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and Human Services*

*Maine People Living
Safe, Healthy and Productive Lives*

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**Report to the Legislature regarding
Resolve, To Improve the Continuity of Care for Individuals with Behavioral
Issues in Long Term Care**

February, 2010

Submitted by:

Maine Department of Health and Human Services

The 124th Maine State Legislature passed this Resolve and asked that the Department of Health and Human Services report back by February 1, 2010 regarding the progress made in six specific areas. Each area will be addressed in this report.

Section 1 - Implementation of recommendations.

In implementing these recommendations, the department shall:

1. Redirect its services to adult MaineCare members to focus on earlier intervention so as to treat challenging behaviors at an earlier stage;
2. Identify individuals for earliest possible intervention and provide support and training to nursing facility staff in regard to managing the challenging behaviors of these individuals;
3. Provide support and training to in-state long-term care facilities that accept individuals who have been placed outside the State and who are returning to the State;

Response for 1-3:

Nursing facilities have received education and consultation on managing difficult behaviors and on mental illness by both the Office of Elder Services and the Office of Adult Mental Health Services. Further, training materials have been updated and placed on the websites of Laura Cote for OES and the Division of Licensing and Regulatory Services. Maine Healthcare Association has also distributed these materials to all of its members.

Nursing facilities have in place the plan to contact Laura Cote in OES as well as the UR nurses for mental health immediately upon identifying behaviors that pose significant risk to persons remaining in place. Assessments and behavior plans are available to facilities that are dealing with a difficult patient and should always precede sending that individual to the emergency department.

For the past two years materials available on the websites include an updated behavioral guide and assessment form and, in the past year, a geriatric mental health curriculum. For the last three years, Mental Health Utilization Review nurses have provided trainings on management of difficult behaviors, dementia and caring for persons with personality disorders. Maine Healthcare Association has also listed all available resources and how best to access them in their newsletters to facilities. The Office of Elder Services offered “Best Friends” training to facilities.

4. Convene an integrated team to develop a means to prevent placement outside the State and to assist in developing appropriate placements for individuals in in-state facilities;

Response: Continuing the work which began in response to the original resolve (2007, Chapter 61), a work group has been meeting on a regular basis for over two years. The focus of this work group has been to facilitate the return of Maine citizens from out-of-state facilities to facilities in Maine. This group has been working closely with Schaller-Anderson to evaluate each MaineCare member who is in an out-of-state placement, determine the kind and extent of the need of each member and identify or develop a placement in Maine for each member. To date, 14 members have been returned to Maine at a projected savings on over \$600,000. Only eight (8) members remain out of state and of those who remain

out-of-state, three (3) have no current connection with this state and have chosen not to return. The remaining individuals have been evaluated and the work group is actively reviewing resources to assure that as soon as the individual member is ready and wants to return to Maine, that every effort is made to assure that they can do that.

5. Review each out-of-state placement annually to assess the individual's functional and behavioral status to determine if the individual may be returned safely to an in-state facility;

Response: Each individual who is out of state is being evaluated at least yearly by the staff of Schaller-Anderson to determine not only what their needs are but also to assure that each member is receiving all of the services they need in their current placements while waiting to return to Maine.

6. Educate long-term care facility staff regarding the obligations of the facilities under licensing rules governing transfer and discharge requirements;

Response: Each long-term care facility in Maine is reminded yearly about their obligations under the licensing rules. Training is offered by the Long Term Care Ombudsman Programs and other organizations as applicable. This will continue. Additionally, nursing facilities are educated on the Transfer and Discharge Rights biannually as part of the PASRR trainings offered by mental health services through the Maine Healthcare Association. Licensing rules are reviewed during these trainings and instruction is provided on a case-by-case basis as issues regarding transfer and discharge of a person occur.

7. Review current contracts and practices regarding geropsychiatric units to determine if the geropsychiatric units are being properly used.

Response: Geropsychiatric unit contracts are reviewed and renewed on an annual basis. UR nurses for the Office of Adult Mental Health Services have reviewed all individuals residing on these units. Those residents not meeting criteria were identified and facilities involved were notified to make arrangements to move them to a less restrictive setting. No residents have been transitioned to date. This is based on the inability to locate other long term care units willing to admit a person who has been treated for mental illness due to concerns that they may not be able to meet their care needs.

The Office of Adult Mental Health Services continues to approve all admissions to the geropsychiatric units. As of FY 2009, APS Healthcare monitors all of the residents for appropriate placement and continued stay based on the Office of Adult Mental Health Services criteria for these units.

UR nurses continue to assure day-to-day compliance with the contractual agreement and to offer trainings and support as needed to provide effective services to individuals in these units.

Sec. 2 Reimbursement.

Resolved: That the department shall work with interested parties to undertake a review of the current reimbursement system used to establish payment for individuals in long-term care facilities to determine if current reimbursement is adequate and reasonable for the provision of high-quality care for individuals with behavioral issues.

Response: Please see the attached document ([Word](#), [PDF](#)) describing the case mix reimbursement system that is used in Maine and most other states to reimburse nursing facilities and residential care facilities. Maine continues to research options used by other states to assure that facilities are adequately reimbursed for the care of individuals with very difficult to manage behaviors. Maine's work has been consistent with that of other states in that we recognized difficult to manage conditions such as brain injury and Alzheimer's and have made adjustments in funding for those populations, and have designed specialized services for those groups.

Based on the current state budget and the absence of additional funding, the work group has been unable to develop monetary incentives for providers but will continue to encourage efforts that provide education and support to facilities that care for residents with challenging behaviors.

Sec. 3 Standardized transfer protocol; improved discharge planning.

Resolved: That the department shall work with representatives of the long-term care ombudsman program established pursuant to the Maine Revised Statutes, Title 22, section 5106, subsection 11-C, hospitals, nursing facilities and residential care facilities to improve the transparency and coordination of services between hospital discharge planning and long-term care facility admission to provide patients and their families with a more coordinated, efficient and patient-friendly process that meets the specific needs of individual patients, including behavioral health needs. The department shall develop and implement a standardized transfer protocol, including improving the support offered to a long-term care facility when a hospital has determined that an individual is ready to be discharged back to the long-term care facility, and consider the following:

1. The hospital discharge planning process and methods to provide at the outset all patients with a summary of patients' rights during the discharge process, including the right to await transition out of hospital care until satisfactory placement can be found at a nursing facility, residential care facility or other long-term care facility or with a home health care provider, based on the patient's medical needs;
2. Methods for providing patients in the hospital discharge planning process with a comprehensive list of patient resources and contact information for guidance and support during the discharge process, including contact information for the long-term care ombudsman program and the Department of Health and Human Services, Bureau of Elder and Adult Services, as well as a copy of the most recent report from the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services on the federal ranking system for nursing facilities providing care for Medicare and Medicaid recipients in those areas where the patient resides or wishes to reside; and
3. A hospital discharge planning process in cases where the patient has behavioral health issues that ensures the involvement or consultation with representatives from the Department of Health and Human Services, Bureau of Elder and Adult Services, and Office of Adult Mental Health Services to improve the coordination, planning and efficiency of the discharge process for the patient.

Response: Standardized Transfer Protocol; Improved Discharge Planning Workgroup

This workgroup researched the use and benefit of transfer tools. We found that many states also had concerns that residents were dropped off in emergency rooms or discharged directly to the hospital by nursing facilities or residential care facilities and had no realistic option to return to their facility or to their home.

States use a variety of transfer forms from corporate to multi-page tools and a few states have no process in place. The group worked to develop a standardized and simplified form that provides the information needed by both nursing facilities and hospitals in order to maximize treatment for the individual, improve communication and identify needed resources to assist facilities in providing effective services for these individuals in the least restrictive setting possible.

The Department of Health and Human Services developed a pilot program in conjunction with representatives of the long-term care ombudsman program, Legal Services for the Elderly, hospitals, nursing facilities and residential settings.

The goals of this program are:

- To provide information to both the sending facility and the receiving hospital to build better relationships between the two entities and improve communication.
- To reduce the use of the emergency departments for behavioral management.

This pilot program will run from January 1, 2010-April 1, 2010 and includes MMC and SMMC emergency departments (EDs) and all nursing facilities in York and Cumberland Counties that send residents to these EDs for evaluation and possible admission.

A transfer form with instructions was developed, (see attachment). Instructions were provided to the nursing facilities' staff members and the EDs. The database for data entry by the Department of Health and Human Services is not completed at this time but the pilot program started as planned in January 1, 2010.

Data to be collected from this pilot is as follows:

Identify:

- receiving ED
- sending facility
- outliers
- diagnosis requiring ED visit
- ED diagnosis (if different)
- presence of MI
- presence of dementia
- interventions attempted prior to sending to ED
- Resident outcome
- Identification of needed additional resources for facilities

Currently all facilities have the opportunity and are strongly encouraged to attend individual discharge meetings with the hospitals involved so that a comprehensive care plan can be developed. Participation in the care planning process is expected to reduce the rate of hospital re-admission for each individual.

The non-hospital facilities will be provided with a survey at the end of the pilot to complete and return to the workgroup. The purpose of the survey is to identify whether any changes or improvements should be made to the form and to identify any concerns or lack of resources that are described by the participating facilities.

All nursing facilities were provided with or offered training in the management of difficult behaviors. The mental health curriculum was also offered and provided by the Licensing and Certification Best Practice Committee. This curriculum provides for staff training in 15 minute modules with the flexibility to reach all direct care staff.

Sec. 4 Alternative funding sources.

Resolved: That the department shall undertake a review of existing and potential payment sources for assessments and treatments that are currently unavailable to individuals with behavioral issues because the individuals do not have a diagnosis of severe and persistent mental illness.

Response: Please see response to Section 6. When an individual needs additional assessments or treatments, that person will be referred to the Complex Case Committee for evaluation of needs and the identification of a funding source to meet those needs.

Sec. 5 Levels of care.

Resolved: That the department shall work with interested parties to explore the need for a supplementary level of care to accommodate the needs of individuals with behavioral issues who, because of the severity of their behaviors, are not appropriate candidates for return to an existing long-term care facility but who no longer require an acute hospital setting.

Response: In long term care facilities designed for individuals with developmental disabilities, the Department has authorized an “add-on” for facilities to help cover the additional costs of caring for individuals with severe behavioral issues. Between this option and the increased availability of consultation for facilities in the management of difficult individuals, the existing long-term care facilities should be able to manage more complex clients. This continues to be an issue however because of the lack of additional funds at this time. The Department will continue to look at strategies that encourage the providers to take and keep some of our more challenging individuals.

Sec. 6 Coordination.

Resolved: That the department shall conduct the work required by this resolve within existing resources and to the extent possible shall coordinate it with similar work addressing similar issues for any other population group. The department shall facilitate the exchange of information and communication among workgroups with the goal of maximizing department workload and fiscal efficiencies as well as the impact and effectiveness of approaches or solutions proposed or developed within the work process. A description of coordination efforts must be included in any report required by this resolve.

Response: In order to facilitate communication and resolve complex situations that are presented, the Department established the Adult Services Consortium in October 2009. The adult services consortium consists of the Directors of the Offices of Cognitive and Physical Disabilities, Elder Services, Adult Mental Health, and Substance Abuse Services. The Consortium adopted a joint work plan having as one of its primary goals the development of an integrated approach to meeting the service needs of individuals with complex or multiple issues. A “complex case team” with representatives of each of the four offices of the consortium was established to focus on joint complex case coordination. A major focus of the group is to address the needs of individuals who do not meet categorical eligibility and therefore “fall between the cracks”. These individuals may have needs that cut across multiple service delivery systems, may not meet service eligibility criteria, may have serious medical diagnoses, compounded by major social, psychological, legal, environmental or financial issues.

Integrated services coordination involves collaboration with individuals, state agencies, provider agencies, families and health care systems. Recognizing that there are limited resources, the goal is to utilize proven best practices in order to affect improved client outcomes within a holistic approach.

The process of how a case is referred, timelines, actions, and follow-up is currently being developed by the group. It is believed that situations will be presented either via the respective Office’s representative or from other DHHS source. Relevant information will be obtained in a consistent manner and an action plan will be developed reflecting measurable objectives, time frames, and persons responsible. Follow-up data will be collected and analyzed which will be used to inform systems and policy development. It is anticipated that coordination of efforts, shared resources, and expertise will result in an improved service delivery system.