

CASE STUDY

MaineHealth's approach to transforming post-acute partnerships

MaineHealth has faced growing challenges transitioning patients to post-acute care. Limited bed capacity, reluctance to accept higher-cost and high-acuity patients, and constrained clinical capabilities have all contributed to longer length of stay days. To address these limitations, MaineHealth partnered with Optum's Advisory Services team on this work, which supported the post-acute diagnostic, facility and stakeholder engagement, and the design of the financial alignment approach.

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Audience:

- Post-acute care providers
- Hospital and health systems



Overview

The challenge

MaineHealth faced several major post-acute care (PAC) challenges that contributed to prolonged length of stay (LOS). Limited bed availability, driven by Maine's aging population and the closure of more than 25 facilities over the past decade, reduced placement options across the state. At the same time, many skilled nursing facilities (SNFs) were hesitant to accept higher-cost patients due to Medicaid reimbursement gaps and financial instability. Limited clinical capabilities also further restricted capacity for patients with complex needs, including dialysis, behavioral health conditions, and bariatric care.

The organization

MaineHealth is a not-for-profit, integrated health system that offers a range of care and services. With more than 2,000 employed providers and approximately 24,000 care team members, MaineHealth provides preventive care, diagnosis, and treatment to 1.1 million residents in Maine and New Hampshire.

The approach

MaineHealth has taken three key steps to improve patient throughput and reduce LOS. First, MaineHealth established a post-acute leadership structure, including a multidisciplinary leadership team.

Next, the organization aligned leadership to PAC through relationship-based engagement. Leaders invested time in visiting facilities, understanding their capabilities and constraints, and engaging executive leadership.

Finally, MaineHealth prioritized financial alignment. The organization used single-case agreements, transportation support, and targeted subsidies to improve the financial sustainability of caring for high-needs patients.

The partnership

MaineHealth engaged Optum to assess its post-acute landscape and build a durable improvement plan. Optum advisors supported the facility and stakeholder research across MaineHealth's post-acute network, helped define the new system-level PAC leadership structure, and modeled the financial levers — single-case agreements, transportation support, and targeted subsidies — used to unlock placement for high-acuity patients. MaineHealth led execution; Optum provided the analytics, benchmarking, and change-management support behind it.

The result

These efforts allowed MaineHealth to facilitate smoother care transitions, improve patient throughput, and reduce excess LOS. Compared to its baseline performance, MaineHealth supported 1,811 additional post-acute discharges and reduced excess days by more than 5,300, representing approximately \$5.6 million in avoidable excess-day costs.

3 ways MaineHealth improved patient throughput and LOS

Facing limited post-acute bed and clinical capacity, financial pressures on SNFs, and challenges placing high-acuity patients, MaineHealth implemented a multipronged strategy to improve patient throughput and reduce LOS.

01

ACTION

Create structure and accountability

02

ACTION

Build stronger post-acute partnerships

03

ACTION

Remove barriers to placement

01 Create structure and accountability

As part of its PAC transformation efforts, MaineHealth created several new system-level leadership roles and organized a multidisciplinary team responsible for clinical oversight, nursing strategy, and PAC operational oversight. These leaders standardized care processes, coordinated planning between acute and post-acute providers, and created clear accountability for placement decisions and capacity management. Through these efforts, MaineHealth reduced clinical variation, improved care consistency, and accelerated post-acute placements.

To support this effort, MaineHealth implemented a dedicated centralized team responsible for managing all non-home health post-acute referrals. Team members functioned as experts in the post-acute landscape, with a deep knowledge of each facility. The centralized team also established routine communication with facilities to monitor current capacity, identify barriers to placement, and coordinate transitions across the continuum of care.

By creating a more coordinated and patient-centered placement process, MaineHealth ensured patients' needs were aligned with facilities' capabilities, and improved communication across the care continuum, ultimately supporting better patient outcomes.

New roles support post-acute partnerships

	Core responsibilities	Leadership practices	Operational impact
PAC chief operating officer	- Integrate PAC operations - Improve patient flow and access - Develop a sustainable PAC workforce and operating model	- Build a coordinated, high-performing PAC continuum - Foster clinical partnerships - Drive system-wide accountability	- Improved patient access - Stronger hospital throughput - Smoother and safer transitions across care settings
System PAC senior medical director	- System-wide clinical oversight - Standardized PAC protocols - Clinical alignment with system goals	- Coordinate acute and PAC clinicians - Monitor outcomes and performance - Mentor PAC providers	- Reduced clinical variation - Smoother care transitions - Improved patient outcomes
System PAC senior nursing leader	- System nursing strategy - Evidence-based PAC care - Quality and safety alignment	- Standardize nursing practice - Develop and support PAC staff - Lead interdisciplinary care	- Consistent nursing quality - Improved patient experience - Stronger PAC workforce
Operations leader PAC facilities	- PAC operational oversight - Regulatory compliance - Financial and performance management	- Standardize operations - Coordinate system planning - Optimize resources	- Operational consistency - Strong financial control - Faster PAC placement

02 Build stronger post-acute partnerships

At MaineHealth, expanding post-acute capacity required more than just operational changes. Stronger relationships with post-acute providers were also integral. To strengthen its PAC partnerships, system leaders invested significant time engaging with SNFs and other post-acute partners, visiting more than 25 facilities and conducting over 50 stakeholder interviews. These conversations helped MaineHealth better understand operational challenges and clinical capabilities across the post-acute network.

Through these engagements, MaineHealth gained greater insight into the reasons for placement delays and learned that many delays were driven not by unwillingness to partner, but by a combination of bed capacity limitations, reimbursement concerns, and limited clinical capacity to manage patients with complex needs.

To maintain alignment and promote relationship-based engagement with PAC providers, MaineHealth established regular communication across its post-acute network. Daily facility calls focused on current bed capacity, referral status, and barriers to accepting new patients. These ongoing interactions strengthened trust and collaboration between MaineHealth and its post-acute partners, enabling both sides to work more effectively toward shared goals. As a result, PAC partner facilities experienced increased occupancy, greater visibility into referral patterns, and more predictable admissions, while MaineHealth benefited from smoother care transitions, improved throughput, and reduced excess LOS days.

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If there's one thing I would drive home, it's relationships ... Facilities are now willing to take patients they would have unequivocally said no to before, because there's trust that didn't exist previously

JENNIFER SKAGGS

Manager in Advisory Services, Optum (Workstream Lead,
MaineHealth Post-Acute Care Transformation)

03 Remove barriers to placement

Even with stronger partnerships and improved coordination, certain patients continued to experience discharge delays due to financial, clinical, and social factors. To address these challenges, MaineHealth used single-case agreements, transportation support, and targeted subsidies to address the financial barriers that delayed placement for complex patients.

For example, dialysis patients often faced placement delays because facilities were unable to absorb transportation costs associated with ongoing treatment. These transportation costs exceeded \$353,000 annually, with each trip costing approximately \$86 to \$272, depending on the level of transport required. Medically stable patients also sometimes faced delays in discharge due to immigration-related barriers, which required system-funded solutions. These patients often experienced extended lengths of stay, and resolving their discharge needs sometimes required significant one-time investments, including specialized transportation and transition arrangements costing more than \$60,000 or ongoing expenditures of approximately \$275,000 annually for high-acuity SNF placement.

At the same time, small social investments can still make a meaningful difference. In some cases, providing rent assistance and phone service can improve adherence to recommended placements and support timely discharge.

Ultimately, overcoming these complex barriers requires creative, patient-specific solutions, with targeted investments, to reduce avoidable hospital days, improve patient outcomes, and facilitate timely discharge to the most appropriate care setting.

Results

MaineHealth's multipronged approach, centered on stronger post-acute partnerships, greater accountability, and targeted financial support, led to meaningful improvements in patient throughput and LOS.

Compared to baseline performance, MaineHealth achieved an additional 1,811 post-acute discharges, going from 10,276 discharges to 12,087. Despite serving significantly more patients, MaineHealth reduced average excess days from 5.56 to 5.11, avoiding approximately 5,356 excess hospital days and generating an estimated \$5.6 million in avoidable excess-day costs.

The results within SNF settings are also particularly notable as SNF discharges increased by 363 patients while both average and total excess days declined. Average excess days per patient decreased from 8.55 to 7.05 days, eliminating 1,297 total excess days and generating approximately \$4.6 million in avoidable excess-day costs compared to baseline performance. Overall, MaineHealth fundamentally improved patient throughput and strengthened relationships with its SNF partners.

These results underscore important lessons: relationships matter, and trust is the foundation on which transformative change can occur. By strengthening post-acute partnerships, MaineHealth was able to improve care and enable more efficient patient transitions across the care continuum.

The MaineHealth–Optum partnership translated stronger post-acute relationships and targeted interventions into measurable results: 1,811 additional post-acute discharges, 5,356 excess days avoided, and roughly \$5.6 million in avoidable excess-day costs.

\$5.6M

Estimated avoidable
excess-day costs.

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