ATI Final Report on Opportunities for Oregon to Promote Timely and Appropriate Hospital Discharge for Individuals with Complex Care Needs

Summarizing ATI Findings To-Date and Previewing Opportunity Areas

ATI Advisory

AGENDA

1. Zooming Out: Contextualizing the Scope of the Hospital Discharge Crisis
2. Zooming In: ATI Findings on the Hospital Discharge Crisis as Experienced in Oregon
3. Previewing the Opportunity Areas in ATI's Final Report
    - State Opportunities
    - Industry Opportunities

1. Zooming Out: Contextualizing the Scope of the Hospital Discharge Crisis

REFRESHER: HOSPITAL DISCHARGE DELAYS CONSISTENTLY DOCUMENTED AROUND THE U.S.

Oregon

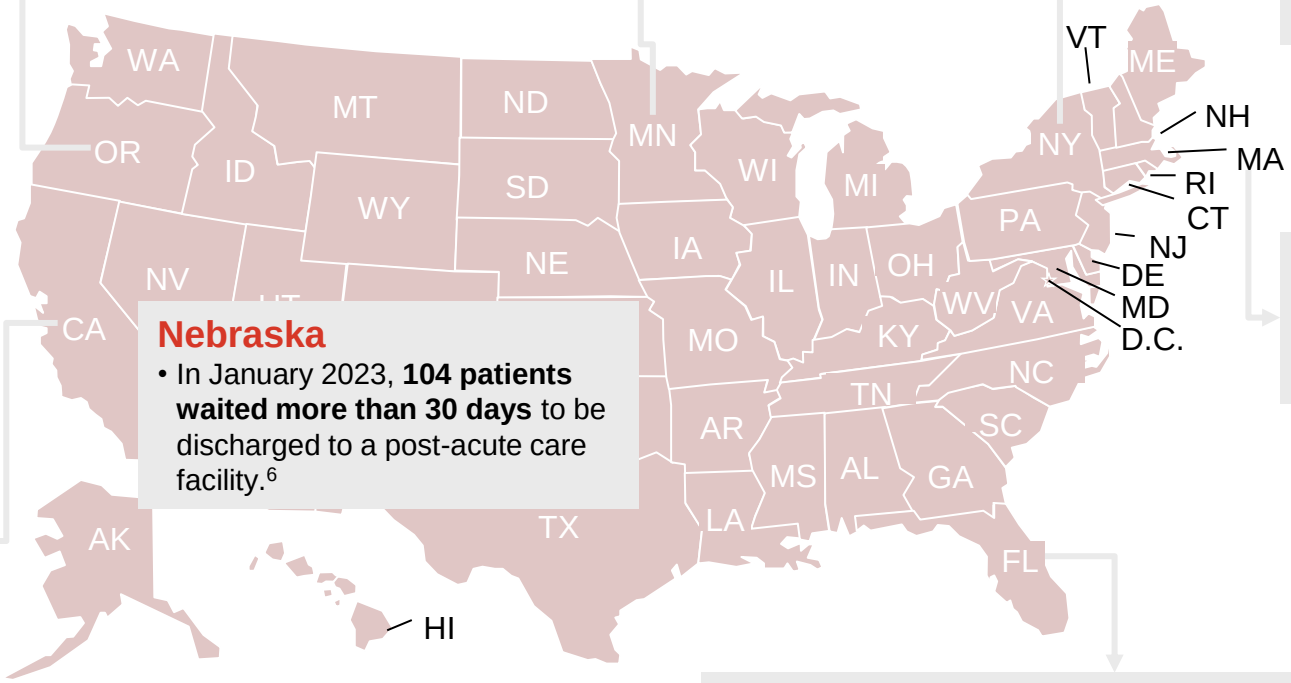
- Hospital discharge volume decreased by 10% from 2017 to 2022, while average length of stay **(ALOS) and total patient hospital days steadily increased** in the same time (ALOS: +27%; total patient hospital days: +20%) [1]

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]



Massachusetts

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

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]

Florida

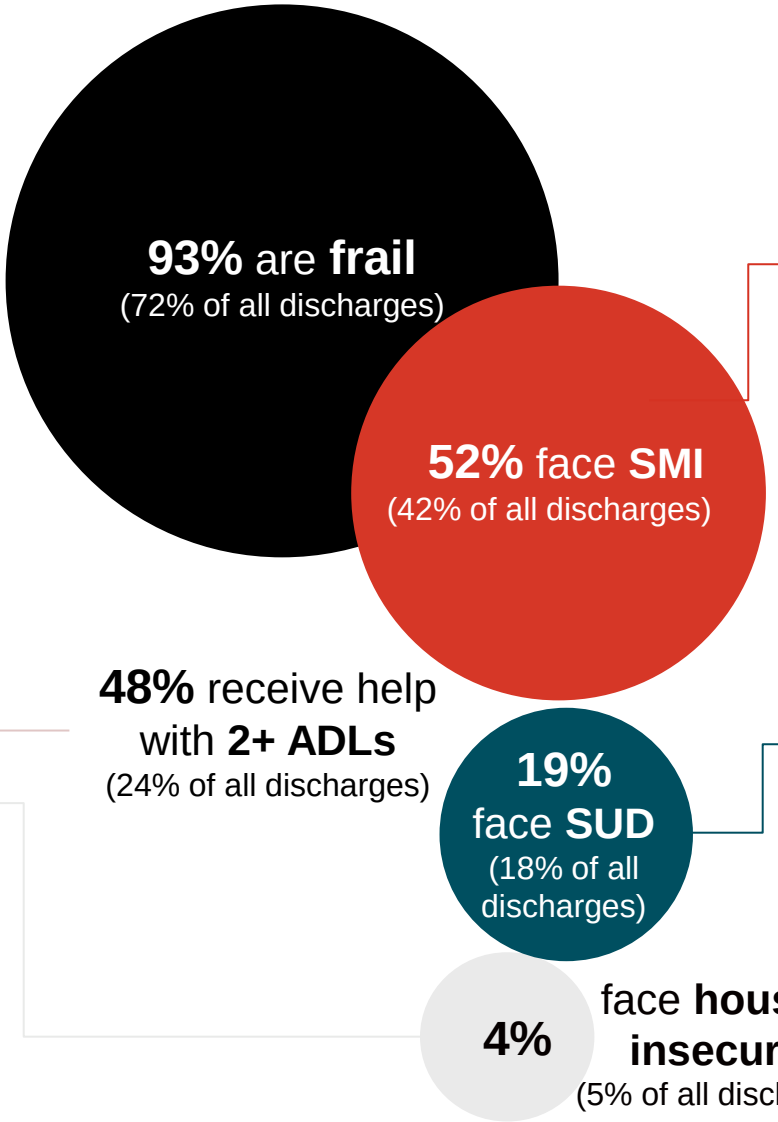
- Hospitals spent **an estimated $540 million* in unpaid care** due to patients awaiting discharge and placement.[7]

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.

REFRESHER: GROWING COMPLEX CARE 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. **Greater behavioral health treatment capacity is needed in community and post-acute care settings.**

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**.

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Source: ATI analysis of Medicare Current Beneficiary Survey (MCBS) (2017-2020) and fee-for-service Medicare claims
ADL – Activity of Daily Living, SMI – Serious Mental Illness, SUD – Substance Use Disorder, SNF – Medicare Certified Skilled Nursing Facility

2. Zooming In: ATI Findings on the Hospital Discharge Crisis as Experienced in Oregon

REFRESHER: ATI'S SUPPORT TO THE JOINT TASK FORCE SPANNED THREE RESEARCH PHASES, WITH A FINAL REPORT SYNTHESIZING SOLUTIONS ACROSS ALL

Assessment of provider & workforce capacity

- ATI presented findings at April 2024 Task Force meeting

Assessment of hospital discharge needs, processes and outcomes

- ATI presented findings at **May 2024** Task Force meeting

Analysis of benefit coverage/payment rates among commercial & public payers

- ATI presented findings at June 2024 Task Force meeting

Report on Oregon's hospital discharge and post-acute care system

- ATI delivers final report to Task Force in early **August 2024**

Findings from ATI's work to-date across Phase 1 - 3 will be reflected in the Final Report

Critical gaps in the current system are:

1. Staffing shortages limit post-acute care capacity
2. Growing patient complexity strains capacity in every setting
3. Post-discharge options for individuals with complex care needs, especially those without housing, are lacking
4. Medicaid requirements and payer policies exacerbate discharge delays, particularly for LTSS-eligible individuals

ATI directly engaged diverse stakeholders across Oregon's care continuum and analyzed Oregon agency data to better understand how the following impede timely and appropriate hospital discharge:

- Post-acute provider and workforce capacity
- Process-related discharge challenges
- Payment and coverage-related gaps

3. Previewing ATI’s Final Report

Previewing State and Industry Opportunities to Promote Timely and Appropriate Hospital Discharges in Oregon

Influencing Timely and Appropriate Hospital Discharge: **State Opportunities**

STATES AND THEIR MANAGED CARE PARTNERS CAN PLAY A SIGNIFICANT ROLE IN EXPEDITING DISCHARGES

→ Oregon can enable improvements in timely hospital discharge and access to appropriate services and supports for individuals with complex needs by exploring solutions that (1) streamline eligibility processes, (2) build effective provider capacity, and (3) expand alternative care settings post-discharge.

1

Streamline Existing Hospital Discharge and Medicaid Eligibility Processes

→ Assess existing processes to determine where efficiencies and / or additional flexibility from CMS may promote more timely functional and / or financial eligibility determinations

2

Build Effective Provider Capacity

→ Explore provider payment policies, including incremental investments in value-based purchasing models, that incentivize investments in the clinical capabilities and resources providers need to meet individuals' complex medical and social needs

3

Expand Alternative Care Settings

→ Invest in care delivery models that provide alternative settings for individuals to continue recovery and recuperation post-discharge, when level of care needs either exceed or are not appropriate for common post-acute care providers

Oregon can leverage its existing CCO and D-SNP managed care infrastructure and partnerships to advance all goals outlined above.

Influencing Timely and Appropriate Hospital Discharge: **Industry Opportunities within Existing System**

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

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