patients need to go to a nursing home? What happens when they need to go long-term care in a hospital? What should those transitions look like?
- MHA, in conjunction with Mass. Senior Care, the Home Care Alliance of Massachusetts, the Hospice Federation, LeadingAge Massachusetts, the Massachusetts Assisted Living Association and the State, established a workgroup to think through all of the challenges that we faced.

Post-Acute Transitions of Care & Emergency Preparedness (PATCEP) Workgroup: What is it? What did it do?

The goal of the group is to document and apply lessons learned during the COVID-19 pandemic and draft guidance to improve outcomes for future waves of COVID or any other crisis that challenges the usual care of patients in post-acute settings.

To continue the work of the Post-Acute Transitions of Care Workgroup and plan for future waves of COVID and any other potential future crisis affecting the healthcare system, with an emphasis on but not limited to the following

- Transition of patients between settings, including data on bed availability/surge capacity, procurement of PPE and other materials;
- Guidance for transfer of patients;
- Infection control policies;
- Testing protocols; and
- Drafting and/or revising guidelines as needed and influencing related regulations/legislation.
- To assess the ability of the group to shift focus to broader transitions of care post-pandemic

Enhanced and Frequent Communication and Coordination Among All Stakeholders!

Some of the outcomes of the PATCEP workgroup include:

- Explored LTACH and IRF bed and surge capacity and process of sharing ventilators. This led to **statewide LTACH and IRF data collection** & identification of delayed patient transitions, plus **establishment of state-based discharge resource line** to assist in patient transitions.
- *Developed a **Post-Acute Care Resurgence Communication and Coordination Model***
- *Created a **Standardized COVID-19 Testing Recommendation for Transitions of Care** Between Acute Care Hospitals and Post-Acute Care Facilities*
- *Developed **Hospital Discharge Guidance for Assisted Living Residents** with a special emphasis on COVID-19*
- Clarified the ability of health systems to **provide telemedicine to patients within skilled nursing facilities** without undergoing a full credentialing review at the SNF
- Developed **Best Practices for Vaccine Information Sharing for Care Transitions**
- Conducting a **COVID-19 Post-Acute Care Response After Action Review**

But then came Omicron……

- Healthcare system that was already depleted.
- Healthcare workforce was greatly impacted.
- Patients were “stuck” in hospitals for months at a time – even after their COVID symptoms have resolved.

What do we do?

Discharge Escalation Process

Post-Acute Care Transition (PACT Collaborative)

- **Mechanism for hospital discharge case managers to communicate with MHA and Mass. Senior Care to escalate and address challenges in skilled nursing facility placements** for patients who have been medically cleared for at least 7 days.
- In situations where no placement can be found, cases are elevated to the state's hospital discharge ombudsman (if the hospital hasn't already elevated it to the ombudsman).

PACT – Regional Collaboration Meetings

- **Purpose:** for hospital and skilled nursing facility colleagues to identify and understand any capacity constraints that they are facing and escalate any issues to MHA, Mass. Senior Care, and the state; and to strengthen relationships between these facilities to support efficient patient discharge.
- MHA and Mass. Senior Care have jointly held 12 bi-weekly meetings with hospital directors of case management and skilled nursing facility administrators, admissions directors, and/or nursing directors from facilities within each of the 5 EMS regions of the state.

Ongoing Collaboration with State Healthcare Ombudsman and State Colleagues

PACT Discharge Escalation Process

What have we learned thus far?

- Out of approximately 150 cases, most are patients with needs for long-term care, with dementia diagnoses, require 1:1 supervision, or with significant behavioral healthcare needs.
- Most have a MassHealth application pending, an uncompleted MassHealth application, or no insurance identified.
- Many have needs for the courts to act on conservatorships or guardianships. There is a significant backlog of these cases and many patients have been waiting in hospitals for months.

What is the ideal case for the PACT Collaborative to assist with?

Cases that:

- ✓ Do not require 1:1 supervision
- ✓ Are not MassHealth-pending
- ✓ Do not require restraints or virtual supervision
- ✓ Are substance use disorder cases with an identified skilled need

Close collaboration has been established with the state's healthcare ombudsman, particularly regarding case management for complex care patients.

MHA Throughput Survey

Purpose: Monthly patient throughput survey launched on March 4 to **assist in our collective efforts to address the backlog of patients** awaiting placement to post-acute care services.

Survey Questions Related to:

- ✓ Number of patients awaiting discharge to skilled nursing facilities, long-term acute care hospital/inpatient rehabilitation facilities, and home health services
- ✓ Length of time that patients have been awaiting discharge
- ✓ Vaccination barriers to discharge
- ✓ COVID positivity of patients
- ✓ Patients with dementia, psychiatric supervision, substance use disorder concerns, among others
- ✓ Payer mix
- ✓ Patients experiencing homelessness/housing instability, transportation delays, and outpatient hemodialysis transportation concerns
- ✓ Patient demographics

Initial reports on the first 3 months of data coming in early summer!

What are our unmet post-acute needs going forward?

- COVID is NOT over. We are still in response mode.
- There is a significant accumulation of patients stuck in hospitals who stay there from a month to six months waiting for Skilled Nursing Facility (SNF) Placement due to a number of factors.
- Our most urgent need is to find services for patients who require SNF bariatric care, dementia care, and geriatric psychiatric services.

Thank You

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