

COMMISSION TO STUDY DIFFICULT-TO-PLACE PATIENTS

MEETING AGENDA

Thursday, November 5, 2015

Room 216, Cross State Office Building, Augusta

- 10:00 a.m. Welcome and introductions
Commission Chairs
- 10:05 a.m. Briefings on:
- The approval process for admission to the 3 geropsychiatric facilities in Maine, an explanation of the rate structure for these geropsychiatric units and a discussion of their operational capacity and turnover rates
Richard Erb, Maine Health Care Association
Michelle Bellhumeur, Gorham House (Gorham)
Larry Davis, Hawthorne House (Freeport)
Diane Sinclair, Mount St. Josephs (Waterville)
 - PNMI and residential/community living options for increasing capacity for special populations at the community living level
Richard Erb, Maine Health Care Association
 - The public and private psychiatric hospital populations and barriers to placement in specialized facilities for children/adults
Jeff Austin, Maine Hospital Association
 - The potential expansion of the role of the Office of the Long-Term Care Ombudsman in order to increase efforts to facilitate the placement of patients in specialized facilities by addressing barriers to placement
Brenda Gallant, Long-Term Care Ombudsman
- 12:00 p.m. Break for lunch (1 hour)
- 1:00 p.m. Commission discussion on potential options for recommendations to increase the availability of residential care and long term care facilities for specialized patient populations that are difficult to place for care
- 2:15 p.m. Future meetings planning
- 2:30 p.m. Public comment opportunity
- 3:00 p.m. Adjourn

Sen. Roger J. Katz, Chair
Sen. Anne M. Haskell
Jeffrey A. Austin
Melvin Clarrage
Richard A. Erb
Brenda C. Gallant
Ricker Hamilton

Rep. Andrew M. Gattine, Chair
Rep. Richard S. Malaby
Rep. Peter C. Stuckey
Michael Lemieux
Simonne Maline
Kim Moody



STATE OF MAINE
COMMISSION TO STUDY DIFFICULT-TO-PLACE PATIENTS

October 29, 2015

Hon. Paul LePage, Governor
Office of the Governor
1 State House Station
Augusta, ME 04333-0001

Re: Request for Department of Health and Human Services staff attendance at November 5 meeting of Commission to Study Difficult-to-place Patients

Dear Governor LePage:

As you know, the Commission to Study Difficult-to-place Patients, established by Resolve 2015, chapter 44, is meeting this fall to identify the primary barriers to placement of patients with complex medical and mental health conditions and options for increasing the availability of residential care 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.

The Commission held its first meeting on October 26, 2015. During that meeting, the Commission identified several information requests for the Department of Health and Human Services that would inform their work and assist with developing recommendations for policy changes in this area. The questions that were posed to Commission member Mr. Ricker Hamilton, the designee of the Commissioner of Health and Human Services, are as follows:

- (1) Can you generally describe the process by which the Department negotiates reimbursement rates for providers caring for specific patient populations within the long-term care system (i.e., provide a general background on negotiated rates)?
- (2) More specifically, is the reimbursement rate for geropsychiatric patients a negotiated rate or a set rate? If set, can you share with the Committee the rate for facilities that receive it? If negotiated, can you share with the Committee the range of rates that the Department currently pays and details regarding the factors and criteria that impact the negotiation? What are the eligibility criteria and service level/scope of service expectations for the geropsychiatric rate? Is there any difference in the reimbursement rate or eligibility criteria for traditional facilities as compared to home care service providers?
- (3) If available, what is the population size served by the geropsychiatric rate? What is the geographic distribution of that population? What is the "turnover rate" for patients at geropsychiatric facilities (i.e., on average, for how long do patients typically continue to receive specialized care at these facilities)?

- (4) Does the Department track reimbursements paid by the State with respect to patients housed at out-of-state facilities (children and adults)? If so, can you provide approximate amounts of the numbers of patients housed at out-of-state facilities for which the State is paying all or a portion of care costs, as well as the total annual reimbursements paid to out-of-state facilities for such patients? Are these patients housed out-of-state solely due to a lack of available facilities or facility space in-state, or are there other reasons for which the State would be reimbursing care costs paid for Maine residents housed out-of-state?
- (5) How many patients (civil and forensic) are currently housed inpatient at each of the State-run mental health hospitals? How many of those patients are currently eligible for discharge, but remain at those facilities due to the lack of a facility or community placement to discharge those patients to?
- (6) What actions is the Department authorized to take with respect to a licensed facility that improperly discharges a patient and/or improperly refuses to readmit a patient for care who was previously discharged improperly? Are there additional statutory or regulatory changes you would recommend or support to augment the Department's ability to enforce its laws and rules to address such violations? Are there opportunities that the Department has identified to strengthen agreements or contracts with providers to ensure that patients are not improperly discharged or refused readmission?
- (7) It was noted at the first meeting of the Commission that a RFI was under development by the Department to address reimbursement rates for geropsychiatric populations, populations with medically-rare diseases and other complex patient populations. To the extent that you are able to discuss the details of this RFI, can you provide any additional information on this proposal?
- (8) Given the recent regulatory changes made involving the reimbursement rate process for ventilator care services, would the Department be interested in or consider it feasible to replicate that same process for the reimbursement rate for geropsychiatric care services or other special needs populations within the long-term care system?

We understand that Mr. Hamilton has a conflict that prevents his attendance at the next Commission meeting, scheduled for November 5, 2015 (10:00 am in Room 216, Cross Building). If possible, we would greatly appreciate the opportunity to have someone from the Department of Health and Human Services attend the next meeting in his absence. If you require additional information on any of the requests above, please contact one of our Commission staff analysts, Natalie Haynes or Dan Tartakoff, at 287-1670.

Sincerely

Senator Roger Katz
Commission Chair

Representative Drew Gattine
Commission Chair

Cc: Members, Commission to Study Difficult-to-place Patients
Mary Mayhew, Commissioner, Department of Health and Human Services
Nick Adolphson, Director of Government Relations and Policy, DHHS



STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

Paul R. LePage
GOVERNOR

November 4, 2015

Hon. Roger Katz
3 State House Station
Augusta, ME 04333-0003

Hon. Drew Gattine
2 State House Station
Augusta, ME 04333-0002

Dear Senator Katz and Representative Gattine:

As I was traveling out of the country for a trade mission last week, I only received your October 29 letter about the Commission to Study Difficult-to-Place Patients yesterday. Ricker Hamilton is Commissioner Mayhew's designee to serve on the Commission. Mr. Hamilton has had a long-standing family commitment that will not allow him to appear at the meeting on November 5. I believe this was already known by the Commission when the upcoming meeting was scheduled.

If the Commission believed Mr. Hamilton's appearance was essential at the next meeting, it could have scheduled the meeting for a date when he could attend. I am not going to make the Commissioner designate someone else to appear in Mr. Hamilton's place.

Sincerely,

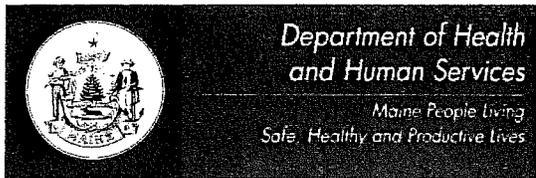
A handwritten signature in black ink that reads "Paul R. LePage".

Paul R. LePage
Governor

cc: Commissioner Mary Mayhew
Natalie Haynes
Daniel Tartakoff



PRINTED ON RECYCLED PAPER



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

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Commissioner's Office
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Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
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November 5, 2015

To: Senator Roger J. Katz, Chair
Representative Andrew M. Gattine, Chair
Members of Commission to Study Difficult-to-Place Patients

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: DHHS Response to questions from the Difficult-to-Place Patients (Resolve 2015, c 44) meeting held on October 26, 2015

Question #1: Can you generally describe the process by which the Department negotiates reimbursement rates for providers caring for specific patient populations (i.e., a general background on negotiated rates)?

Response: Rates are set in MaineCare rule, and only negotiated in the rare exception that no provider can serve the MaineCare member under the current rates. In the case of a rate negotiation, negotiated rates are based on the medical level service of the particular member. This information is provided by the specific office (i.e. OCFS, OADS, etc.) and the information is used to work with the specific provider to set the rate structure. This structure is driven by the need of the member as well as the usual and customary charge of the provider, along with the association of our state policies. Most rate negotiations occur with out-of-state providers after all in state placement options have been exhausted.

Question #2: More specifically, is the reimbursement rate for geropsychiatric patients a negotiated rate or a set rate? If set, can you share that rate? If negotiated, can you share with the Committee what that rate is generally negotiated at (reimbursement rate range)? What are the eligibility criteria and service level/scope of service expectations for the geropsychiatric rate? Is there any difference in the reimbursement rate or eligibility criteria for facility providers as compared to home care service providers?

Response: There are no set or negotiated "geropsychiatric" rates in MaineCare today. Rates paid specifically for geriatric patients occur only in the three specialized geriatric units and one PNMI unit that exists in Maine today. The rate for these units is based on the allowable costs (as outlined in Section 67 of MaineCare policy) of the unit, with no cost cap.

Question #3: If available, what is the population size served by the geropsychiatric rate? What is the geographic distribution of that population? What is the "turnover rate" for patients at geropsychiatric facilities (i.e., on average, how long to patients typically continue to receive care at such facilities)?

Response: There are currently 53 geriatric nursing facility beds and 16 PNMI beds. The beds are split almost equally between Waterville, Freeport and Gorham. The churn rate for these beds has not yet been identified, but the Department is continuing to review data for that effort.

Question #4: Does the Department track reimbursements paid by the State with respect to patients housed at out-of-state facilities (children and adults)? If so, can you provide approximate amounts of the numbers of patients housed at out-of-state facilities for which the State is paying all or a portion of care costs, as well as the total annual reimbursements paid to out-of-state facilities for such patients? Are these patients housed out-of-state solely due to a lack of available facilities or facility space in-state, or are there other reasons for which the State would be reimbursing care costs paid for Maine citizens housed out-of-state?

Response: Patients are only housed out-of-state when all appropriate in-state resources have been exhausted. In SFY 2015, 126 MaineCare members received services at locations outside of Maine – 79 adults and 47 children. \$11.7 million (all funds) was paid for their care.

Question #5: How many patients (civil and forensic) are currently housed inpatient at each of the State-run mental health hospitals? How many of those patients are currently eligible for discharge, but remain at those facilities due to a lack of a facility or community placement to discharge those patients to?

Response: The DDPC total census is 39 and the RPC total census is 83. There are 17 civil patients who are clinically ready for discharge but remain hospitalized due to lack of appropriate community placements.

Question #6: What actions is the Department authorized to take with respect to a licensed facility that improperly discharges a patient and/or improperly refuses to readmit a patient for care who was previously discharged improperly? Are there additional statutory or regulatory changes you would recommend or support to augment the Department's ability to enforce its laws and rules to address such violations?

Response:

DHHS licensing authority

- The Division of Licensing and Regulatory Services (DLRS) is responsible for State licensing and federal certification of healthcare facilities and investigating complaints to ensure that patients/residents are free from abuse, neglect, misappropriation of property and substandard quality of care. For failure to comply with federal or state regulations, DLRS completes a statement of deficiencies (SOD) and requires the facility to respond to each deficiency with a plan of correction (POC).

DHHS enforcement authority

Enforcement for violations by federally certified facilities is in accordance with federal regulations, and varies depending upon

- the type of facility,
- the level of the deficiency,
- and, for nursing facilities, the scope and severity of the deficiency.

Enforcement actions against federally certified facilities may include (depending upon the type of facility):

- a directed plan of correction;
- directed in-service training;
- denial of payment for Medicare and Medicaid patients;
- prohibition on new Medicare or Medicaid admissions;
- civil monetary penalties;
- state monitoring;
- transfer of residents; and
- transfer of residents *with closure of facility and termination of participation* in the Medicare program.

Enforcement for violations by state licensed facilities is in accordance with state regulations and varies depending upon

- the type of facility and
- the seriousness of the deficiency.

Excerpts of federal and state regulations

Attached (Attachment A) please find excerpts from federal and state regulations governing admission, transfer and discharge related to:

- swing beds and skilled nursing facilities,
- assisted housing facilities and
- hospitals.

➤ **Improper discharge of a patient by a licensed facility:**

- Improper discharge of a patient is a violation that is cited by DLRS as failure of the facility to comply with state or federal regulations; DLRS issues a statement of deficiency (SOD) and the facility is required to submit a written plan of correction (POC) for this deficiency.
- Depending on the type of facility, residents subject to discharge also may take action to contest the discharge. The facility must give the resident written notice of discharge before the actual date of discharge. The resident may appeal the discharge and remain in the facility pending outcome of their appeal. When the resident prevails (the discharge is found to be “improper”), the resident continues to receive care in the facility.

➤ **Refusal to readmit a patient for care:**

- The DLRS does not have the authority, either through State statute or federal regulation, to force a facility to admit or readmit a patient/resident, or to keep a resident that the facility plans to discharge.
- That said, a licensed facility’s “improper refusal” to readmit a resident for care that was previously discharged improperly may be subject to DLRS investigation and, if found to be in violation of federal or state regulations, DLRS issues and a SOD and requires the facility to submit to DLRS a plan of correction for the deficiency.

➤ **Are there additional statutory or regulatory changes you would recommend or support to augment the Department’s ability to enforce its laws and rules to address such violations?**

- The Department currently has the ability to enforce the law related to violations of licensing standards.

Question #7: It was noted at the first meeting of the Commission that a RFI was under development to address reimbursement rates for geropsychiatric populations, populations with medically-rare diseases and other complex patient populations. To the extent that you are able to discuss the details of this RFI, can you provide any additional information on this matter?

Response: Information regarding the RFI is not currently available, but will be shared with the Commission as soon as practicable.

Question #8: Given the recent regulatory changes made involving the reimbursement rate process for ventilator care services, would the Department be interested in or find it feasible to replicate that same process for reimbursement of geropsychiatric care services?

Response: The Department is committed to ensuring appropriate services for Medicaid members, and adequate rates for the provision of those services.

Swing Beds and Skilled Nursing Facilities, Appendix PP of the State Operations Manual and 42 CFR §483.12 Admission, Transfer and Discharge Rights

The intent of the regulation on transfer and discharge provisions is to significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility to prevent dumping of high care or difficult residents. This requirement applies to transfer or discharges that are initiated by the facility, not by the resident.

§483.12(a) (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

- (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- (iii) The safety of individuals in the facility is endangered;
- (iv) The health of individuals in the facility would otherwise be endangered;
- (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
- (vi) The facility ceases to operate.

§483.12(a)(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

- (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
- (ii) Record the reasons in the resident's clinical record; and
- (iii) Include in the notice the items described in paragraph (a)(6) of this section.

§483.12(a)(5) Timing of the notice. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

when--

- (A) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;
- (B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;
- (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;
- (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or
- (E) A resident has not resided in the facility for 30 days.

§483.12(a)(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:

- (i) The reason for transfer or discharge;
- (ii) The effective date of transfer or discharge;
- (iii) The location to which the resident is transferred or discharged;
- (iv) A statement that the resident has the right to appeal the action to the State;
- (v) The name, address and telephone number of the State long term care ombudsman;
- (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.12(a)(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Interpretive Guidelines §483.12(a)(7) "Sufficient preparation" means the facility informs the resident where he or she is going and assures safe transportation. The facility should actively involve the resident and the resident's family in selecting the new residence. Some examples of orientation may include trial visits by the resident to a new location; working with family; and orienting staff in the receiving facility to the resident's daily patterns.

Generally this notice must be provided at least 30 days prior to transfer. Exceptions to the 30 day requirements apply when the transfer is effected because of:

- Endangerment to the health or safety of others in the facility;
- When a resident's health has improved to allow a more immediate transfer or discharge;
- When a resident's urgent medical needs require more immediate transfer; and
- When a resident has not resided in the facility for 30 days.

In these cases, the notice must be provided as soon as practicable before the discharge. (See §483.12(a)(4).)

Finally, the facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. (See §483.12(a)(6).)

Under Medicaid, a participating facility is also required to provide notice to its residents of the facility's bed-hold policies and readmission policies prior to transfer of a resident for hospitalization or therapeutic leave. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative of the duration of any bed-hold. With respect to readmission in a Medicaid participating facility, the facility must develop policies that permit residents eligible for Medicaid, who were transferred for hospitalization or therapeutic leave, and whose absence exceeds the bed-hold period as defined by the State plan, to return to the facility in the first available bed. (See §483.12(b).)

A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

§483.12(a)(2) Transfer and Discharge Requirements - The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

- (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- (iii) The safety of individuals in the facility is endangered;
- (iv) The health of individuals in the facility would otherwise be endangered;
- (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or
- (vi) The facility ceases to operate.

§483.12(a)(4) Notice Before Transfer - Before a facility transfers or discharges a resident, the facility must--

- (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
- (ii) Record the reasons in the resident's clinical record; and
- (iii) Include in the notice the items described in paragraph (a)(6) of this section.

§483.12(a)(5) Timing of the notice.

(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when—

(A) The safety of the individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under (a)(2)(iv) of this section;

§483.12(b) Notice of Bed-Hold Policy and Readmission

§483.12(b)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies--

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

§483.12(b)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

Interpretive Guidelines §483.12(b)(1) and (2)

The nursing facility's bed-hold policies apply to all residents.

These sections require two notices related to the facility's bed-hold policies to be issued. The first notice of bed-hold policies could be given well in advance of any transfer. However, reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice, which specifies the duration of the bed-hold policy, must be issued at the time of transfer.

In cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. Bed-hold for days of absence in excess of the State's bed-hold limit are considered non-covered services which means that the resident could use his/her own income to pay for the bed-hold. However, if such a resident does not elect to pay to hold the bed, readmission rights to the next available bed are specified at §483.12(b)(3). Non-Medicaid residents may be requested to pay for all days of bed-hold.

§483.12(b)(3) Permitting Resident to Return to Facility - A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident--

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

Interpretive Guidelines §483.12(b)(3)

"First available bed in a semi-private room" means a bed in a room shared with another resident of the same sex. (see §483.10(m) for the right of spouses to share a room.) Medicaid-eligible residents who are on therapeutic leave or are hospitalized beyond the State's bed-hold policy must be readmitted to the first available bed even if the residents have outstanding Medicaid balances. Once readmitted, however, these residents may be transferred if the facility can demonstrate that non-payment of charges exists and documentation and notice requirements are followed. The right to readmission is applicable to individuals seeking to return from a transfer or discharge as long as all of the specific qualifications set out in §483.12(b)(3) are met.

10-144, Chapter 110, Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities

10.Q. Transfer and Discharge Rights

10.Q.1. Definition - Transfer and discharge includes movement of a resident to a bed outside of the certified unit, whether that bed is in the same facility or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified unit.

10.Q.2. Transfer and Discharge Requirements. The facility must permit each resident to remain in the unit or facility, and not transfer or discharge the resident from the unit or facility unless:

- a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the unit or facility.
- b. The transfer or discharge is appropriate because the resident's health and/or functional ability has improved sufficiently so that the resident no longer needs the services provided by the unit or facility.
- c. The safety and/or health of individuals in the facility are endangered.
- d. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only those charges allowable under Medicaid.
- e. The facility ceases to operate.

10.Q.3. Notice Before Transfer - Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons. The resident's clinical record shall contain documentation describing the basis for the transfer or discharge.

10.Q.4. Contents of the Notice - Each notice must be written and include, in a language and manner understood by the resident.

- a. In order to provide for informed resident decisions, a nursing facility shall provide lists of licensed providers of care and services for all patients prior to discharge for which home health care is needed.
 - i. For all residents requiring home health care, the list must include all licensed home health care providers that request to be listed and any branch offices, including addresses and telephone numbers that serve the area in which the resident resides.
 - ii. The nursing facility shall disclose to the resident any direct or indirect financial interest which the nursing facility has in the home health care provider.
- b. For all residents transferring to another nursing facility, a list must be provided of all nursing facilities that request to be listed that serve the area in which the resident resides or wishes to reside.
- c. The reason for the transfer or discharge, including events which are the basis for such action.
- d. The effective date of the transfer or discharge.
- e. The location to which the resident is transferred or discharged.
- f. Notice of the resident's right to appeal the transfer or discharge as set forth in the Maine Medical Assistance Manual.
- g. The location to which the resident is transferred or discharged.
- h. Notice of the resident's right to appeal the transfer or discharge as set forth in the Maine Medical Assistance Manual.
- i. The mailing address and telephone number of the Long Term Care Ombudsman Program.

- j. In the case of residents with developmental disabilities or mental illness, the mailing address and telephone number of the Office of Advocate, Department of Mental Health, Mental Retardation and Substance Abuse Services.
- k. The resident's right to be represented by himself or herself or by legal counsel, a relative, friend or other spokesman.

10.Q.5. Timing of the Notice - Except when specified in Chapter 10.Q.2.c., the notice of transfer or discharge must be made by the facility at least:

- a. Thirty (30) days before the resident is transferred or discharged.
- b. As soon as practicable before transfer or discharge when:
 - 1. The safety and/or health of individuals in the facility would be endangered.
 - 2. The resident's health improves sufficiently to allow a more immediate transfer or discharge.
 - 3. An immediate transfer or discharge is required by the resident's urgent medical needs, or
 - 4. A resident has not resided in the facility for thirty (30) days.

10.Q.6. Appeal of Transfer or Discharge - The resident has the right to appeal a transfer or discharge to the Administrative Hearings Unit of the Department.

10.Q.7. Transfer or Discharge Orientation - The resident has the right to receive sufficient preparation and orientation to ensure safe and orderly transfer or discharge from the facility. This shall be documented in the resident record.

Enforcement

22.B.4. Failure to Correct Deficiencies The failure to correct any deficiency or deficiencies or to file a Plan of Correction with the Division may lead to the imposition of sanctions or penalties as described in this Chapter.

22.C. Intermediate Sanctions The Division is authorized to impose one or more of the following intermediate sanctions when any of the circumstances listed in Section 22.D., below, are present and the Division determines that a sanction is necessary and appropriate to ensure compliance with State licensing regulations or to protect the residents of a nursing facility or the general public.

22.C.1. The Division may direct a nursing facility to stop all new admissions regardless of payment source or to admit only those residents the Division approves, until such time as it determines that corrective action has been taken.

22.C.2. The Division may issue a Directed Plan of Correction.

22.C.3. The Division may impose a financial penalty upon a nursing facility.

22.D. Grounds for Intermediate Sanctions - The following circumstances shall be grounds for the imposition of intermediate sanctions:

22.D.1. Operation of a nursing facility without a license.

22.D.2. Impeding or interfering with the enforcement of laws or regulations governing the licensing of nursing facilities, or giving false information in connection with the enforcement of such laws and regulations.

22.D.3. Failure to submit a Plan of Correction within ten (10) working days after receipt of a Statement of Deficiencies.

22.D.4. Failure to take timely corrective action in accordance with a Plan of Correction or a Directed Plan of Correction.

22.D.5. Failure to comply with State licensing laws or regulations when this failure poses an immediate threat of death or substantial probability of serious mental or physical harm to a resident or residents.

22.D.6. The occurrence of a repeated deficiency that poses a substantial risk to any resident's health or safety or infringes upon any resident's rights.

22.D.7. Failure to comply with 42 United States Code, Title 42, Section 1396 r (b) Requirements Relating to Provision of Services; (c) Requirements Relating to Residents' Rights; and (d) Requirements Relating to Administration and Other Matters.

22.E. Procedure for Imposing Financial Penalties on Nursing Facilities

22.E.1. **Assessment of Financial Penalties** - Upon review or inspection of a nursing facility, the DLRS compile a list of deficiencies found (if any) and send out a Statement of Deficiencies. The Division will also review the deficiencies to ascertain whether there are any grounds for assessment of financial penalties in accordance with Sections 22.C., 22.D., and 22.F. of this Chapter. If the Division determines it is appropriate to assess financial penalties against a nursing facility, based on a Statement of Deficiencies, the Division shall issue to that facility an Assessment of Financial Penalties. That Assessment shall describe the grounds for the imposition of the penalty, the regulation or law that has been violated, and the scheduled amount of the fine corresponding to that violation.

Penalties shall accrue with interest for each day that grounds for imposition of the penalty exist, after the date upon which an Assessment of Financial Penalties is issued. The burden of demonstrating correction of the grounds that support any penalty rests with the facility.

In any instance where the Division imposes a penalty or penalties for conduct described in Section 22.D.7., penalties will not be imposed pursuant to Sections 22.D.5. or 22.D.6. for that same conduct.

22.G. Other Sanctions for Failure to Comply with Applicable Laws/Regulations

22.G.1. **Refusal to Renew** - When an applicant fails to demonstrate consistent compliance with applicable laws and regulations, the Department may refuse to issue or renew a license to operate a nursing facility.

22.G.2. **Conditional License** - If, at the expiration of a full or provisional license, or during the term of a full license, the facility fails to comply with applicable laws and regulations, and, in the judgment of the Division, the best interest of the public would be served, the Division may issue a conditional license, or change a full license to a conditional license. Failure by the conditional licensee to meet the conditions specified by the Department shall permit the Division to void the conditional license or refuse to issue a full license. The conditional license shall be void when the Division has delivered in hand or by certified mail a written notice to the licensee, or, if the licensee cannot be reached for service in-hand or by certified mail, has left written notice thereof at the agency or facility. For the purposes of this subsection, the term "licensee" means the person, firm, corporation or association to whom a conditional license has been issued.

22.G.3. **Emergency Suspension or Revocation** - Whenever, upon investigation, conditions are found which, in the opinion of the Department, immediately endanger the health or safety of the persons living in or attending a facility, the Department may take action for an emergency suspension or temporary revocation of the license pursuant to either 5 M.R.S.A., Section 10004 or 4 M.R.S.A., Section 1153. If the Department acts pursuant to 5 M.R.S.A., Section 10004, it shall give written notice of such emergency suspension by delivering notice in hand to the licensee. If the licensee cannot be reached for personal service, the notice may be left at the licensed premises. Whenever a license is suspended by the Department under this emergency provision, the Department shall file a complaint with the Administrative Court within thirty (30) days if the Department determines that a longer period of suspension or revocation is required.

22.G.4. **Revocation** - Any license issued under these regulations may be suspended or revoked for violation of applicable laws and regulations, committing, permitting, aiding or abetting any illegal practices in the operation of the facility or conduct or practices detrimental to the welfare of persons living in or attending a facility. When the Division believes a license should be suspended or revoked, it shall file a complaint with the Administrative Court as provided in the Maine Administrative Procedures Act, Title V, Chapter 375.

22.G.5. **Receivership** - Pursuant to 22 M.R.S.A. Section 7931 et. seq., the Department may petition the Superior Court to appoint a receiver to operate a nursing facility in the following circumstances:

1. When the facility intends to close but has not arranged at least thirty (30) days prior to closure for the orderly transfer of its residents;
2. When an emergency exists in the facility which threatens the health, security or welfare of residents; or

3. When the facility is in substantial or habitual violation of the standards of health, safety or resident care established under State or Federal regulations to the detriment of the welfare of the residents.

Assisted Housing, 10-144 Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs (from Level IV PNMI)

5.3 Rights regarding transfer and discharge. Each resident has the right to continued residence whenever a valid contract for services is in force. The facility must show documented evidence of strategies used to prevent involuntary transfers or discharges. A resident shall not be transferred or discharged involuntarily, except for the following reasons:

- 5.3.1 When there is documented evidence that a resident has violated the admission contract obligations, despite reasonable attempts at problem resolution; *[Class IV]*
- 5.3.2 A resident's continued tenancy constitutes a direct threat to the health or safety of others; *[Class IV]*
- 5.3.3 A resident's intentional behavior has resulted in substantial physical damage to the property of the assisted housing program or others residing in or working there; *[Class IV]*
- 5.3.4 A resident has not paid for his/her residential services in accordance with the contract between the assisted housing program and the resident; *[Class IV]*
- 5.3.5 When there is documented evidence that the facility cannot meet the needs of the resident as the program is fundamentally designed; *[Class IV]* or
- 5.3.6 The license has been revoked, not renewed, or voluntarily surrendered. *[Class IV]*

5.4 Transfer or discharge. When a resident is transferred or discharged in a non-emergency situation, the resident or his/her guardian shall be provided with at least fifteen (15) days advance written notice to ensure adequate time to find an alternative placement that is safe and appropriate. The provider has an affirmative responsibility to assist in the transfer or discharge process and to produce a safe and orderly discharge plan. If no discharge plan is possible, then no involuntary non-emergency discharge shall occur until a safe discharge plan is in place. Appropriate information, including copies of pertinent records, shall be transferred with a resident to a new placement. *[Class IV]* Each notice must be written and include the following:

- 5.4.1 The reason for the transfer or discharge, including events which are the basis for such action; *[Class IV]*
- 5.4.2 The effective date of the transfer or discharge; *[Class IV]*
- 5.4.3 Notice of the resident's right to appeal the transfer or discharge as set forth in Section 5.28; *[Class IV]*
- 5.4.4 The mailing address and toll-free telephone number of the Long Term Care Ombudsman Program; *[Class IV]*
- 5.4.5 In the case of residents with developmental disabilities or mental illness, the mailing address and telephone number of the Office of Advocacy, Department of Health and Human Services (formerly known as the Department of Behavioral and Developmental Services (BDS)); *[Class IV]*
- 5.4.6 The resident's right to be represented by himself/herself or by legal counsel, a relative, friend or other spokesperson. *[Class IV]*

5.5 Emergency transfer or discharge. When an emergency situation exists, no written notice is required, but such notice as is practical under the circumstance shall be given to the resident and/or resident's representative. The facility shall assist the resident and authorized representatives in locating an appropriate placement. Transfer to an acute hospital is not considered a placement and the obligation in regard to such assistance does not necessarily terminate. *[Class IV]* (2.20 "Emergency" means either those events that demonstrate that a resident has an urgent medical or psychological need, which requires immediate acute care treatment, poses imminent danger to other residents or a natural disaster, which damages or interrupts vital services to residents or the integrity of the physical plant.)

5.6 Leaves of absence. When a resident is away, and continues to pay for services in accordance with the contract, the resident shall be permitted to return unless any of the reasons set forth in Section 5.3 are present and the resident or resident's legal representative has been given notice as may be required in these regulations. *[Class IV]*

- 5.7 Assistance in finding alternative placement.** Residents who choose to relocate shall be offered assistance in doing so.
- 4.5 Enforcement process.**
- 4.5.1** After inspection, an SOD will be sent to the licensee if the inspection identifies any failure to comply with licensing regulations. An SOD may be accompanied by a Directed POC.
- 4.5.2** The licensee shall complete a POC for each deficiency, sign the plan and submit it to the department within ten (10) working days of receipt of any SOD.
- 4.5.3** Failure to correct any deficiency(ies) or to file an acceptable POC with the department may lead to the imposition of sanctions or penalties as described in Sections 4.7 and 4.8 of these regulations.
- 4.6 Grounds for intermediate sanctions.** The following circumstances shall be grounds for the imposition of intermediate sanctions:
- 4.6.1** Operation of an assisted living program or Private Non-Medical Institutions without a license;
- 4.6.2** Operation of an assisted living program or Private Non-Medical Institutions over licensed capacity;
- 4.6.3** Impeding or interfering with the enforcement of laws or regulations governing the licensing of assisted housing programs, or giving false information in connection with the enforcement of such laws and regulations;
- 4.6.4** Failure to submit a POC within ten (10) working days after receipt of an SOD;
- 4.6.5** Failure to take timely corrective action in accordance with a POC, a Directed POC or Conditional License;
- 4.6.6** Failure to comply with state licensing laws or regulations that have been classified as Class I, II, III or IV pursuant to Sections 4.8.2 & 4.8.3.
- 4.7 Intermediate sanctions.** The department is authorized to impose one or more of the following intermediate sanctions when any of the circumstances listed in Section 4.6 are present and the department determines that a sanction is necessary and appropriate to ensure compliance with State licensing regulations to protect the residents of an assisted housing program or the general public:
- 4.7.1** The assisted living program, residential care facility, or private non-medical institution may be directed to stop all new admissions, regardless of payment source, or to admit only those residents the department approves, until such time as it determines that corrective action has been taken.
- 4.7.2** The department may issue a Directed POC or Conditional License.
- 4.7.3** The department may impose a financial penalty.
- 4.8 Financial penalties.**
- 4.8.1** Certain provisions of these regulations have been classified as noted below. Financial penalties may be imposed only when these regulations are violated.
- 4.8.3** Certain regulations have been given alternative classifications. Such regulations are followed by an alternative notation (i.e., Class I/II or Class II/III). When these regulations are not complied with, the department will determine which classification is appropriate, on a case-by-case basis, by reference to the standards set forth in Section 4.8.2.
- 4.8.4** If the department assesses financial penalties, an Assessment of Penalties will be issued. The Assessment shall describe the classification of each violation found to have been committed by the facility, the regulation or law that has been violated and the scheduled amount of time corresponding to that violation. If the provider does not contest the imposition or amount of the penalty, the provider must pay within thirty (30) calendar days of receipt of the Assessment of Penalties. If the provider disagrees with the imposition or amount of the penalty, the provider must notify the department, in writing, stating the nature of the disagreement, within ten (10) working days of receipt of the Assessment of Penalties. The department will schedule an informal conference to resolve the dispute and a written decision based upon this conference will be provided. If the provider is still dissatisfied with the written decision, an administrative hearing may be requested in accordance with Section 4.10.

- 4.8.6 The department may impose a penalty upon a licensee of a Level IV PNMI for a violation of these rules. Each day of violation constitutes a separate offense. A penalty or a combination of penalties imposed on a facility may not be greater than a sum equal to \$10 times the total number of residents in the facility per violation, up to a maximum of \$10,000 for each instance in which the department issues a statement of deficiency to a licensee of a Level IV PNMI.
- 4.9 **Other sanctions for failure to comply.**
- 4.9.1 When an applicant fails to comply with applicable laws and regulations, the department may refuse to issue or renew a license to operate an assisted living program, residential care facility, or private non-medical institution.
- 4.9.2 If, at the expiration of a full or Provisional license, or during the term of a full license, the provider fails to comply with applicable laws and regulations, and, in the judgment of the Commissioner, the best interest of the public would be served, the department may issue a Conditional license, or change a full license to a Conditional license. Failure by the licensee to meet the conditions specified by the department shall permit the department to void the Conditional license or refuse to issue a full license. The conditional license shall be void when the department has delivered in hand or by certified mail a written notice to the licensee, or, if the licensee cannot be reached for service in hand or by certified mail, has left written notice thereof at the agency or facility. For the purposes of this subsection the term "licensee" means the person, firm, or corporation or association to whom a conditional license or approval has been issued.
- 4.9.3 Upon investigation, whenever conditions are found which, in the opinion of the department, immediately endanger the health or safety of the persons living in or attending the assisted living program, residential care facility, or private non-medical institution, the department may request that the District Court suspend the license on an emergency basis, pursuant to Title 4 M.R.S.A. §184, subsection 6.
- 4.9.4 Any license may be suspended or revoked for violation of applicable laws or regulations, committing, permitting, aiding or abetting any illegal practices in the operation of the assisted living program, residential care facility, or private non-medical institution, or conduct or practices detrimental to the welfare of persons living in or attending the facility/program. When the department believes a license should be suspended or revoked, it shall file a complaint with the District Court as provided in the Maine Administrative Procedure Act, Title 5 M.R.S.A., Chapter 375 §10051.
- 4.9.5 Pursuant to Title 22 M.R.S.A. §7931 *et seq.*, the department may petition the Superior Court to appoint a receiver to operate the assisted living program, residential care facility, or private non-medical institution in the following circumstances:
- 4.9.5.1 When the assisted living program, residential care facility, or private non-medical institution intends to close, but has not arranged for the orderly transfer of its residents at least thirty (30) calendar days prior to closure;
- 4.9.5.2 When an emergency exists which threatens the health, security or welfare of residents; or
- 4.9.5.3 When the assisted living program, residential care facility, or private non-medical institution is in substantial or habitual violation of the standards of health, safety or resident care established under State or Federal laws and regulations, to the detriment of the welfare of the residents.
- 5.26 **Reasonable modifications and accommodations.** To afford individuals with disabilities the opportunity to reside in an assisted living program, residential care facility, or a private non-medical institution, the provider shall:
- 5.26.1 Permit directly, or through an agreement with the property owner, if the property owner is a separate entity, reasonable modification of the existing premises, at the expense of the disabled individual or other willing payer. Where it is reasonable to do so, the provider may require the disabled individual to return the premises to the condition that existed before the modification, upon discharge of that individual. The provider is not required to make the modification at his/her own expense, if it imposes a financial burden. *[Class IV]*

5.26.2 Make reasonable accommodation in regulations, policies, practices or services, including permitting reasonable supplementary services to be brought into the facility/program. The provider is not required to make the accommodation, if it imposes an undue financial burden or results in a fundamental change in the program. *[Class IV]*

5.27 **Right of action.** In addition to any remedies contained herein, any resident whose rights have been violated may commence a civil action in Superior Court for injunctive and declaratory relief pursuant to Title 22 M.R.S.A. §7948 *et seq.* *[Class IV]*

5.28 **Right to appeal an involuntary transfer or discharge.** The resident has the right to an expedited administrative hearing to appeal an involuntary transfer or discharge. A resident may not appeal a discharge due to the impending closure of the program unless he/she believes the transfer or discharge is not safe or appropriate. To file an appeal regarding an involuntary transfer or discharge, the resident must submit the appeal within five (5) calendar days of receipt of a written notice. If the resident has already been discharged on an emergency basis, the provider shall hold a space available for the resident pending receipt of an administrative decision. Requests for appeals shall be submitted to the Assistant Director, Division of Licensing and Certification, Community Services Programs for submission to the Office of Administrative Hearings, 11 State House Station, Augusta, Maine 04333-0011. The provider is responsible for defending its decision to transfer or discharge the resident at the administrative hearing. *[Class IV]*

Hospitals, Appendix A and Appendix W of the federal CMS State Operations Manual

Admissions:

Emergency Medical Treatment and Labor Act (EMTALA) - § 489.24 Special responsibilities of Medicare hospitals in emergency cases. If a hospital has an emergency department (ED), the hospital is required to provide an appropriate medical screening examination and stabilizing treatment to any individual who presents to the hospital with an emergency medical condition. A hospital may transfer a patient who has not been stabilized only if the medical benefits of the transfer outweigh the risks of not transferring the patient, the transfer is to a facility that has the capability to stabilize the patient, and the receiving facility accepts the transfer.

A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at § 412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

An allegation of a potential EMTALA violation is considered to constitute 'immediate jeopardy'. If the hospital is deemed (accredited by a CMS acknowledged accrediting agency), DLRS contacts the CMS Regional Office (RO), and the RO determines if DLRS will investigate the complaint. If the hospital is not deemed, DLRS makes the determination whether or not to investigate the complaint. If a determination is made to investigate the allegation, DLRS will commence an investigation within 2 business days of receipt of the allegation.

An EMTALA violation that has been substantiated can result in significant sanctions such as fines and/or termination of the CMS contract.

Discharges

§ 489.27 Beneficiary notice of discharge rights. – Medicare beneficiaries have the right to seek review by the Quality Improvement Organization (QIO) to appeal premature discharges (42 CFR 482.12(a)). The DLRS surveyors review medical records and interview inpatients to ascertain that Medicare beneficiaries have received the required notice outlining their discharge appeal rights (§ 405.1205).

Discharge Planning: Hospital discharge planning is a process that involves determining the appropriate post-hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient's identified post-discharge needs. This approach recognizes the shared responsibility of health care professionals and facilities as well as patients and their support persons throughout the continuum of care, and the need to foster better communication among the various groups. Much of the interpretive guidance for this CoP has been informed by newer research on care transitions, understood broadly.

Hospitals are expected to have knowledge of the capabilities and capacities of not only of long term care facilities, but also of the various types of service providers in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient's needs in theory, but also can be implemented. This includes knowledge of community services, as well as familiarity with available Medicaid home and community-based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients.

§ 482.43 Condition of participation: Discharge planning. The hospital must have in effect a discharge planning process that applies to all patients.

§482.43(a) Standard: Identification of Patients in Need of Discharge Planning

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

§482.43(b)(3) requires the evaluation to consider the patient's likelihood of needing post-hospital services and the availability of such services.

Interpretive Guidelines §482.43(d)

The hospital must take steps to ensure that patients receive appropriate post-hospital care by arranging, as applicable, transfer to appropriate facilities or referrals to follow-up ambulatory care services.

"Appropriate facilities, agencies, or outpatient services" refers to entities such as skilled nursing facilities, nursing facilities, home health agencies, hospice agencies, mental health agencies, dialysis centers, suppliers of durable medical equipment, suppliers of physical and occupational therapy, physician offices, etc. which offer post-acute care services that address the patient's post-hospital needs identified in the patient's discharge planning evaluation.

Once the determination has been made that services will be necessary post-discharge, the team must then determine availability of those services or identify comparable substitutions. Included in the evaluation is coordination with insurers and other payors, including the State Medicaid agency, as necessary to ensure resources prescribed are approved and available.

The hospital is required to arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. It also includes arranging:

- Transfers to rehabilitation hospitals, long term care hospitals, or long term care facilities;
- Referrals to home health or hospice agencies;
- Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;

- Referral to medical equipment suppliers; and
- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation, or other post-discharge needs.

Medical and other information needed for care and treatment of residents, and , when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions

(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

10-144, 112, Rules for Licensing Hospitals

Section 3. STANDARDS

3.1 Federal standards and certification requirements. All applicants and licensees must comply with the federal standards and certification requirements for hospitals, adopted by the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) as set forth in 42 C.F.R. §482.1 through §482.104 and §485.601 through §485.647, revised as of October 1, 2007, which is incorporated herein by reference.

Commission to Study Difficult to Place Patients

Proposals to Consider

1. Hospital Payment for Care Provided Pending Placement.

Pay all hospitals a daily “days awaiting placement” rate for the care of patients following the conclusion of medical care.

Issue to discuss: What is the daily rate?

We would propose that the daily rate should be either the NF daily rate or the SNF daily rate depending on the acuity/needs of the patient.

Issue to discuss: At what day should the daily rate begin to be paid?

We would propose a 48-hour/two midnight non-payment period following the end of medical care/acute episode to account of routine delays in placement. After 48-hours or after the second midnight the patient spends in the hospital awaiting placement the daily rate would kick-in.

2. Expand Role of Ombudsman to Assist Finding Placements.

Ombudsman’s Office has done great work helping place individual patients. It is time-intensive work and Ombudsman would need more staff to expand assistance provided to patients in hospitals.

Issue to discuss: Amount of funding/staffing necessary to expand role of Ombudsman. Is there a need to change Ombudsman statute to authorize this work?

3. Issue RFP for geropsychiatric residential unit in Northern Maine.

The number of gero-psych beds has not grown with demand and there are none in Northern Maine. Maine DHHS should issue RFP for a gero-psych unit north of Augusta.

Issue to discuss: Should the RFP include a rate or request that respondents propose a rate? RFI?

4. Contract/Enforcement Issues.

5. Other patients (Vent/ALS/Bariatric).

Is the draft DHHS RFI on costly patients the start?

6. Other – 60 mile rule; presumptive eligibility; home care; psychotics in LTC; other.

MHA

Maine Hospital Association
Representing community hospitals and the patients they serve.

Commission to Study Difficult to Place Patients November 5, 2015

MHA Response to Data Request

1. *How many patients are awaiting placement in Maine's two private Psychiatric Hospitals (Acadia and Spring Harbor)?*

These hospitals were included in the MHA survey from December 2014.

In addition, the patients at MMC in the psychiatric unit (P6) were identified in our survey separately.

The two psychiatric hospitals and the MMC P6 unit had the following:

- **Total Patients Awaiting Placement - 17**
 - Of those, Patients Waiting More than 40 Days - 11
- **Type of Setting Needed:**
 - Dementia Unit – 2
 - Psych Bed – 4
 - Res Care – 8
 - Other (NF, PNMI, CSU) – 3

There are 361 private/non-state beds;

- 205 are in 7 community hospitals (MidCoast, MaineGen, SMMC, NMMC, St.Mary's, MMC, PenBay and
- 156 are in the two private psychiatric hospitals.



61 Winthrop Street • Augusta, Maine 04330
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Commission to Study Difficult-to-Place Patients

November 5, 2015

The Maine Long-Term Care Ombudsman Program (MLTCOP) is authorized by the Older American's Act, Title VII, Chapter 2, Sections 711/712 to provide advocacy for consumers in nursing homes, residential care and assisted living facilities. Our state enabling statute expanded our role to include advocacy for recipients of home care, homemaker services and adult day services.

MLTCOP serves residents in 338 long-term care facilities:

- 102 nursing homes
- 236 PNMI, private pay residential care and assisted living
- MLTCOP must establish and maintain a presence in long-term care facilities, visiting at least quarterly

MLTCOP serves recipients of home and community based services provided through:

- EIM, Alpha One, Catholic Charities, licensed home care agencies and PCA agencies

Advocacy:

- Investigate and resolve complaints made by or on behalf of long-term care consumers
- Monitor facilities with surveys and/or complaints that indicate poor care
- Provide in-service education for staff concerning resident's rights and mandatory reporting
- Support resident and family councils
- Work with residents and their families to assure a safe and appropriate discharge when facilities close

Homeward Bound Program:

- MLTCOP provides outreach, referrals, advocacy and support for individuals throughout the transition from nursing home back to the community
- Follows program participants after they return to the community

Demonstration Project:

- MLTCOP volunteers receive additional training to follow residents in long-term care facilities that are public wards to assure that they receive the care they need

Current staff and volunteers:

- 9 FTES provide direct service to consumers
- 50 volunteers
- 1.5 administrative FTES

To provide advocacy for hospitalized patients who experience barriers in being admitted to a long-term care facility, the Maine Long-Term Care Ombudsman Program (MLTCOP) would need the following:

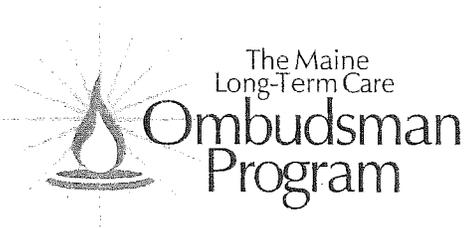
- Two additional full time staff focused on working with patients and hospitals across the state on finding admission to a long-term care facility that is appropriate to meet their needs

MLTCOP would accept referrals when:

- The patient or their legal representative has given consent for the referral
- If indicated, the MaineCare eligibility determination is in process
- The patient has been medically cleared for discharge and;
- Multiple referrals have been made by the hospital Care Manager to long-term care facilities and admission has been denied

MLTCOP staff would:

- Provide outreach and education to hospital Care Managers about MLTCOP's role in providing assistance to patients in need of long-term care services and encourage referrals to MLTCOP
- Visit patients after consent is received and referral is made
- Identify barriers to admission and work to overcome the barriers so that the appropriate level of care is received
- Track referrals and outcomes
- Follow patients after transition to long-term care facility



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Long-term Care Ombudsman Program

§5107-A. Long-term care ombudsman program

In accordance with the program established pursuant to section 5106, subsection 11-C, the ombudsman may enter onto the premises of any residential care facility, as defined in section 7852, subsection 14, licensed according to section 7801, any assisted living facility licensed pursuant to chapter 1663 or 1664 and any nursing facility licensed according to section 1817 to investigate complaints concerning those facilities or to perform any other functions authorized by this section or other applicable law or rules. The ombudsman shall investigate complaints received on behalf of individuals receiving long-term care services provided by home-based care programs, the Medicaid waiver program, licensed home health agencies, assisted living services providers, certified homemaker agencies and licensed adult day care agencies. To carry out this function, any staff member or volunteer authorized by the ombudsman may enter onto the premises of any residential care facility, assisted living facility or nursing facility during the course of an investigation, speak privately with any individual in the facility who consents to the conversation and inspect and copy all records pertaining to a resident as long as the resident or the legal representative of the resident consents in writing to that inspection. The consent, when required and not obtainable in writing, may be conveyed orally or otherwise to the staff of the facility. When a resident is not competent to grant consent and has no legal representative, the ombudsman may inspect the resident's records and may make copies without the written consent of a duly appointed legal representative. The ombudsman may authorize as many individuals as necessary, in addition to staff, to carry out this function except that these individuals may not make copies of confidential client information. Appropriate identification must be issued to all such persons. In accordance with the federal 1987 Older Americans Act, 42 United States Code, as amended, a person may not serve as an ombudsman without training as to the rights and responsibilities of an ombudsman or without a specific plan of action under direction of the ombudsman. The ombudsman shall renew the authorization and issue identification annually. The findings of the ombudsman must be available to the public upon request.

The ombudsman and volunteers shall visit, talk with and make personal, social and legal services available to residents; inform residents of their rights, entitlements and obligations under federal and state laws by distributing education materials and meeting with groups or individuals; assist residents in asserting their legal rights regarding claims for public assistance, medical care and social security benefits or in actions against agencies responsible for those programs, as well as in all other matters in which residents are aggrieved, including, but not limited to, advising residents to litigate; investigate complaints received from residents or concerned parties regarding care or other matters concerning residents; and participate as observer and resource in any on-site survey or other regulatory review performed by state agencies pursuant to state or federal law.

Information or records maintained by the ombudsman concerning complaints may not be

disclosed unless the ombudsman authorizes the disclosure. The ombudsman may not disclose the identity of any complainant or resident unless the complainant, the resident or a legal representative of either consents in writing to the disclosure or a court orders the disclosure.

A complainant, a resident or a legal representative of either, in providing the consent, may specify to whom such identity may be disclosed and for what purposes, in which event no other disclosure is authorized.

Any person, official or institution that in good faith participates in the registering of a complaint pursuant to this section or in good faith investigates that complaint or provides access to those persons carrying out the investigation about an act or practice in any residential care facility licensed according to section 7801, any assisted living facility or program or any nursing facility licensed according to section 1817 or that participates in a judicial proceeding resulting from that complaint is immune from any civil or criminal liability that otherwise might result from these actions. For the purpose of any civil or criminal proceedings, there is a rebuttable presumption that any person acting pursuant to this section did so in good faith.

In addition to the other powers and duties set forth in this section, the ombudsman may, when a patient in a hospital licensed according to chapter 405 has been determined to be ready for discharge from the hospital and has experienced significant barriers to placement, assist the patient to locate, be admitted to and be transferred to a residential care facility, assisted living facility or program or nursing facility that can provide the care that is appropriate for the patient.

Huntington's 101

To understand the immensity of caring for individuals with HD, you must grasp its challenges. HD is a devastating, progressive, genetic, terminal illness. There are no cures and no remissions.

It generally strikes young adults in their 30s and 40s. Death typically occurs about 20 years following onset of symptoms, but there is no hard and fast timeframe.

It's a neuropsychiatric disease characterized by: uncontrolled movements (chorea), psychiatric disorders ranging anywhere from depression to obsessive compulsive disorder and paranoia to psychosis and cognitive deficits. The disease affects a specific part of the brain, the basal ganglia, so there are certain mental functions that will be affected while others are not touched.

People with HD are aware of their environment. Dementia affects their executive functions - their ability to plan, to sequence things. Their processing speed becomes very slow and they eventually lose the ability to verbally communicate because of uncontrolled movements in their mouth and throat. Garbled speech causes frustration for patient and caregiver. It often starts with a delayed response rate or slurred, speech. Problems worsen as time goes on. In the end-stages most with HD are non-verbal.

Weight gain is crucial to quality care in HD Patients have constant, slow, abrupt movement, thus burning thousands of calories each day requiring many meals most requiring slow hand feeding. Sudden violent movement often result in accidental injury to unprepared caregivers, holes in walls, broken furniture, dishes, lamps, etc.

Falls result in stitches, wounds and ER visits, broken bones, Wound Clinic visits.

Loss of bodily functions result in increased laundry, rug shampooing several times a day.

Both the patient and caregiver have extreme sleep deprivation.

Accepting the Challenge

With additional behavioral challenges accompanying HD, it is not surprising many long-term care facilities simply do not admit patients from this population, due to the increased need for trained staff and implementing whatever safety precautions are needed.

Residents will ambulate the hall with uncontrolled movements, some residents wear helmets or hip protection just in case they do fall.

The best way to care for them is to anticipate their needs to avoid the anxiety and agitation.

Finding Quality of Life

The optimal way to meet daily needs is to offer true quality of life. Recreation is a big part in caring for these residents, younger by most LTC standards they enjoy trivia or music suited to their age group. They love movies, video games, playing Wii and they love to eat.

Because of patients' posture and movement, they are not easy to transport. They require special chairs that cannot be placed in an ambulance.

My story

After 17 years of 24/7 care, months of paperwork, phone calls and tears, I was forced to place my 40 year old son in a facility in Massachusetts. There was no facility in Maine willing and/or able to take him as a patient. After 2 attempts to find at least respite care, I had no choice.

Driving to MA each week, staying in hotels was exhausting and expensive.

His final week of life:

Care in Maine is woefully inadequate for patients who are young and have challenging conditions. The cost to send patients out of state is exorbitant.

GOAL: to ensure facilities in Maine that can provide the comprehensive care needed for all challenging conditions requiring 24/7 services close enough to home of their loved ones so they can continue to be part of their lives.