

Discharge Process

Maui Health

Thursday June 2, 2022



Regulations Guiding our Process

- Governed by the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation
 - Discharge planning evaluation must be made on a timely basis to avoid unnecessary delays in discharge.
 - Regular re-evaluation of the patient condition necessary to identify changes that require modification to the plan
 - Must include patient treatment preferences
- Accredited by The Joint Commission

Discharge Planning Process & Teams

- The attending physician of record makes a clinical decision when it is appropriate and safe for a patient to be discharged
- The discharge process includes a multidisciplinary team, which includes Case Management, Nursing, Hospital Medicine, Pharmacy and Social Work.
- Patient's case manager and health care team develop a plan for each patient:
 - Clinically appropriate
 - Focused on the patient's care needs and goals for care
 - Includes caregivers/support person(s)
 - Treatment plan that is consistent with patient choice
 - Treatment plan based on available resources

Community partners

- Maui Health leases three Medical Respite Shelter beds from Ka Hale A Ke Ola (KHA KO)
 - Must be independent with ADLs and have a skilled medical need.
 - Skilled need may be met through home health or outpatient services and paid for by insurance or the Maui Health Financial Assistance Program.
- Family Life Center
 - Temporary housing if patient meets criteria; priority is given to women and families
- Malama I Ke Ola
 - A street medicine program, including a hygiene trailer
 - Works closely with the Maui Rescue Mission
- Mental Health Kokua
 - Drop-in center for homeless adults providing a hygiene center, meals, classes, and advocacy
- Aloha House Licensed Crisis Residential Shelters (LCRS)
 - Shelter available for 2-3 weeks for patients with mental health needs

Discharge challenges for patients experiencing homelessness

- Medical Respite Shelter capacity - not always enough shelter beds available
- COVID + patients - no shelter, or transportation available
- Must be independent – For patients who need help with ADLs, they would not meet eligibility for services.
- Lack Social Support Network – Caregiver support, family, friends, to help with transitions
- Challenged to find nursing facilities, home health and home care willing to accept
- Patient may not accept or follow through on community referrals
- Substance abuse limits access to programs
- Patients with previous behavioral issues at shelters
- No accepting facilities for patients receiving IV antibiotics if they have a history of intravenous drug use

Opportunities

- Additional crisis shelter beds
- Additional medical respite shelter beds
- Accepting facilities for COVID+ patients
- Facilities willing to take patients who require help with ADLs
- Facilities willing to take patients who are receiving IV antibiotics
- Facilities willing to take patients with a drug dependence