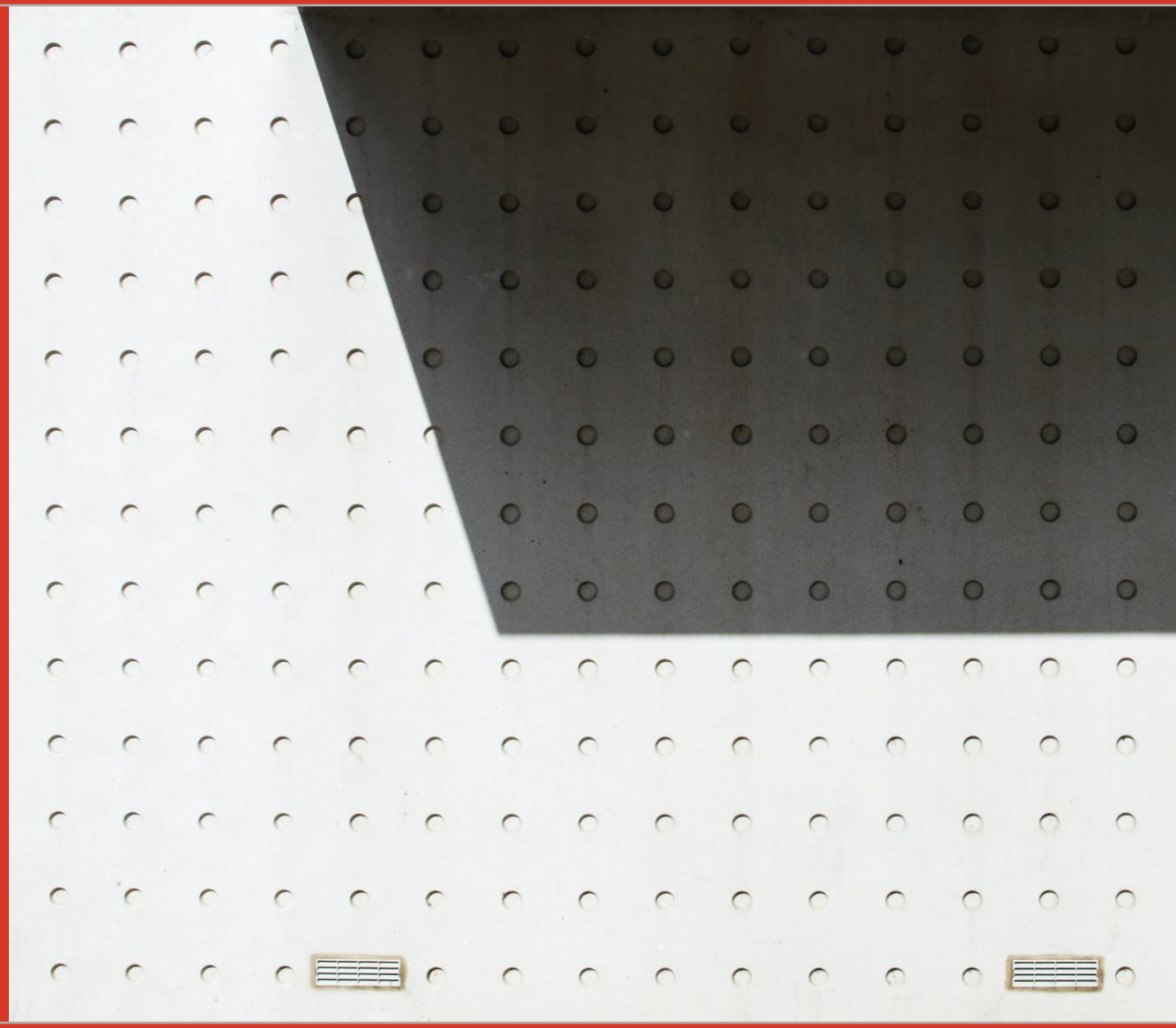
The Hospital Discharge Crisis: *Defining the Challenge*

June 25, 2024

ATI Advisory



INTRODUCTIONS

The Hospital Discharge Crisis: Defining the Challenge

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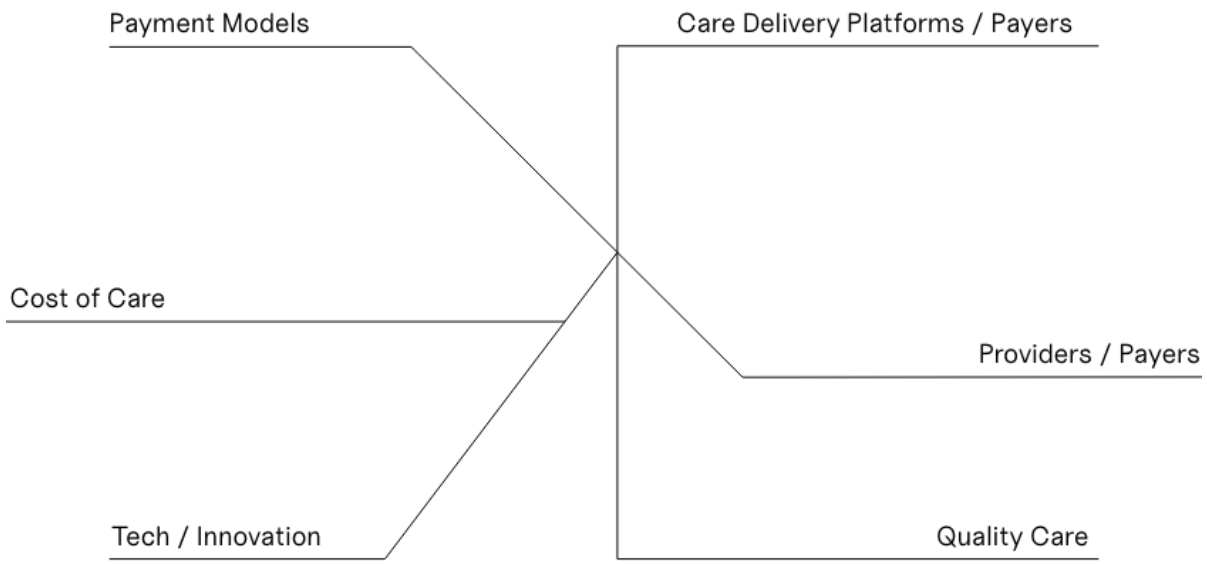
Solving the hardest problems in healthcare

- **Maximizing healthcare value**
  Aligning payment with high quality care
- **Eliminating complexity & inequality**
  Integrating programs and service delivery, including pharmacy
- **Scaling person-centered care and services**
  Shifting to more accessible service delivery infrastructure



1. Quantifying the Size & Scope of the Crisis

2. Identifying the Root Causes

3. Defining the Solution Set

1. Defining the Size & Scope of the Crisis

HOSPITALS AND PATIENTS FACE AN ALL-TOO COMMON DILEMMA

300-Bed Community Hospital in Massachusetts

- Mary, 74 year-old living with diabetes, obesity, and early stages of dementia
- Lives alone; adult daughter lives in another state ~1,000 miles away
- Admitted to hospital for shoulder surgery after falling at home
- Could qualify for Medicaid, but not yet enrolled
- Ready for discharge, but no clinically appropriate settings are available

→ Patients stuck in inpatient beds as hospital staff struggle to find an appropriate setting for post-discharge care and support

Skilled Nursing Facilities

- SNFs in hospital's primary and secondary service areas decline referral
- SNFs point to lack of CNAs, therapists and dementia spaces to support Mary

Home with Home Health

- Not optimal given Mary's extensive rehab, daily ADL needs and co-morbidities requiring med management
- Also, not practical given lack of unpaid caregivers at home

Memory Care Units

- Assisted living-based memory care with home health could be an option, but Mary cannot afford without financial assistance

Source: Massachusetts Health and Hospital Association, A Clogged System Report, 2023.

HOSPITAL DISCHARGE DELAYS CONSISTENTLY DOCUMENTED AROUND THE U.S.

Oregon

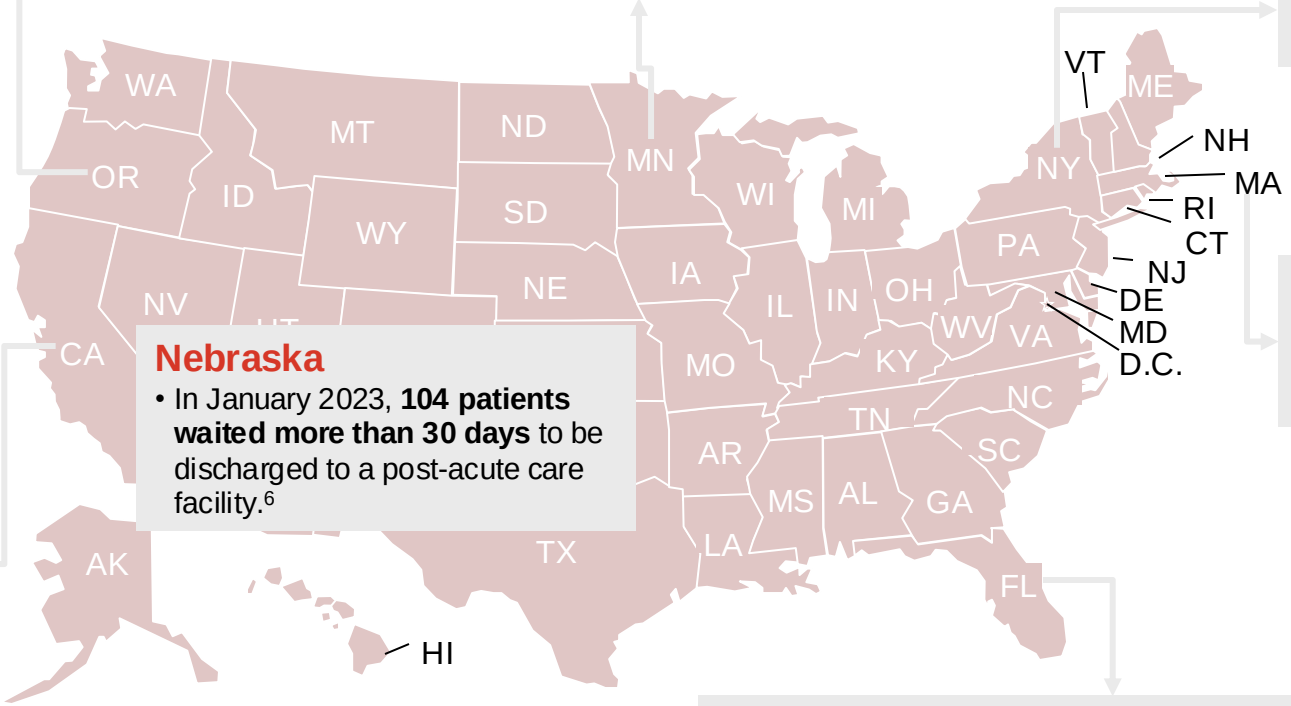
- Hospital discharge volume decreased by 10% from 2017 to 2022, while average length of stay **(ALOS) and total patient hospital days steadily increased** in the same time (ALOS: +27%; total patient hospital days: +20%) [1]

Minnesota

- Study by MN Hospital Association estimated **65,555 additional days of unnecessary patient stays** between June and October 2023.[3]

New York

- **992 patients across 50 hospitals** experienced discharge delays of over two weeks between April 1 and June 30, 2022. Over half of these patients faced delays exceeding 30 day.[4]



California

- An estimated **4,500 patients boarding in California hospitals and emergency rooms** despite being medically cleared for discharge[2]
- Every year in California, an estimated **300,000 hospital patients (9% of all patients) face discharge delays of at least three** days after medical clearance, adding 14 days to their hospital stays on average[2]

Nebraska

- In January 2023, **104 patients waited more than 30 days** to be discharged to a post-acute care facility.[6]

Massachusetts

- **Nearly 1 in 7** med-surg beds currently occupied by a patient who **no longer needs acute hospital care.**[5]

Florida

- Hospitals spent **an estimated $540 million* in unpaid care** due to patients awaiting discharge and placement.[7]

Sources: **1**. ATI analysis of Oregon All-Payer All-Claims data, 2017-2022 **2**. California Hospital Association, 2024 **3**. Minnesota Hospital Association, 2023. **4.** Healthcare Association of New York State, 2023. **5**. Massachusetts Health and Hospital Association, 2023. **6**. Nebraska Hospital Association, 2023. **7.** Florida Hospital Association, 2024.

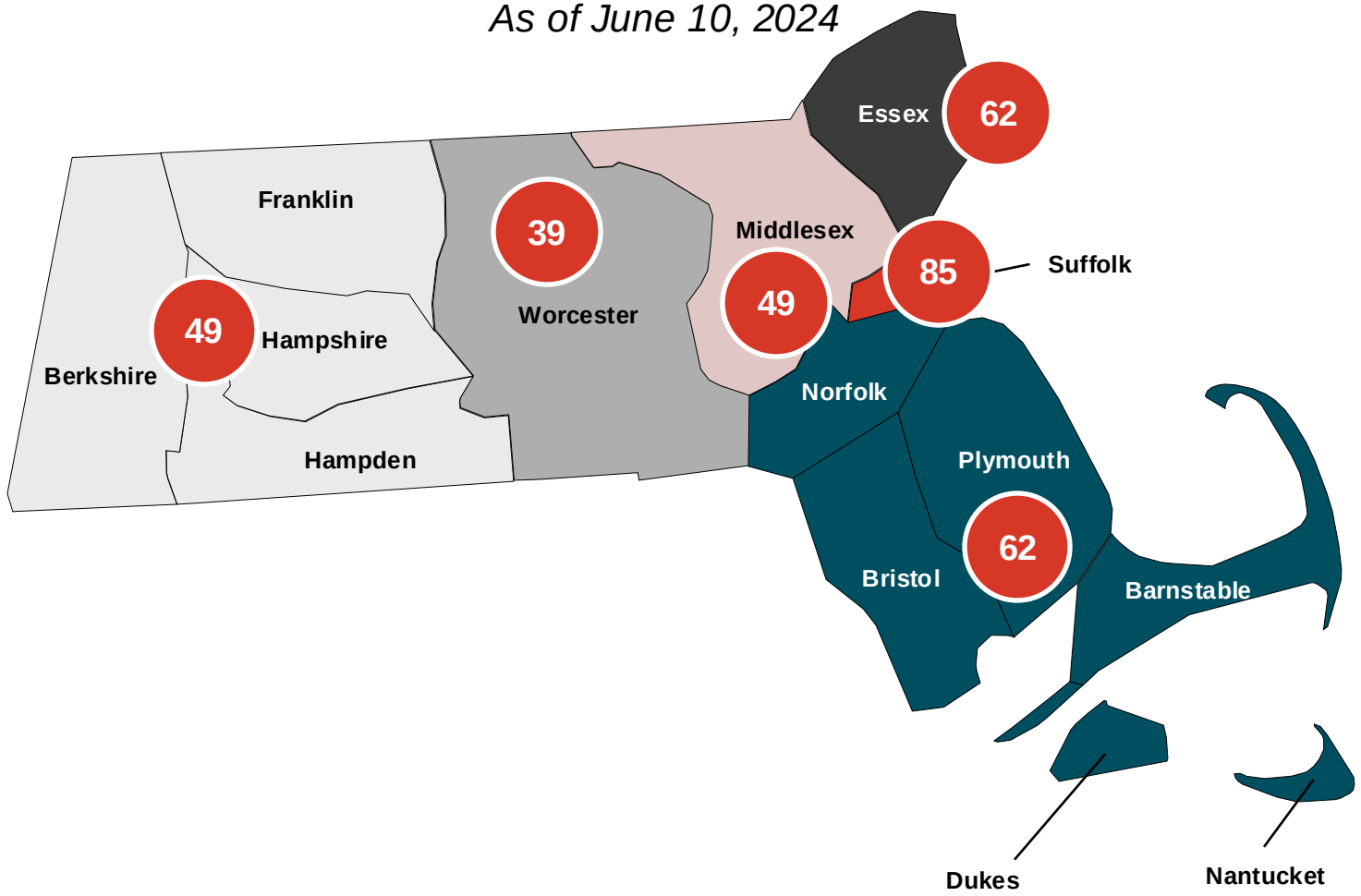
HOSPITAL DISCHARGE CRISIS IMPACTING URBAN, SUBURBAN, AND RURAL COMMUNITIES

No. of Hospital Boarders with Behavioral Health Needs

- Berkshires/Western Mass.
- Central Mass.
- North Shore
- Boston
- Metro West / Western Boston Suburbs
- South Shore/ Cape Cod

Average Number of Patients with Behavioral Health Issues Awaiting Discharge to a Post-Acute Care Setting

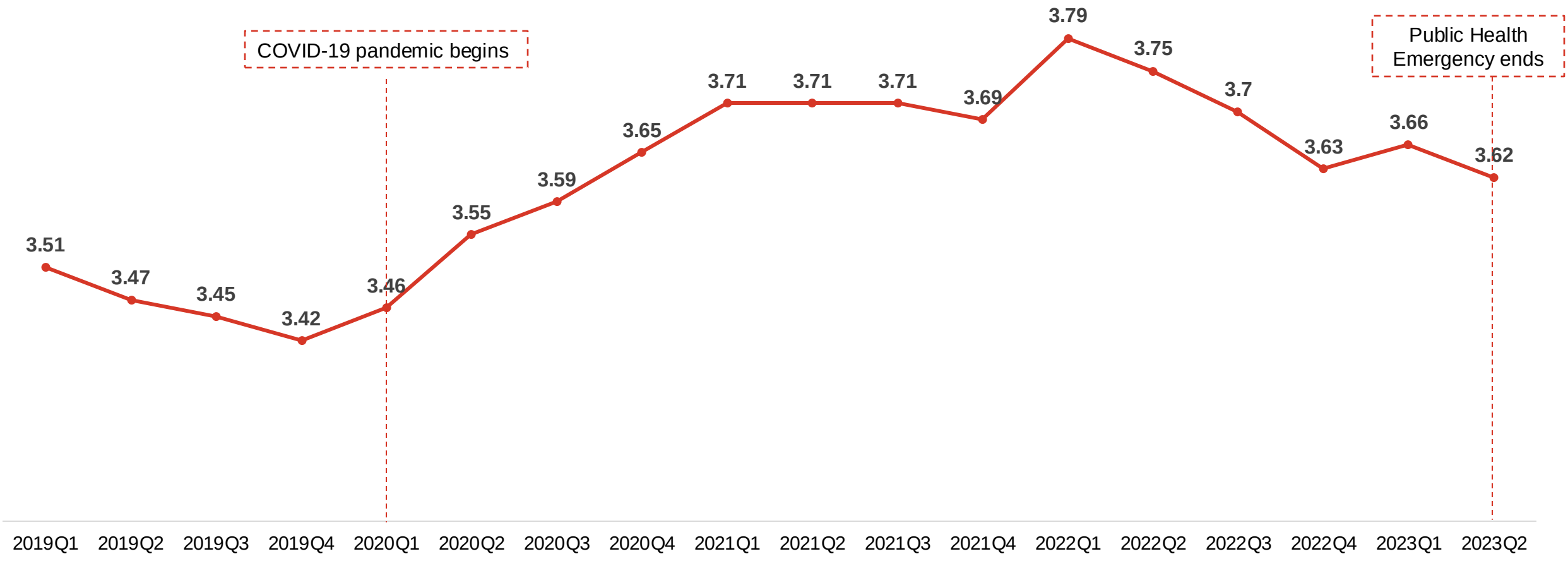
As of June 10, 2024



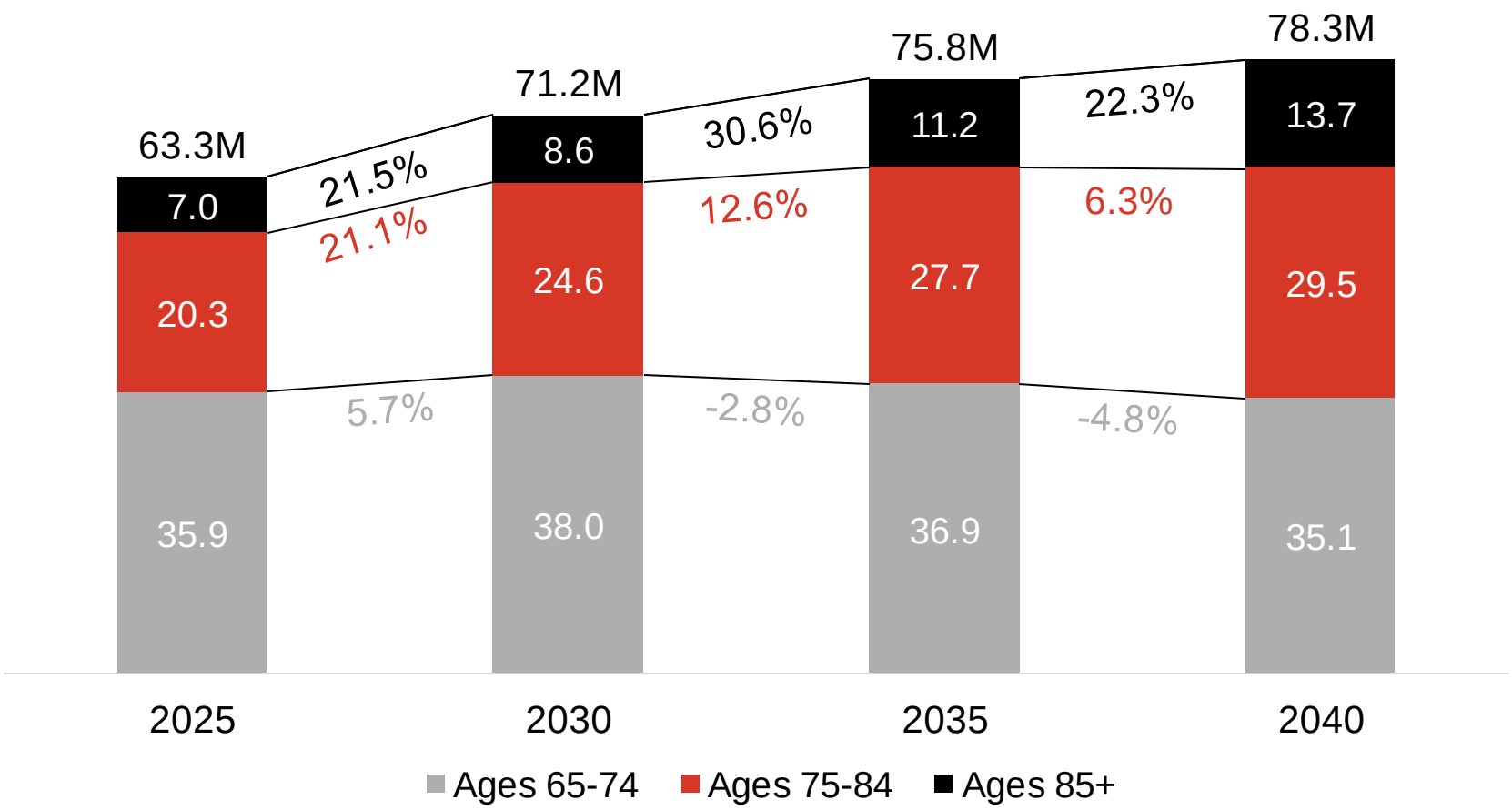
Source: Massachusetts Health and Hospital Association; Capturing a Crisis: Massachusetts Behavioral Health Boarding Metrics, 2024.

HOSPITAL LENGTHS OF STAY SHOT UP DURING PANDEMIC AFTER DECADES-LONG DECLINE

Average Hospital Length of Stay for Hospitalized Medicare FFS Beneficiaries, 2016-2023
(*3-Quarter Rolling Average*)



PANDEMIC IS OVER, BUT DISCHARGE CHALLENGES LIKELY TO CONTINUE GIVEN AGING POPULATION AND STEADILY RISING ACUITY LEVELS



Rapidly Aging Population

1 in 6

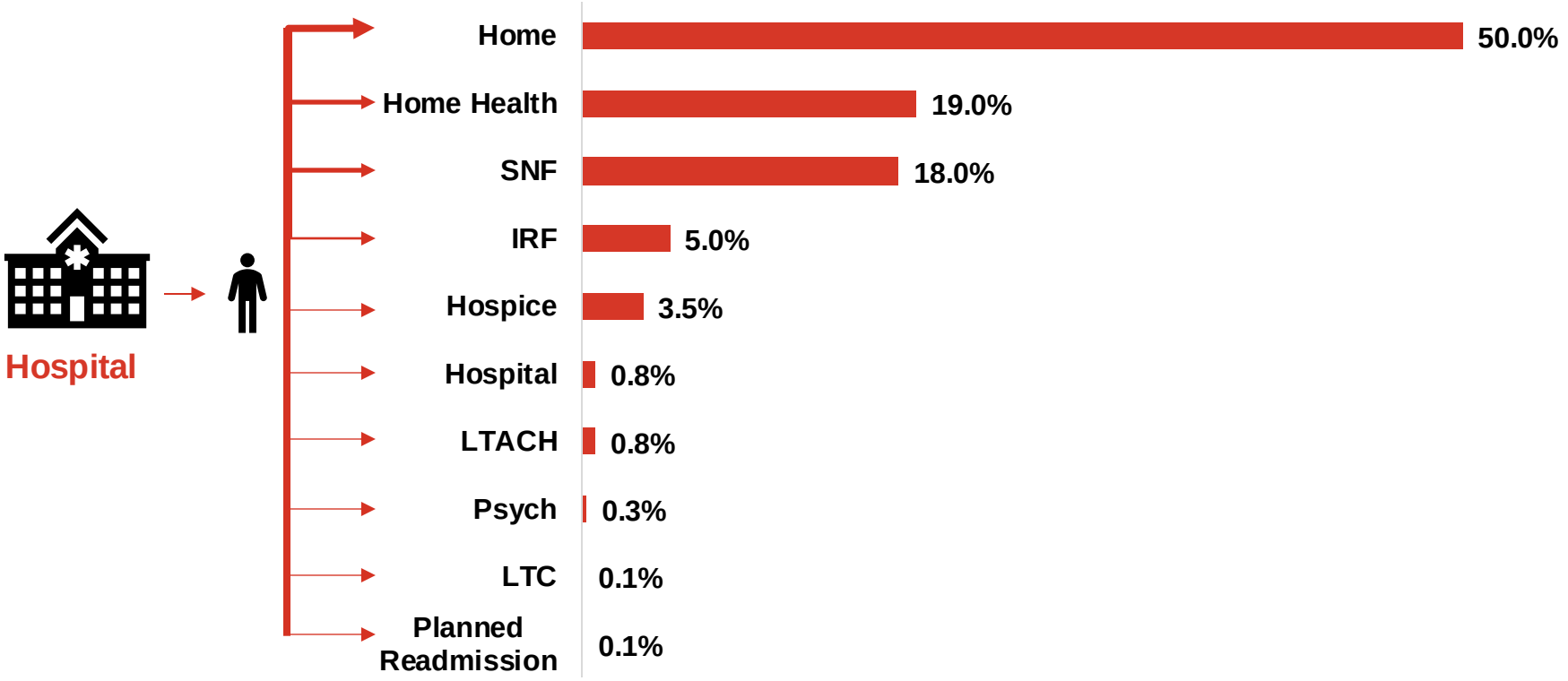
Americans are 65+ and a growing proportion are 80+

Healthcare utilization, social and support needs much higher as well
There is no infrastructure to support older adults and families organize services around the vast array of care needs

2. Identifying the Root Causes

ROUGHLY HALF OF MEDICARE FFS PATIENTS RELY ON POST-DISCHARGE BENEFITS FOR REHABILITATION AND RECOVERY

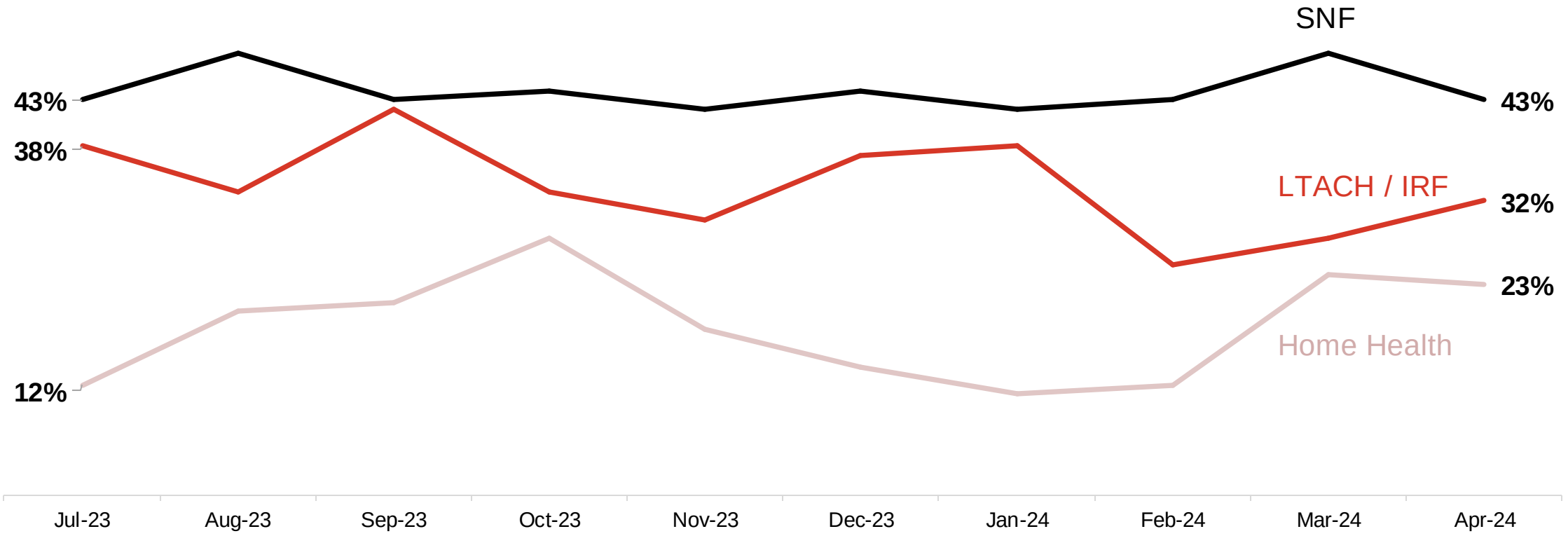
Share of Medicare FFS Discharges by Destination (2023 Q2)



These ratios have stayed consistent over time, except for early on during the pandemic when there were some shifts

IN SOME STATES, LONG-TERM BOARDERS ARE AWAITING DISCHARGE TO A SNF

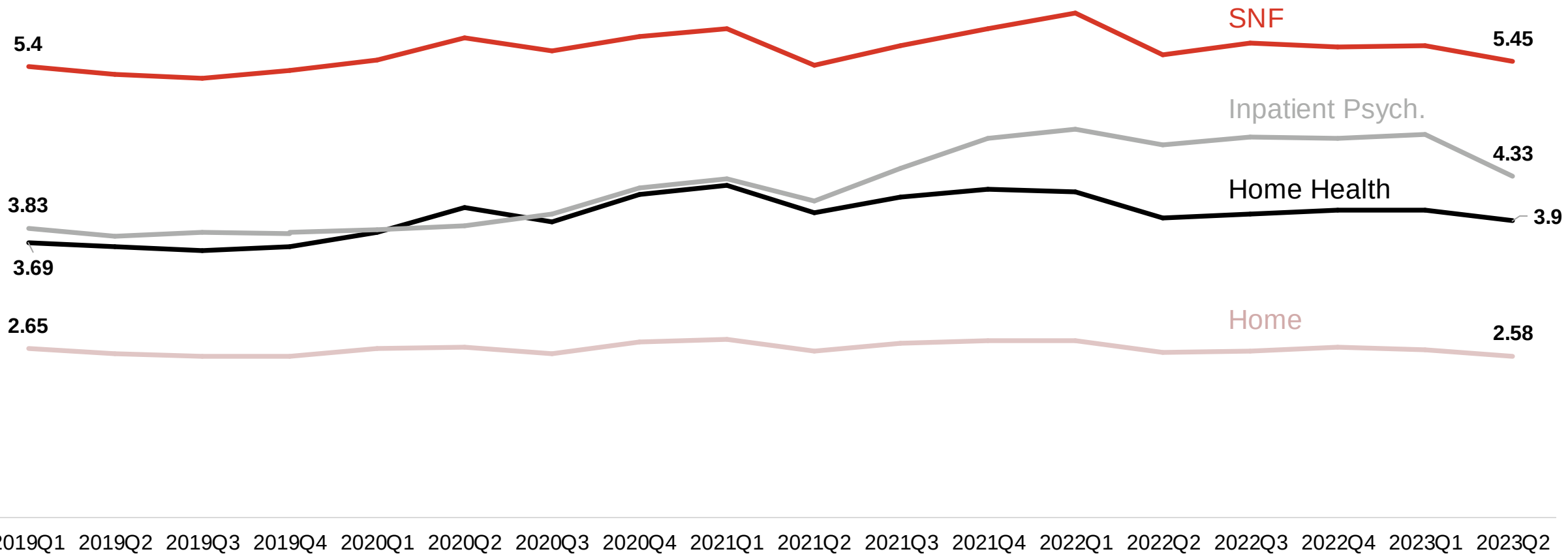
Post-Acute Destination for Patients Waiting 30+ Days for Discharge in Massachusetts



Source: Massachusetts Hospital Association, April 2024.

NATIONALLY WE SEE BOTTLENECKS IN SNF AND PSYCHIATRIC FACILITY CAPACITY

Average Hospital Length of Stay for Hospitalized Medicare FFS Beneficiaries
by Discharge Destination, 2019- 2023



Source: ATI analysis of 100% Medicare Part A claims data.

SEVERE WORKFORCE SHORTAGES LIMITING SNF CAPACITY

Results from March 2024 Survey of SNF Executives

n = 441 executives

72%

→ report current workforce levels are still lower than pre-pandemic staffing levels

45%

→ have limited new admissions due to labor shortages

19%

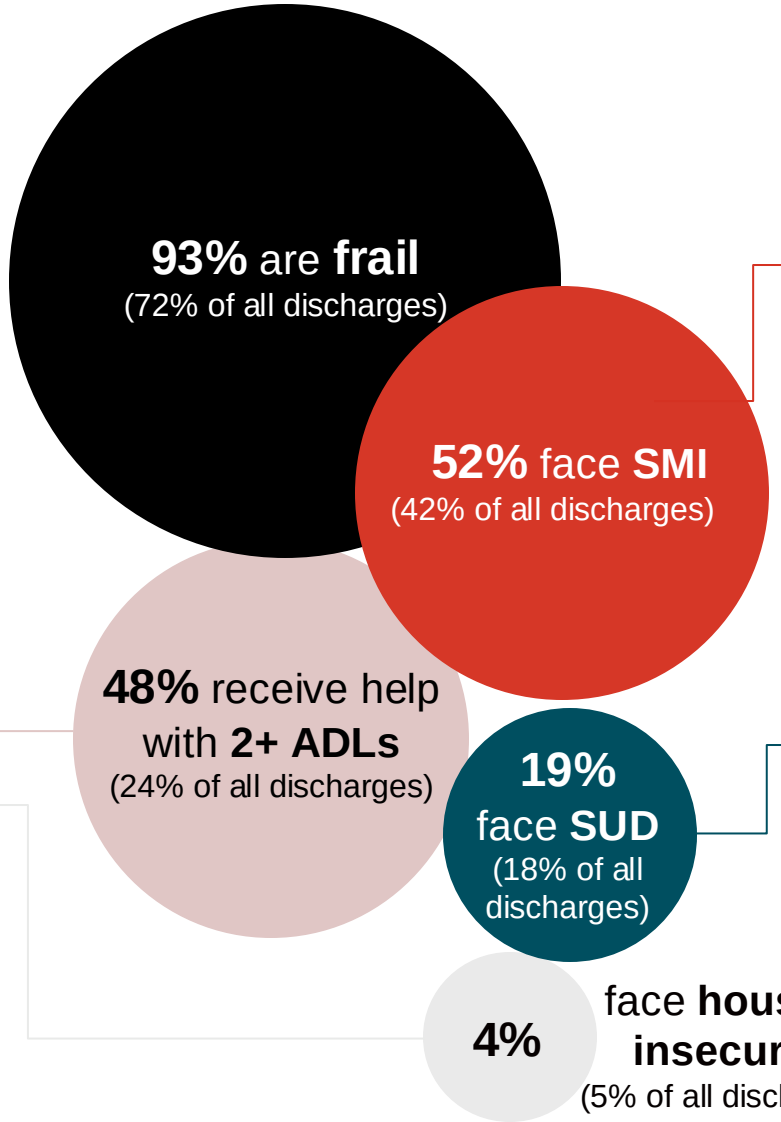
→ have closed a unit, wing, or floor due to labor challenges

Source: AHCA: State of the Nursing Home Sector Report, March 2024

GROWING BEHAVIORAL HEALTH NEEDS ARE CHALLENGING CAPACITY IN EVERY SETTING

Beneficiaries receiving help with 2+ ADLs are discharged to SNFs at high rates, yet two in three rely on family caregivers and/or Medicaid services for help with their ADL limitations at home. **Strong community-based ADL support is needed.**

Low-income seniors housing serves 17% of housing insecure beneficiaries age 65+; because **half of housing insecure Medicare beneficiaries are younger and therefore ineligible for low-income seniors housing, short- and long-term housing support is needed**. Housing insecure beneficiaries experience ADL and SMI needs at high rates as well.



Only 1% of beneficiaries with SMI are discharged to a psychiatric hospital or unit. **More mental health treatment capacity in SNFs is needed.**

Beneficiaries with SUD are the most likely to be discharged home without home health and experience some of the highest readmission rates. **Other discharge options are needed to curb readmission rates**.

Note: The term 'beneficiaries,' as used in ATI's MCBS analyses, refers to Medicare beneficiaries; the term 'individuals' is used throughout the roadmap to reference all individuals, regardless of payer source.
ADL – Activity of Daily Living, **SMI** – Serious Mental Illness, **SUD** – Substance Use Disorder, **SNF** – Medicare Certified Skilled Nursing Facility
See Appendix B. Profile of Beneficiaries with Complex Needs for more information.

MEDICAID REQUIREMENTS AND PAYER POLICIES EXACERBATING DISCHARGE DELAYS

Medicaid long-term care determinations take time

- Applying for and securing Medicaid long-term care benefits is a complex, time-consuming process that often requires detailed documentation and court intervention for patients with cognitive impairments

Insurers' prior authorization processes prolonging hospital stays

- Obtaining approval from insurance companies for necessary treatments involves lengthy administrative procedures, frequent follow-ups, and potential denials, all of which can contribute to discharge delays

Guardianship and healthcare proxy decisions exacerbate delays

- Legal processes resolving guardianship, conservatorship, and healthcare proxy cases involve filing petitions, attending hearings, and waiting for court decisions; these processes can take months, leaving patients in hospitals long after they are ready for discharge

3. Defining the Solution Set

TARGETED INVESTMENTS AND ENHANCED COLLABORATION AMONG PROVIDERS CAN REMOVE SOME ROADBLOCKS TO TIMELY DISCHARGES

Primary Care Providers

- Prevent unnecessary ED visits and hospitalizations through Improve care management and preventive care
- Expand care transition support to expedite patient placement in appropriate post-discharge settings

Hospitals & Health Systems

- Engage with top post-acute partners to address staffing and capacity challenges
- Partner with regional providers to develop post-acute capacity tracking system to expedite patient placement
- Develop alternative care settings (e.g., medical respite centers, Rehab at home)

Post-Acute Care Providers

- Develop specialized capabilities (e.g., ventilators, wound care, dialysis) to accommodate more complex patients
- Invest in staff training to support patients with behavioral health challenges
- Double down on recruiting and retaining clinical staff to maximize effective capacity

Behavioral Health Providers

- Partner with regional health systems to help identify available capacity more quickly
- Provide training for hospital and post-acute clinicians to manage patients with behavioral health challenges
- Invest in staffing and infrastructure to expand capacity where feasible

Physical & Behavioral Healthcare Continuum

STATES CAN ALSO PLAY A SIGNIFICANT ROLE IN EXPEDITING DISCHARGES

→ To enable improvements in timely hospital discharge and access to appropriate services and supports for individuals with complex needs, states and payers are increasingly forging new partnerships and leveraging innovation in delivery and payment systems.

1

Promote Timely Hospital Discharge

→ Assess existing processes to determine where efficiencies may promote more timely level of need determinations

2

Build Effective Capacity in Nursing Facilities

→ Explore NF payment policies, including value-based purchasing models, that incentivize investments in the clinical capabilities and resources NFs need to treat individuals with complex medical and social needs

3

Maximize Value from Medicaid Managed Care Arrangements

→ Harness purchasing power with managed care entities (MCEs) to ensure that MCEs are leveraging full managed care authority

→ Example: Address members' HRSNs (e.g., "in lieu of" services), invest in community infrastructure (e.g., affordable housing), requiring VBP arrangements between MCEs and skilled and long-stay NFs

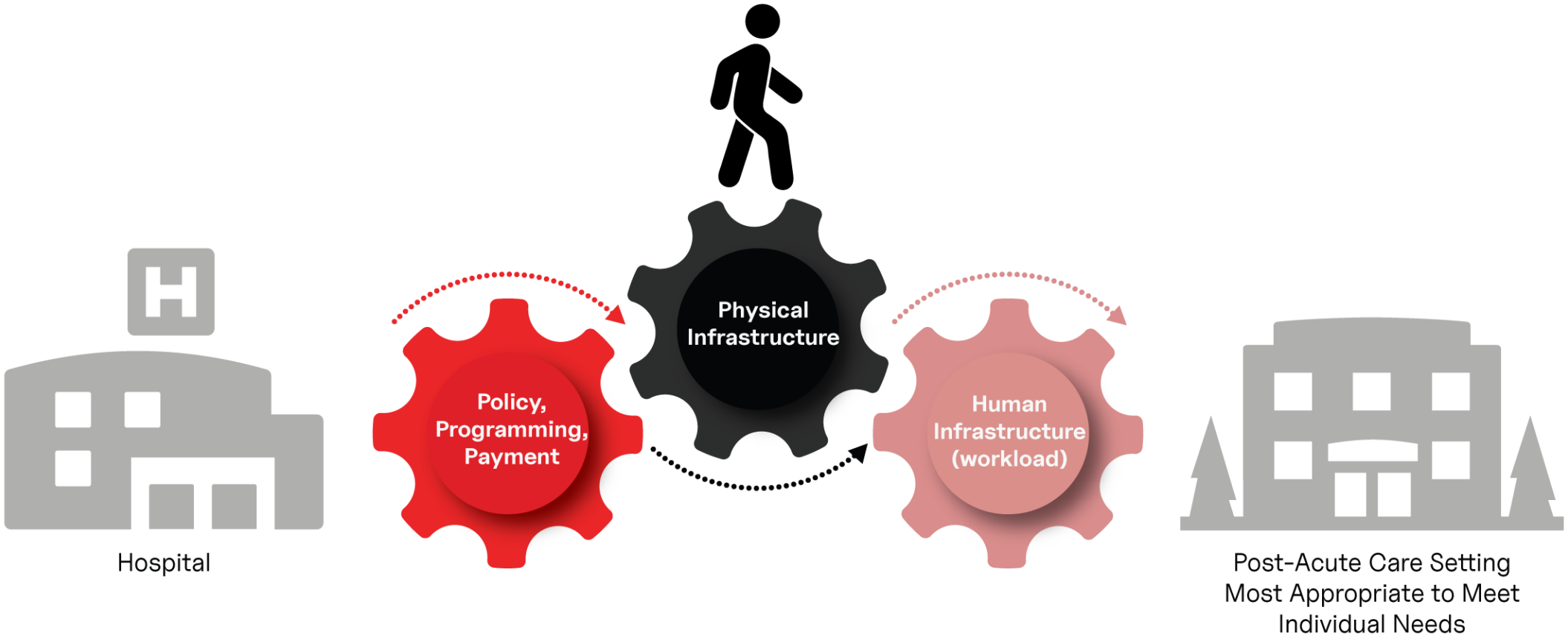
4

Drive Innovation via Section 1115 Medicaid Waivers

→ Test Medicaid funding for non-traditional health services (e.g., supportive housing), including investments in the infrastructure needed to address HRSNs

→ Example: Foster CBO ability to engage with MCEs via technical assistance & funds for CBOs to invest in their data-exchange infrastructure

IN UPCOMING WEBINARS, ATI WILL HIGHLIGHT INNOVATIVE POLICY MODELS AND PROVIDER STRATEGIES TO ADDRESS THE DISCHARGE CRISIS



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TEAM Readiness: Analytics & Benchmarking

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TEAM Readiness: Optimizing the Network

SEPTEMBER 17, 2024 | 2-2:30 p.m. ET

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ATI Advisory

Thank you for attending

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