The scope of complex case discharge delays in New York state

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Acknowledgments

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EXECUTIVE SUMMARY

Hospitals across the country have reported an alarming rise in patients who become caught in limbo in emergency departments and inpatient units for weeks, months and even years after they are medically ready for discharge. These delays most often occur due to a lack of care options, the inability to pay for post-discharge care and/or administrative gridlock. Complex case discharge delays, also known as bed blocking or boarding, are devastating for patients, exacerbate bed shortages and result in enormous, unnecessary costs.[1,2]

HANYS' 2021 white paper, *The complex case discharge delay problem*, provided an overview of this long-standing challenge and offered suggested actions.[3] To learn more about the scope of complex case discharge delays in New York, HANYS conducted a three-month data collection pilot with hospitals statewide. This report includes a summary of the pilot findings and a framework to focus solutions.

Data collection pilot

Fifty-two New York hospitals volunteered to report patients who experienced delays of more than four days in the ED and/or more than 14 days in inpatient units between April 1 and June 30, 2022.

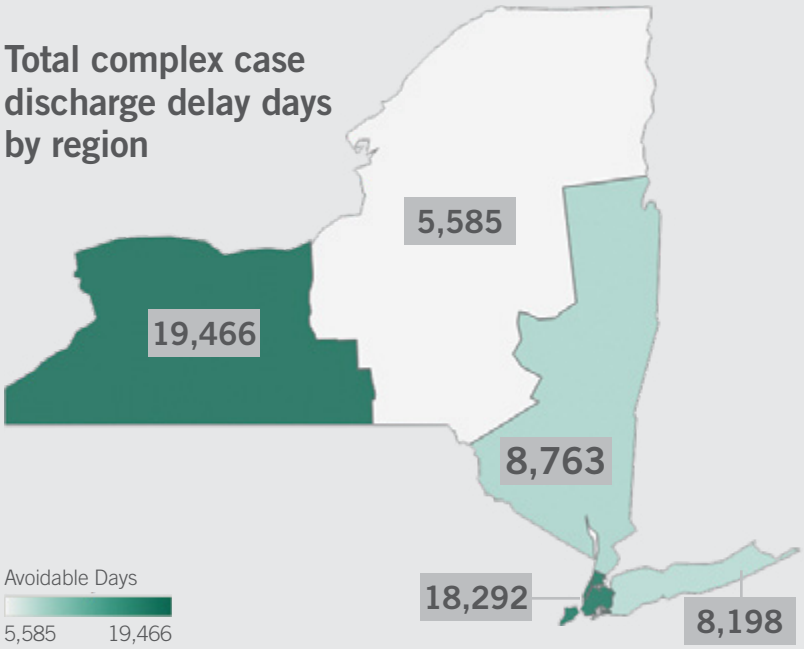
Results of the pilot echoed concerns shared by hospitals, patient advocates and others across New York and the country.[4,5,6,7] During the three-month data collection period, participating hospitals reported:

- 1,115 patients;
- 60,000 delay days;
- $169 million in estimated costs;
- an average ED discharge delay of close to two weeks;
- an average inpatient discharge delay of two months;
- children and older adults living with medically complex and/or behavioral health conditions experiencing the most frequent and longest delays; and
- delays overwhelmingly due to an absence of care options, followed by a lack of insurance coverage or means to pay for post-discharge care and extended administrative processes, such as state and local agency referral and eligibility for services and benefits.

Pilot results

	MOST FREQUENT	LONGEST DELAYS
WHO IS IMPACTED?	• Older than age 65 • Medical complexity, e.g., dialysis	• Younger than age 18 • Individuals with intellectual/developmental disabilities and/or mental illness
WHAT IS CAUSING THE DELAYS?	• Lack of care options • Lack of payment for discharge setting	• Guardianship • Agency process (eligibility/referral)

Total complex case discharge delay days by region



Participating hospitals by region

Central New York	6
Hudson Valley	10
New York City	16
Long Island	13
Western New York	7

Framework for change

Hospitals are sentinels for the health needs in our communities. When all other care options are exhausted and preventative care is not accessible, patients arrive at the hospital. When safe post-discharge care is not available or delayed, patients have no choice but to wait in the hospital.

The pilot's results demonstrated tremendous care gaps for individuals with complex care needs. The healthcare system must be designed for individuals with co-occurring care needs as the expectation, not the exception. The need for change is urgent.

HANYS continues to convene stakeholders, offer expertise in setting policy, strengthen relationships and share best practices to achieve better patient outcomes. We've developed four priority areas to focus efforts to address complex case discharge delays in New York state.

PREVENTION | **EARLY INTERVENTION** | **RESPONSE** | **VISIBILITY**

Complex case discharge delays: A framework for change

HANYS developed the following framework to help focus efforts to ensure patients no longer languish in hospitals for months to years after they are ready for discharge.

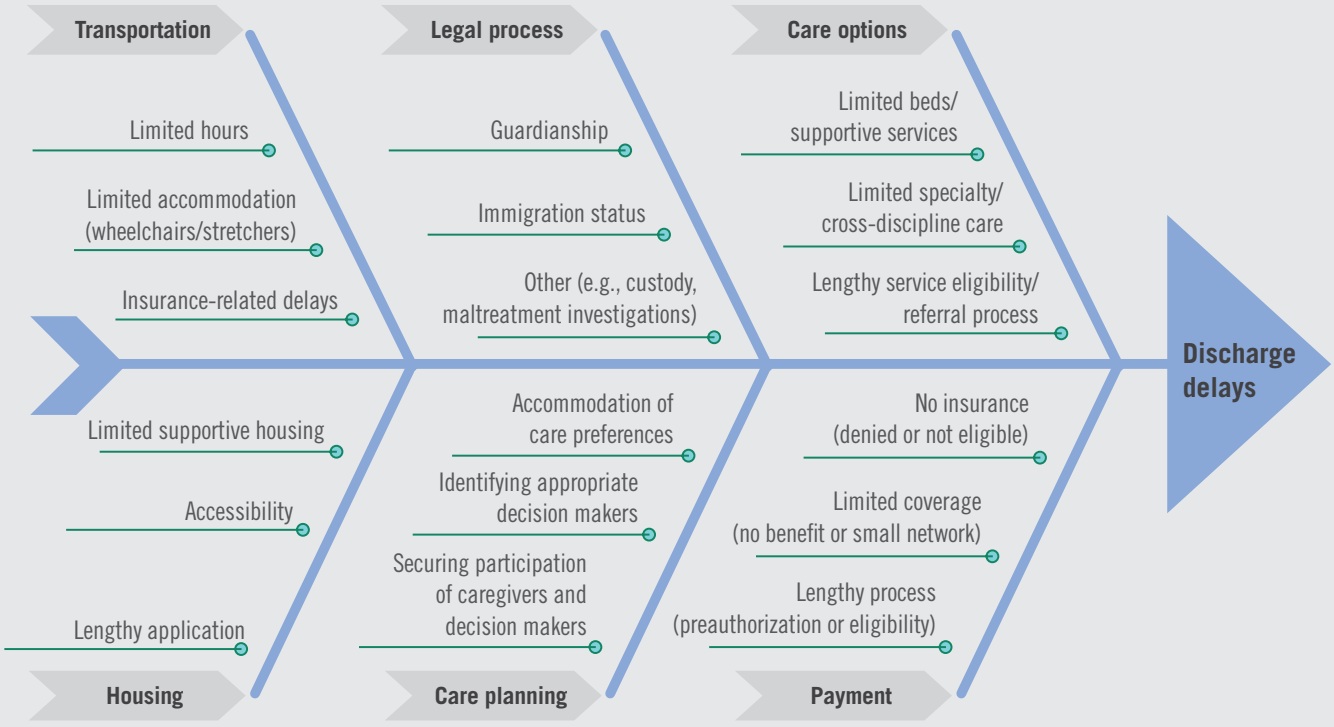
Prevent unnecessary hospital visits and discharge delays due to limited care options	Expand and expedite access to more appropriate and therapeutic care settings so that individuals who are in need of services, but not hospital-level care, are not forced to go to the hospital or stay for months to years as a last resort; educate the public, schools, law enforcement and others about care in the community and other supportive resources.
Intervene early	Establish a multi-agency escalation process for patients who are at high risk of discharge delay; create a timeline for development of discharge plans in coordination with relevant agencies; eliminate payment barriers for post-discharge care; and prioritize patients in the hospital for legal and administrative processes.
Respond to patient needs during unavoidable extended discharge delays	Provide support to hospitals to ensure they can meet patient needs, e.g., education and emotional well-being; ensure hospitals are reimbursed for services they provide.
Increase visibility	Create benchmarks and use state and agency data on the time between when services are sought to when they are received to more quickly identify and respond to changes in care needs.

INTRODUCTION

Complex case discharge delays, also known as bed blocking or boarding, are a longstanding and growing challenge throughout New York, the United States and the world.[1,2] These delays happen for many reasons but are most commonly attributed to difficulty finding safe post-discharge care and navigating lengthy administrative or legal processes. Individuals experiencing behavioral health, intellectual or developmental disabilities and/or co-occurring conditions are most profoundly impacted.

Our healthcare delivery system has undergone significant transformation to reduce unnecessary hospitalization. Despite these improvements, a persistent lack of coordinated care options for individuals with complex care needs has resulted in an environment where patients unnecessarily languish in hospital beds for weeks, months and even years after they are ready for discharge. Hospitals have adapted to try to meet these patients' needs, but they are expertly engineered to provide acute care in the short term and are not acceptable places to live.

Why complex case discharge delays happen : A snapshot of survey results



Impacts on patients

Unnecessary hospital stays can lead to an irreversible decline in functional status and negatively impact psychological well-being, especially for older adults and children.[8, 9, 10] Patients living in limbo in the hospital environment lose their autonomy, become socially isolated and lack access to the intellectual and physical activity necessary to thrive.

Discharge delays also exacerbate hospital bed shortages, risk staff safety and well-being and result in extraordinary costs to our healthcare delivery system.

Attempts to address the problem

Other countries and states have begun efforts to address complex case discharge delays. For example, in England, the National Health Service issued the Community Care Delayed Discharges Act to specifically address delays caused by the failure of local authorities to provide post-discharge arrangements in a timely manner.[11] In 2022, Massachusetts passed legislation creating a data portal to facilitate collaborative data sharing regarding individuals waiting for behavioral health services and an interagency review team responsible for decision-making in complex cases.[12]

In New York, the Council on Children and Families was established to help guide and coordinate services for children with emotional and/or behavioral disorders and their families.[13] Several prominent insurance companies and nonprofit organizations in New York have developed programs specifically to work with hospitals to help facilitate safe and timely discharge.[14, 15] The Cerebral Palsy Association of New York State, Mental Health Association of New York State, New York Alliance for Inclusion and Innovation, New York State Coalition for Children's Behavioral Health and New York State Conference of Local Mental Hygiene Directors have offered solutions to address barriers to services.[16, 17]

HANYS has been working closely with state agencies and others to raise awareness of the ramifications of complex case discharge delays and contribute to developing solutions. In 2021, HANYS published a white paper providing an overview of complex case discharge delay challenges and recommended next steps.[3]

These efforts have led to increased investments and funding in certain areas, but the response falls short of the coordinated solution that is urgently needed to address the problem.

Scope of complex case discharge delays

States such as Maryland, Minnesota and Hawaii have collected data on complex case discharge delays. A 2019 Maryland Hospital Association report showed that behavioral health discharge delays in EDs alone cost Maryland hospitals an estimated $30 million annually.[18] A 2016 report from Minnesota estimated that one in five patient bed days are potentially avoidable delay days.[19] Hawaii identified more than 7,000 complex case patients experiencing discharge delays, with an annual loss to hospitals of $60 million in 2011.[20]

Complex case discharge delays have not been captured in initiatives to reduce hospital length of stay because the measures used are largely based on reimbursement and discharge data, and these patients are often not admitted, nor are the hospitals always reimbursed. For example, when a patient is evaluated in the ED and does not meet criteria for admission, hospitals cannot discharge them until a safe discharge option is found. Since the patient does not meet the definition of medical necessity for hospital-level care, the hospital receives only partial reimbursement or is not reimbursed for non-hospital level care provided in the hospital.[21]

To learn more about the scope of complex case discharge delays in New York, HANYS conducted a three-month data collection pilot with member hospitals statewide. The purpose of the pilot was to demonstrate the scope of the problem in the state, identify reasons for delays, uncover the cost burden and identify areas for changes to rules and/or administrative processes. This report provides an overview of the results and offers a framework to address this problem.

APPROACH

Participation

HANYS offered an open invitation to our member hospitals to participate in the data collection pilot. Fifty-two hospitals elected to participate. Fifty hospitals submitted data for inpatient units and 13 submitted data for EDs. Eight of the 52 hospitals submitted partial data for various reasons, including staff turnover.

Inclusion criteria

There is no clear consensus regarding the definition of prolonged complex case discharge delays (or bed blocking/boarding). Consequently, the pilot inclusion criteria were developed in an effort to balance the ability to capture discharge delay characteristics and minimize the data reporting burden.

Participating hospitals were asked to report details on patients meeting the following criteria:

- more than four avoidable days in the ED and/or more than 14 avoidable days in an inpatient unit;
- discharged between April 1 and June 30, 2022 or not discharged by June 30, 2022; and
- not in a swing bed.

An "avoidable day" was defined as a day when a patient is stabilized and ready for discharge but is unable to be discharged.

Data components

HANYS collected data on characteristics of the hospital stay, patient factors and external elements, including:

HOSPITAL STAY CHARACTERISTICS:

- total avoidable hours; and
- estimated cost per day.

PATIENT FACTORS:

- patient residence prior to hospitalization;
- supportive services enrolled in on arrival;
- age range;
- insurance on arrival; and
- complex care needs.

EXTERNAL FACTORS:

- placement setting;
- insurance or financial coverage;
- agency referral and eligibility process;
- guardianship; and
- advanced care planning.

This data collection pilot focused on external factors because the longest delays are attributed to reasons outside of the scope of hospitals' control.

SCALE OF THE COMPLEX CASE DISCHARGE DELAY PROBLEM

WHO IS IMPACTED?

Inpatient

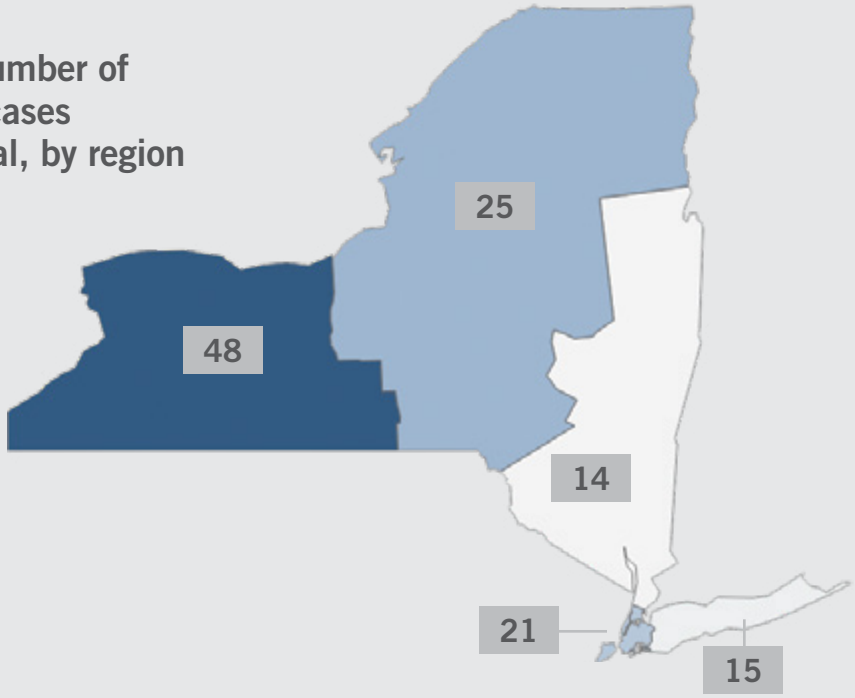
Fifty hospitals reported 992 patients with discharge delays of more than two weeks in their inpatient units between April 1 and June 30, 2022. Over half experienced a discharge delay of over one month. Almost half of these patients were 65 years of age or older. However, young adults and children experienced the longest average delays at about three months compared with two months for individuals who are older than 65 years of age.

Inpatient discharge delays by region and statewide

Regions	# Hospitals	# Patients	Avg. delay days	Total delay days
Central New York	5	124	41	5,100
Hudson Valley	10	134	65	8,641
Long Island	13	141	58	8,190
New York City	16	306	59	18,076
Western New York	6	287	58	18,703
Statewide	50	992	59	58,710

Inpatient cases, April 1 to June 30, 2022

Average number of inpatient cases per hospital, by region



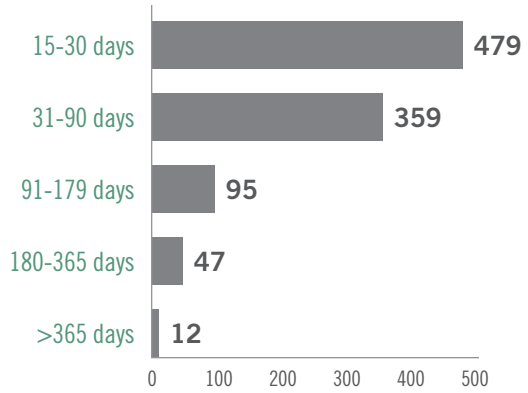
Total cases/reporting hospitals in a region; not including eight partial reporters, April 1 to June 30, 2022

WHO IS IMPACTED? Inpatient (continued)

People most commonly delayed in inpatient units were those living with a medical complexity and/or mental illness and those who were living at home with caregiver support prior to hospitalization. Individuals with intellectual and developmental disabilities and/or who were transferred from another acute care hospital or had unstable housing/were unhoused had the longest average delays.

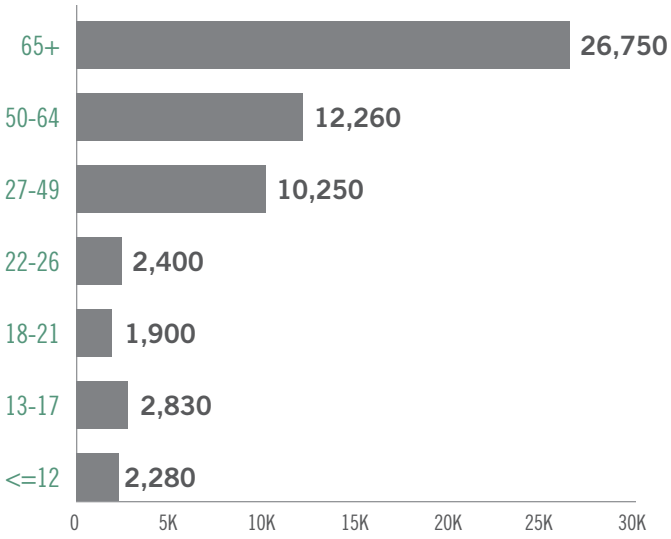
Among cases reported with optional details about medical complexities, the most common included dialysis, infection (e.g., COVID-19), intravenous medications, end-of-life care and wound care.

Inpatient delay days by number of patients



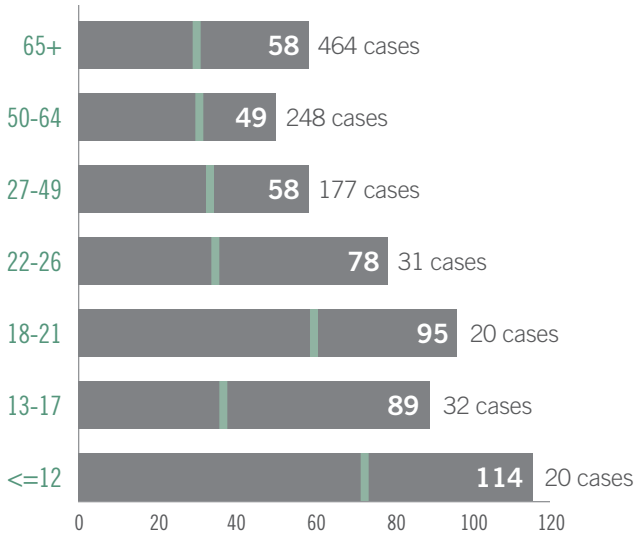
April 1 to June 30, 2022

Total inpatient delay days by age



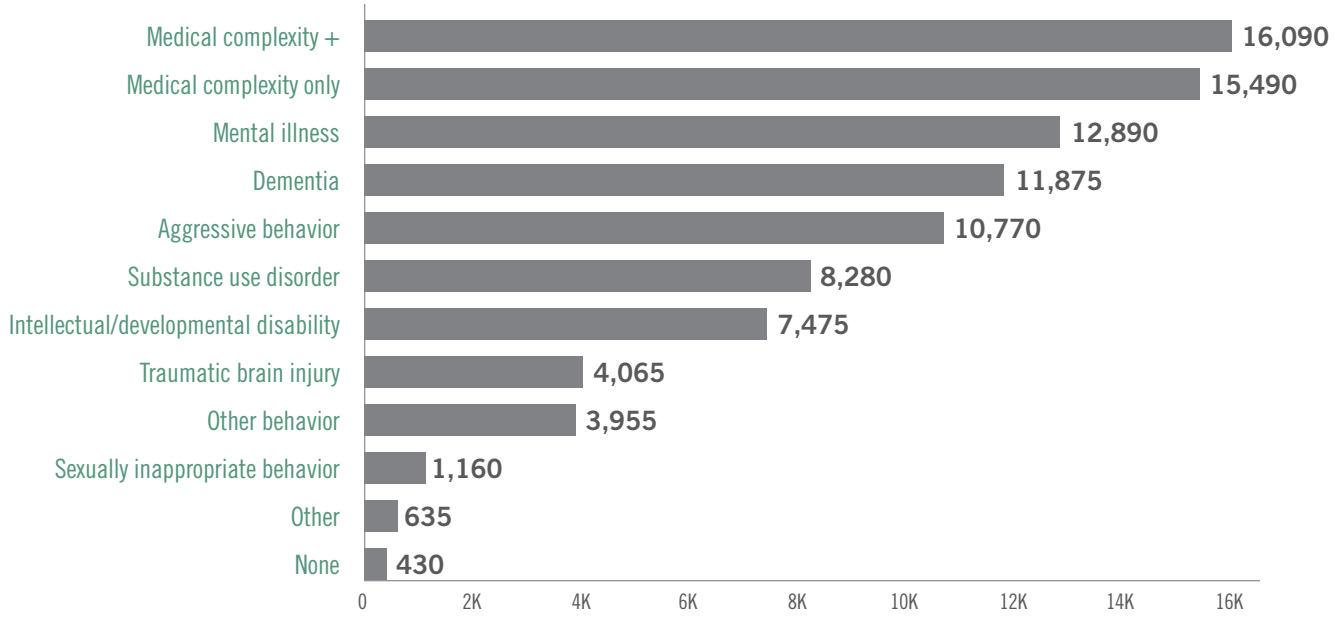
April 1 to June 30, 2022

Average inpatient delay days by age



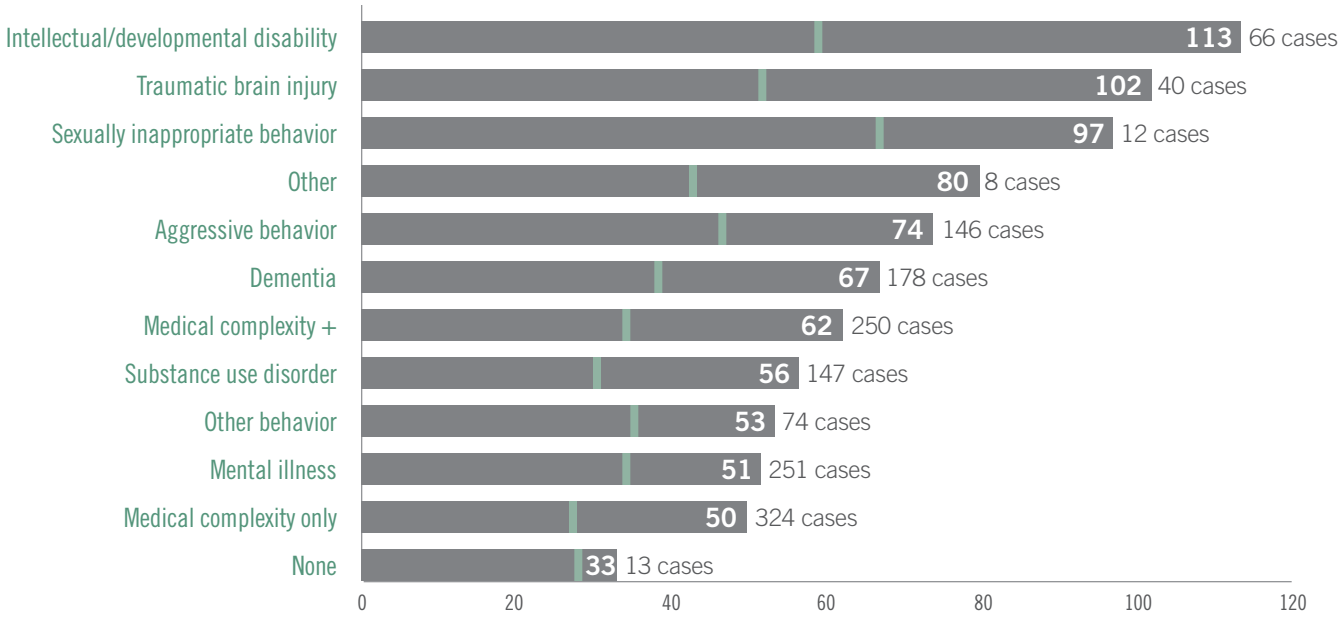
April 1 to June 30, 2022; green bar indicates median

Total inpatient delay days by complex care needs



"Select all that apply" question; April 1 to June 30, 2022

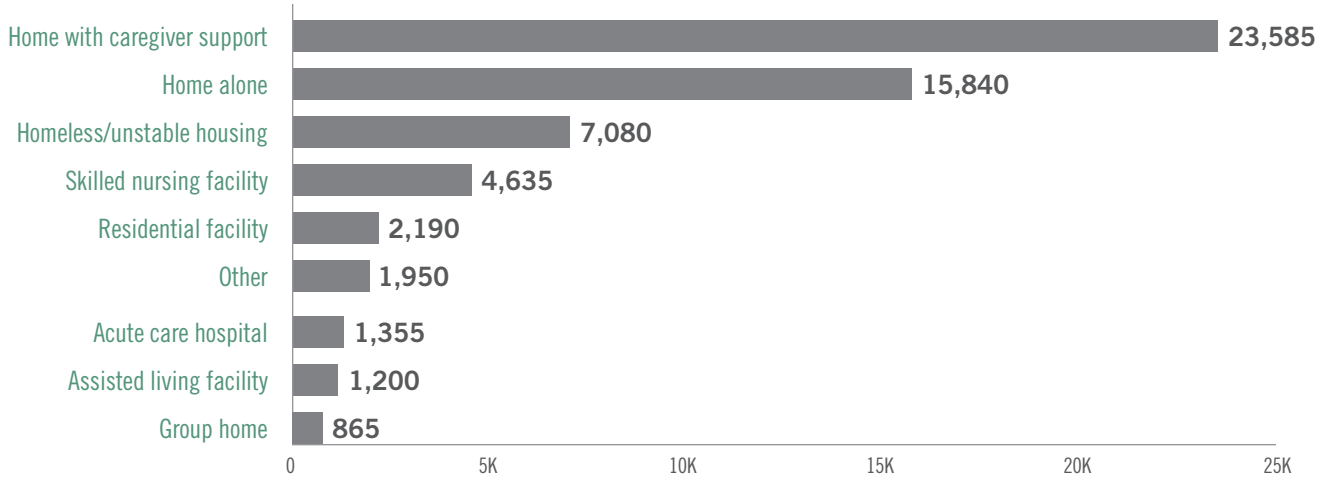
Average inpatient delay days by complex care needs



"Select all that apply" question; April 1 to June 30, 2022; green bar indicates median

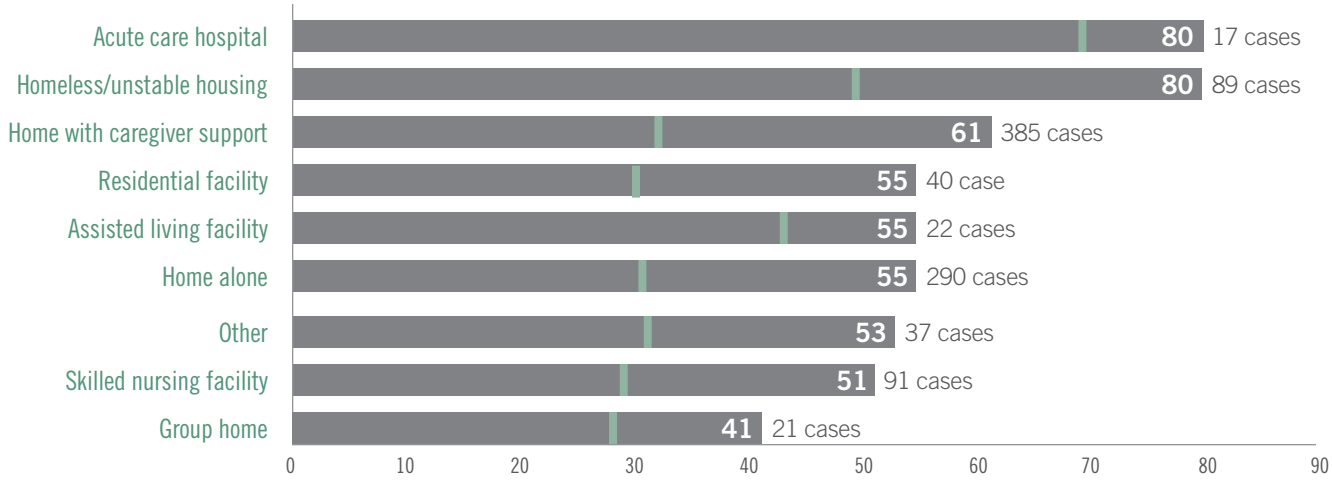
WHO IS IMPACTED? Inpatient (continued)

Total inpatient delay days by prior residence



April 1 to June 30, 2022

Average inpatient delay days by prior residence



April 1 to June 30, 2022; green bar indicates median

Emergency department

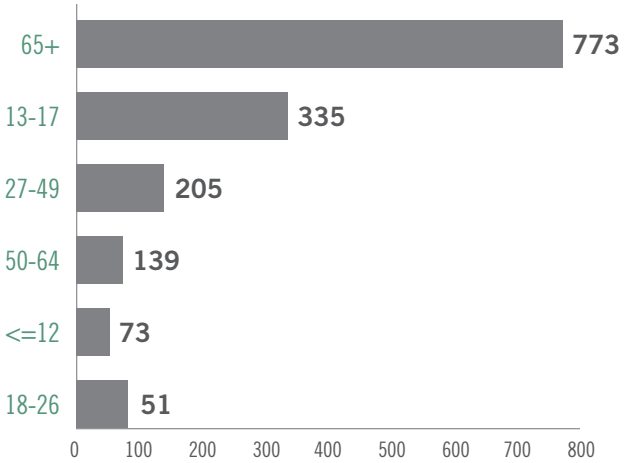
Twelve hospitals reported 123 patients with discharge delays of more than four days in their ED between April 1 and June 30, 2022. Adults age 65 and older, patients with mental illness and/or those who previously resided at home with caregiver support most often experienced delays. Patients with intellectual or developmental disabilities and those who previously lived in an assisted living facility experienced the longest average delays.

ED delays by region and statewide

Regions	# Hospitals	# Patients	Avg. delay days	Total delay days
Central New York	4	46	11	487
Hudson Valley	3	11	11	122
Long Island + NYC	2	24	9	224
Western New York	3	42	18	763
Statewide	12	123	13	1.598

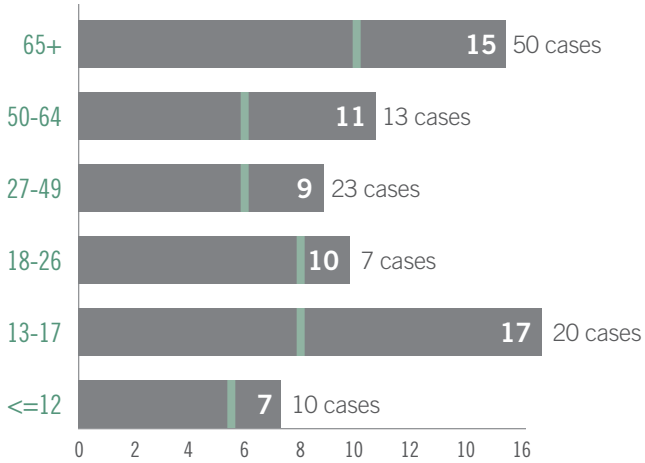
April 1 to June 30, 2022

Total ED delay days by age



April 1 to June 30, 2022

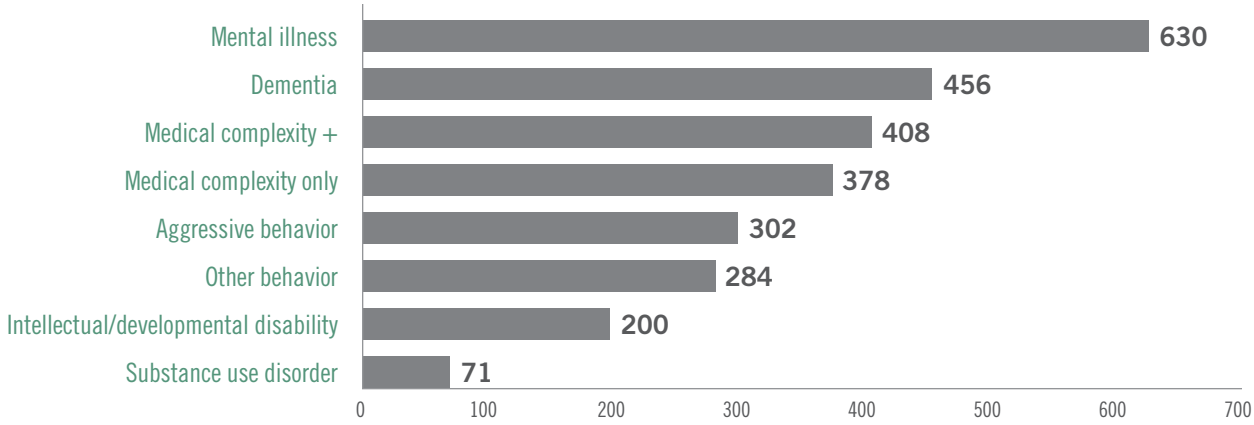
Average ED delay days by age



April 1 to June 30, 2022; green bar indicates median

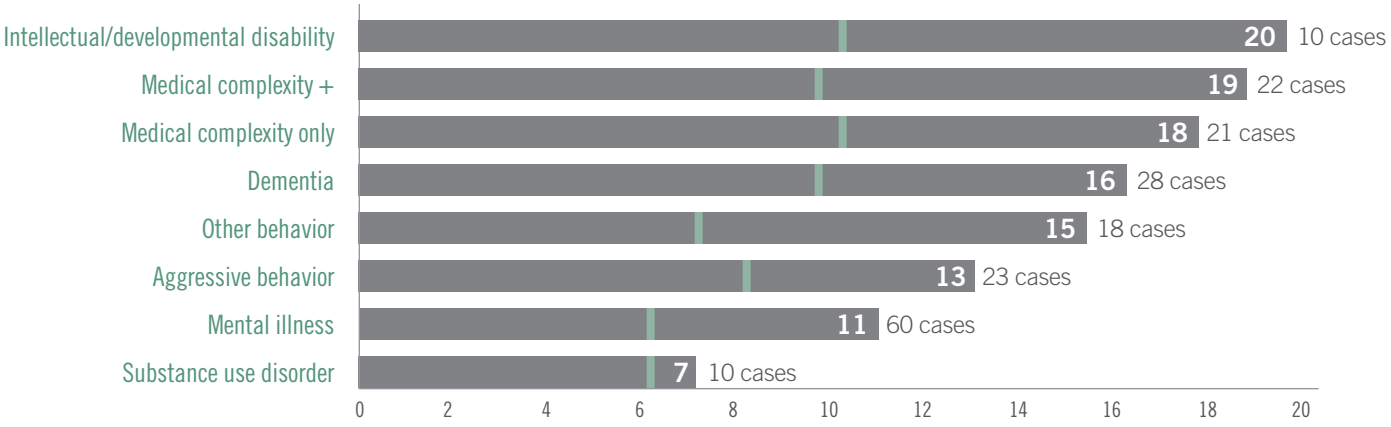
WHO IS IMPACTED? Emergency department (continued)

Total ED delay days by complex care needs



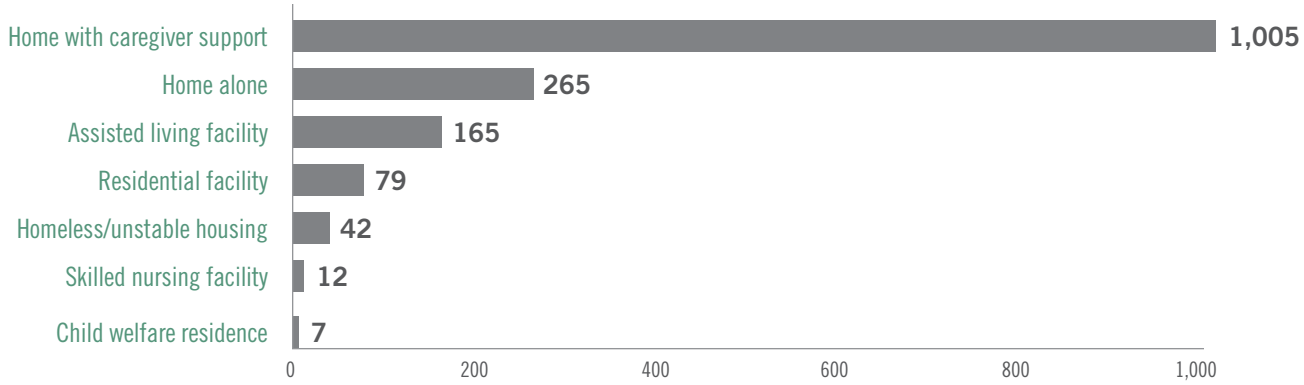
"Select all that apply" question; removed categories with <5 patients; April 1 to June 30, 2022

Average ED delay days by complex care needs



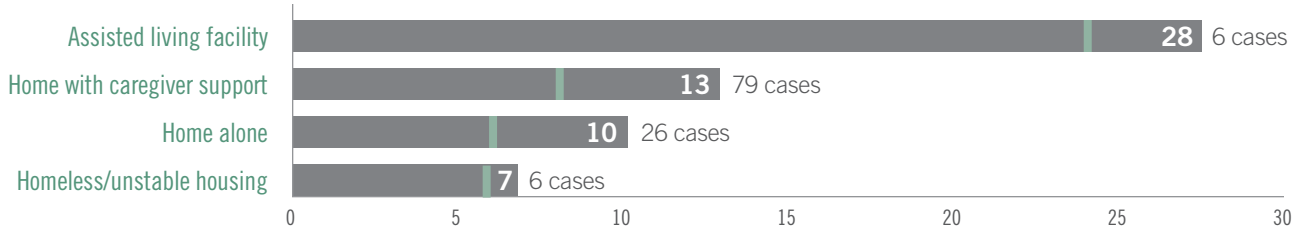
"Select all that apply" question; removed categories with <5 patients; April 1 to June 30, 2022; green bar indicates median

Total ED delay days by prior residence



April 1 to June 30, 2022

Average ED delay days by prior residence



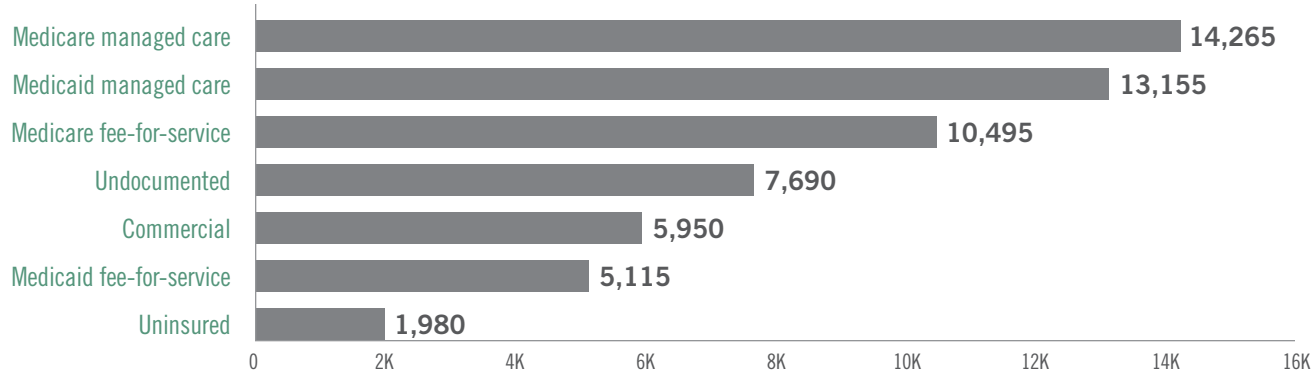
Removed categories with <5 patients; April 1 to June 30, 2022; green bar indicates median

WHAT ARE THE COSTS?

Inpatient

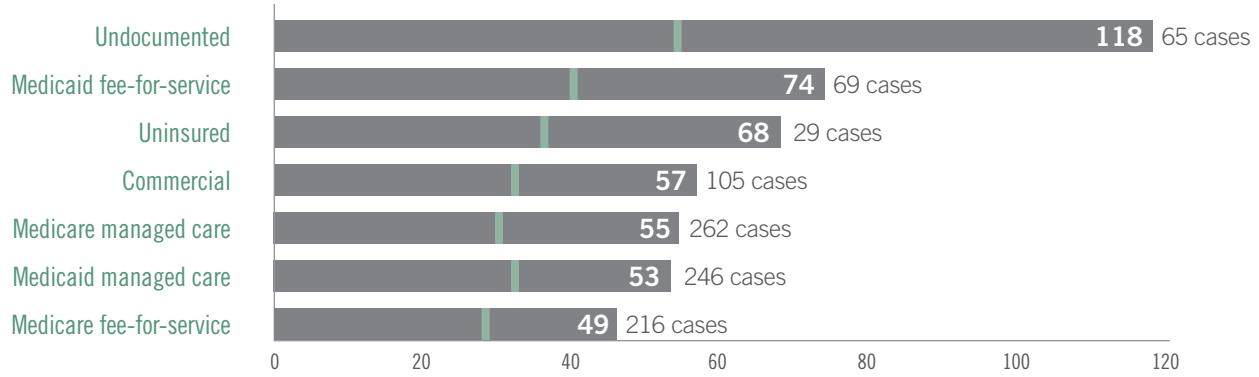
Fifty hospitals reported 992 patients experiencing discharge delays of more than two weeks between April 1 and June 30, 2022, at an estimated total cost of $167 million, or an average of $168,000 per case. Individuals who had an undocumented non-citizen status (most commonly uninsured or emergency Medicaid) experienced the longest average delayed days, followed by those with Medicaid fee-for-service.

Inpatient delay days by insurance type



April 1 to June 30, 2022

Average inpatient delay days by insurance type

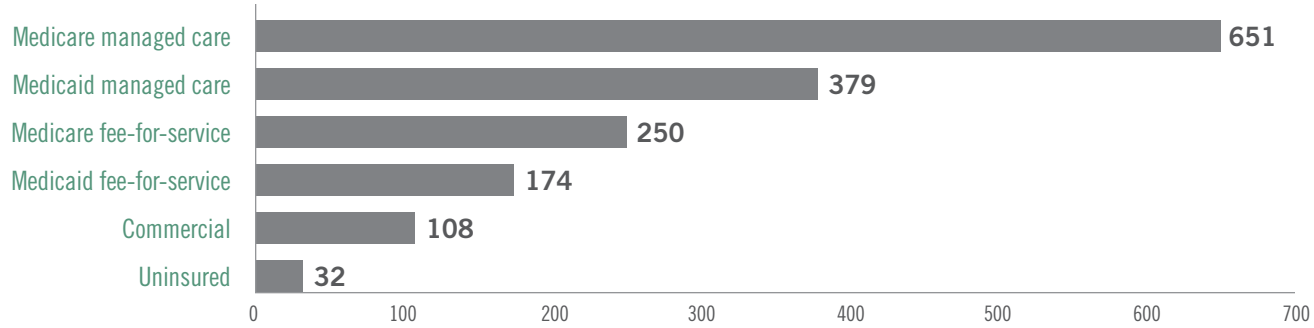


April 1 to June 30, 2022; green bar indicates median

Emergency department

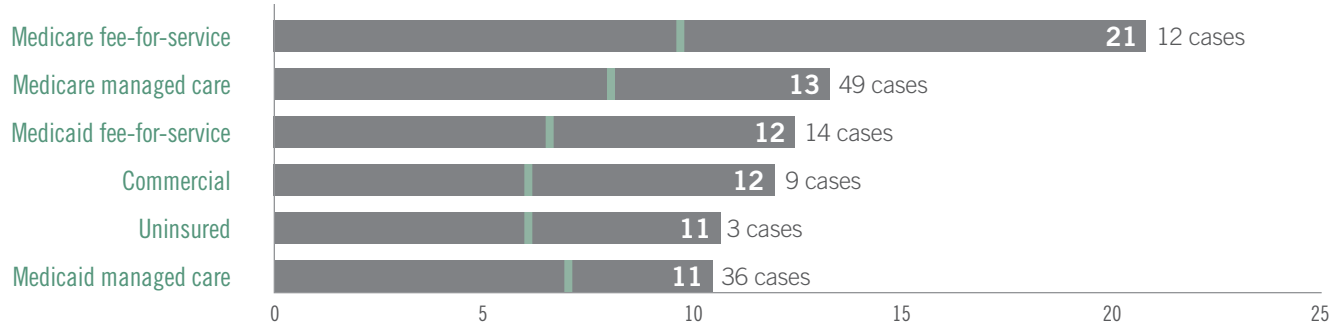
Thirteen hospitals reported 123 patients experiencing discharge delays of more than four days in the ED at an estimated total cost of $2 million, or an average cost of $18,000 per delayed stay. Patients with Medicare managed care (Medicare Advantage) and Medicaid managed care most often experienced delays, while individuals with Medicare fee-for-service coverage experienced the longest average delays.

Total ED delay days by insurance type



April 1 to June 30, 2022

Average ED delay days by insurance type



April 1 to June 30, 2022; green bar indicates median

WHAT IS CAUSING THE DELAYS?

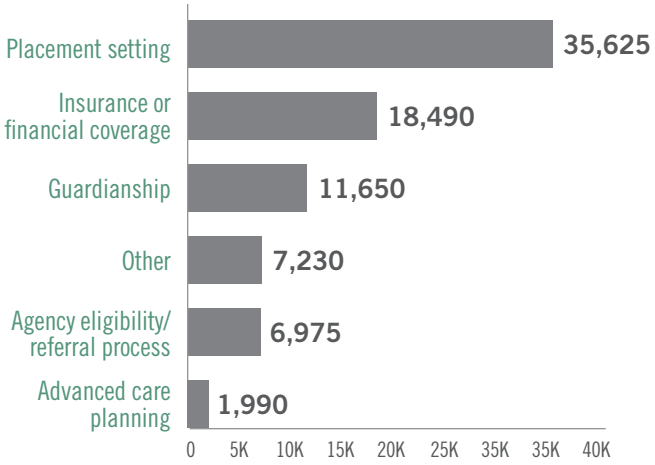
Inpatient

The most frequent contributor to discharge delay was identifying a placement setting. Individuals facing barriers to discharge due to guardianship and advanced care experienced the longest average delays.

The most common obstacle related to discharge placement settings was the inability of the placement setting to accept the patient. Medical comorbidities and mental illness were the most common reasons for declination. A number of hospitals commented that medical needs such as dialysis, wound care and infection status (e.g., COVID-19) were common reasons for placement setting declinations.

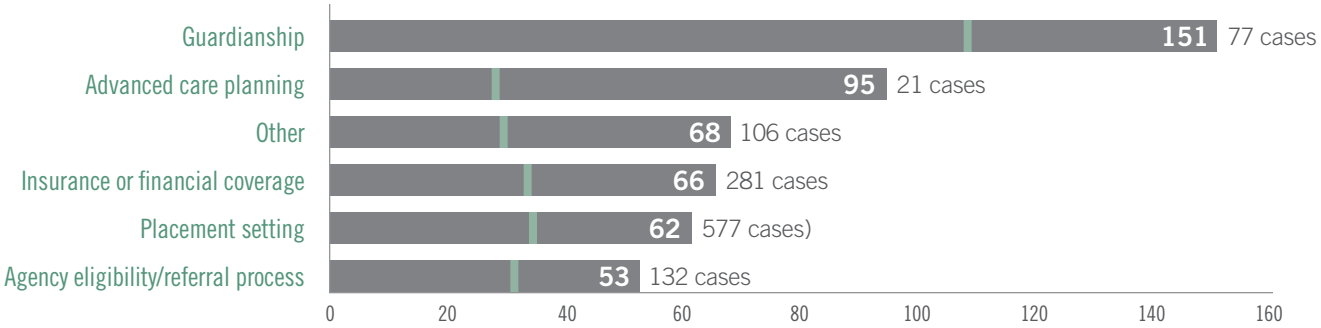
The second-most frequent contributor to discharge delay was "other," followed by insurance or financial coverage issues. Delays in the "other" external factor category were primarily attributed to care preferences, housing and transportation.

Total inpatient delay days by external factor



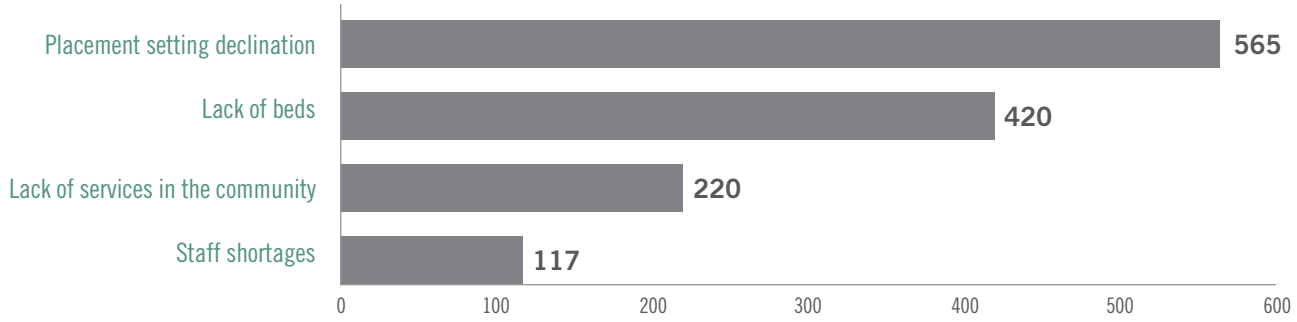
"Select all that apply" question; April 1 to June 30, 2022

Average inpatient delay days by external factor



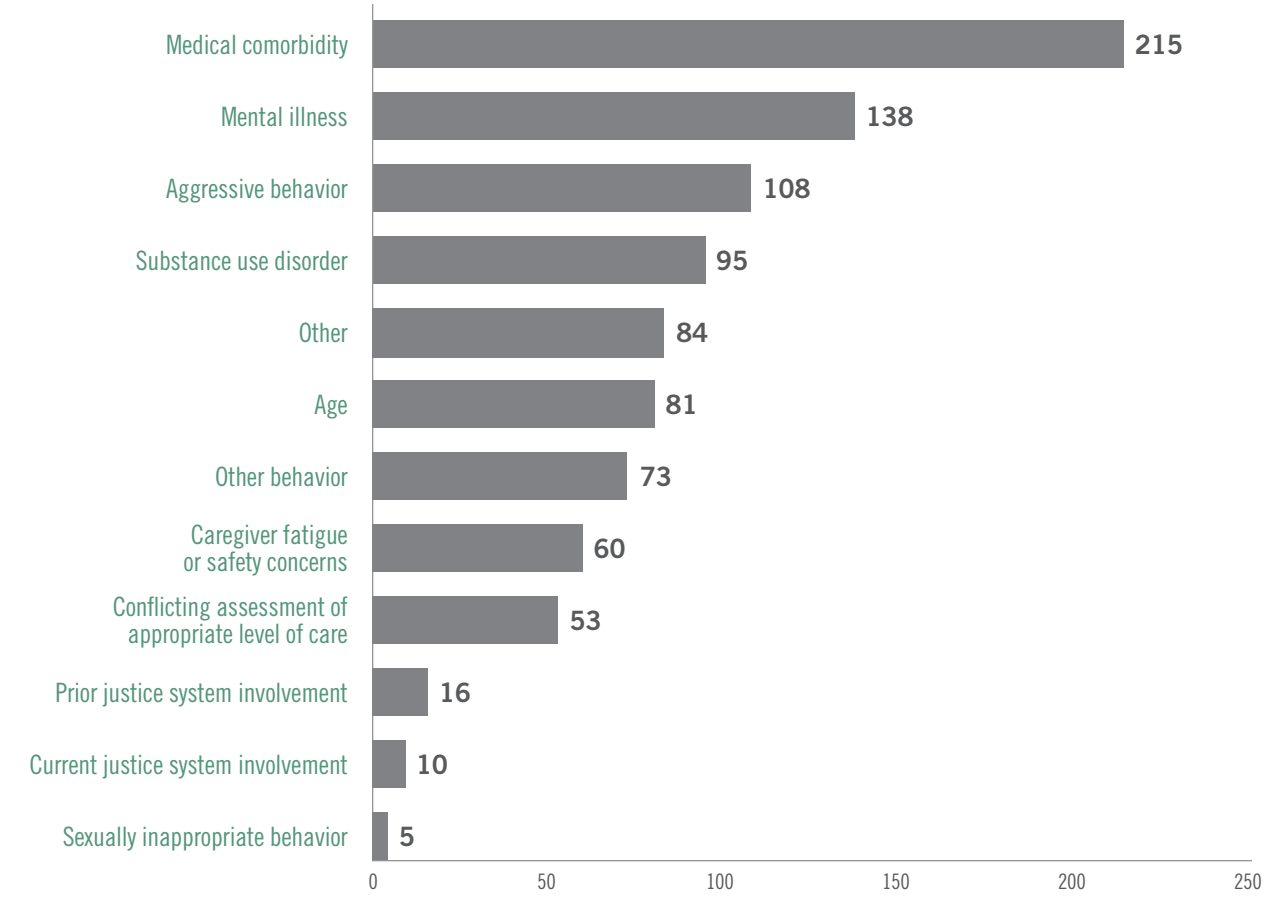
"Select all that apply" question; April 1 to June 30, 2022; green bar indicates median

Total inpatient cases by placement setting challenges



"Select all that apply" question; April 1 to June 30, 2022

Total inpatient cases by reasons for placement setting declinations



"Select all that apply" question, only includes patients who experienced a declination; April 1 to June 30, 2022

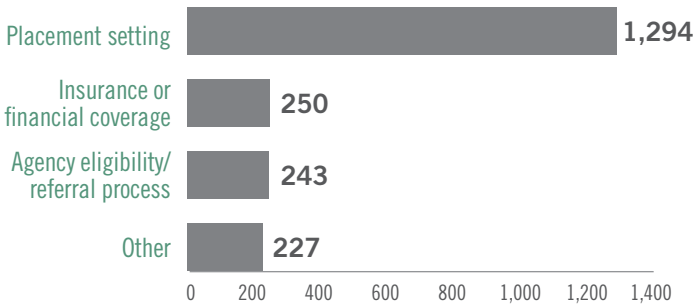
WHO IS CAUSING THE DELAYS? (continued)

Emergency department

Identification of a placement setting was also the most common contributor to discharge delays in the ED. Individuals experiencing barriers due to state and local agency eligibility and referral processes for services and/or benefits had the longest average delay days.

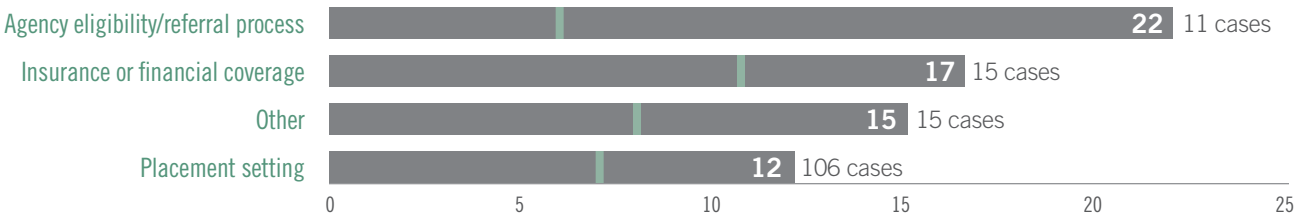
Among those who were declined placement, aggressive behavior and mental illness were the most common reasons for declination. Other external factors included challenges related to placement preference and engagement of patients or caregivers in the planning process.

Total ED delay days by external factors



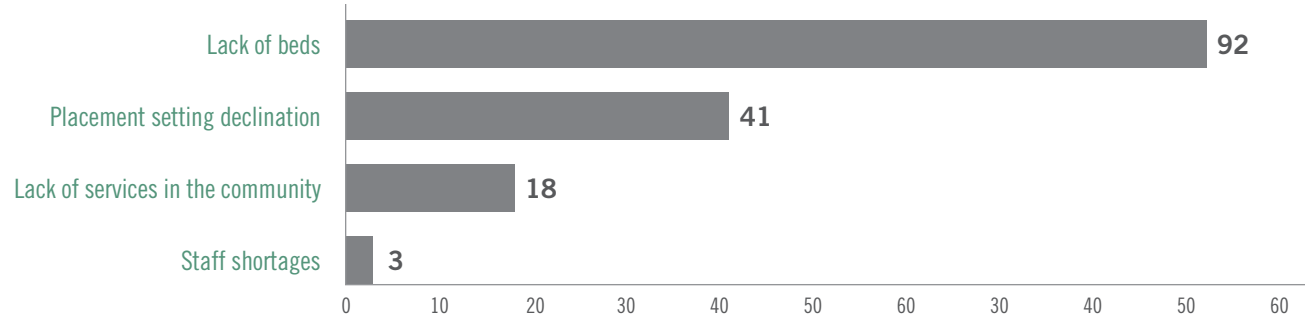
"Select all that apply" question; removed categories with <5 cases; April 1 to June 30, 2022

Average ED delay days by external factors



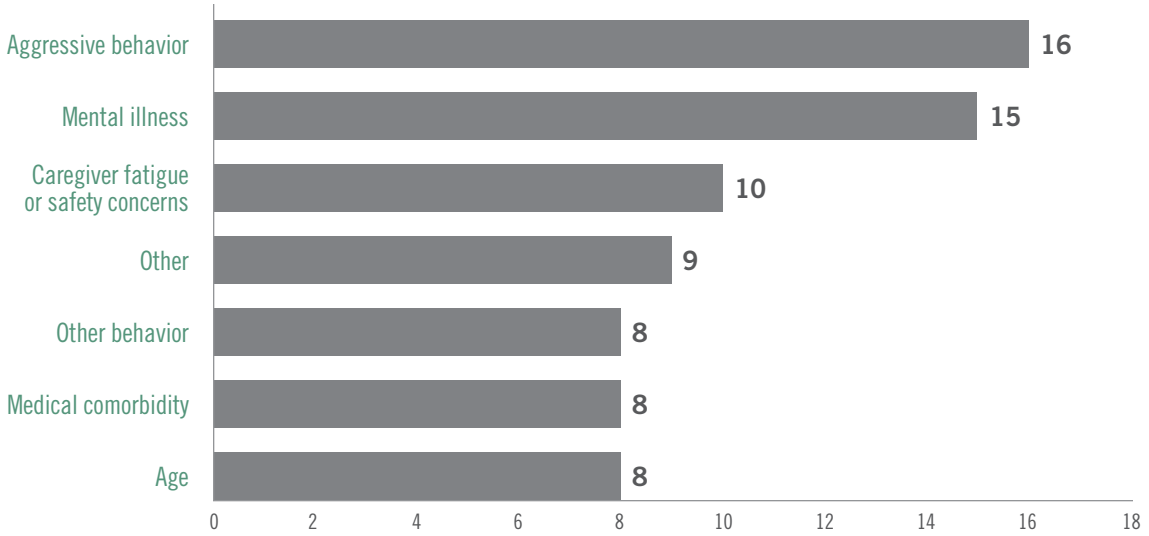
"Select all that apply" question; removed categories with <5 cases; April 1 to June 30, 2022; green bar indicates median

Total ED cases by placement setting challenges



"Select all that apply" question; April 1 to June 30, 2022

Total ED cases by reasons for placement setting declinations



"Select all that apply" question, removed categories with <5 cases; April 1 to June 30, 2022

DISCUSSION

Data collection pilot results were consistent with efforts conducted by other states and echoed the alarm shared by hospitals and other providers in New York state.[16, 17, 4]

The number of patients reported in the pilot represents only a small sample of the many affected in New York state. Depending on the definitions used, there are between 160 and 220 hospitals in New York. While hospitals with the most delays may have been more motivated to participate, we know from our discussions that many non-participating member hospitals experience delays. Hospitals serving the highest-need populations may have been less likely to participate due to resource limitations.

The total number of discharge delay days for the cases reported in this pilot is also higher than reported. Patients who met criteria and had not been discharged by the end of the reporting period were included in the pilot.

Additionally, data were limited only to participants experiencing discharge delays of more than four days in the ED and/or more than 14 days in the inpatient unit. A discharge delay of any duration unnecessarily exposes patients to risks inherent to a hospital setting, limits hospital beds for others and incurs unnecessary significant costs. There are other common external factors, such as transportation, experienced by those with shorter discharge delays.

Participating hospitals used a variety of methods to calculate the estimated cost per day. Some reported estimated costs incurred because of loss of revenue due to lack of patient turnover, legal fees, staff injuries and additional specialty care and security staff. Others included a general estimate for inpatient days. Overall, the average estimated cost per day was lower than estimated costs per ED and inpatient days from Kaiser Permanente, indicating that the estimated costs reported by participating hospitals were conservative.[22, 23]

There is some variation in the criteria used by reporting hospitals to determine when a patient is ready for discharge. However, given the length of delay days in the inclusion criteria, those minor variations are likely to have little impact on the characteristics of patients most impacted and reasons for delay.

RECOMMENDATIONS

HANYS developed the following framework to help focus efforts to ensure patients no longer languish in hospitals for months to years after they are ready for discharge:

- prevent unnecessary hospitalization;
- intervene early when patients at high risk of delay arrive at the hospital;
- respond to patient needs during unavoidable extended delays; and
- increase visibility of delays in access to care.

Prevent unnecessary hospital visits and discharge delays due to a lack of care options

Expand care options

All evidence points to severe care shortages, especially for children, older adults, individuals with behavioral challenges (e.g., I/DD, mental illness, dementia) and those with the most complex medical needs. Our system of care is flawed, as it's designed for those with a clear care path who do not have complex care needs.

To begin to address these challenges, HANYS recommends:

- a re-examination of methods used to determine care needs;
- development of reimbursement models that can sustain services in shortage and cover costs of resource-intensive care;
- identification and removal of regulatory obstacles to cross-disciplinary care;
- investment in the workforce for high-need specialty professions; and
- cultivation of an environment where care providers, insurers and state and local agencies are incentivized to work collaboratively to ensure individuals with complex care needs are not left behind.

Expedite access

Care needs and the ability for caregivers to provide care will inevitably, often unexpectedly, change. When a caregiver cannot secure a timely and safe patient care option, they are often forced to seek care in EDs when their loved ones would be better served in a different setting at a much lower cost.

The expansion of resource centers, crisis services, respite, mobile crisis and technical assistance is helping to address these challenges. However, the availability of these services is severely limited and few programs can serve individuals with co-occurring conditions. Wait times for enrollment in supportive services are often months long and eligibility for services such as emergency respite can be limited to those already enrolled. Lack of timely access to care in the community leads to poor health outcomes and perpetuates health disparities.

HANYS recommends:

- expansion of emergency respite services and crisis residential programs;
- streamlined and updated processes for eligibility and referral to services; and
- removal of unnecessary payment barriers, e.g., lengthy insurance preauthorization and eligibility processes.

Educate patients, caregivers, schools, law enforcement and others

Caregivers and others are often not aware of resources and services that could better serve patients in the community. Making information about these options available to healthcare providers, schools, law enforcement, patients and caregivers will help ensure those in need can take full advantage of existing resources. De-escalation training for caregivers could also help them support loved ones or clients in the comfort of the home environment.

Intervene early for patients at high-risk of delay

Escalate early

Hospitals can often identify a patient at high risk of discharge delay upon arrival, and many have established processes to begin discharge planning at that time. HANYS strongly urges local and state agencies to also work together to re-examine the process for escalating patients with co-occurring conditions who are at high risk of discharge delay. The new process should include a timeline for development and execution of a discharge plan and a routine assessment of the process to ensure patients are receiving timely, coordinated access to care.

Streamline administrative process

While hospitals have made modifications to support individuals experiencing extended discharge delays, hospitals are designed to provide acute care in the short term. Unnecessary long-term stays deprive patients of more therapeutic care options and disrupt hospital-care delivery, with a financial cost that is much higher than more appropriate care settings.

For these reasons, administrative processes, such as eligibility determinations for state and local agency services, preauthorization and eligibility determinations for insurance and legal processes should be expedited and/or eliminated when possible for patients in the hospital.

Response

There will inevitably be circumstances where all other options are exhausted and a patient who is ready for discharge will remain in the hospital for an extended period of time. In these situations, hospitals should be reimbursed for the ongoing intensive care provided to support the patient's long-term needs, including education, therapeutic services and their mental and emotional well-being. Currently, insurance does not cover, or only partially covers, non-hospital-level care in the hospital setting. The unreimbursed costs for care of patients experiencing complex case discharge delays is extraordinary.

Increase visibility

Delays in access to care provide a strong, early indicator of unmet needs within our community. HANYS recommends that state and local agencies begin routinely documenting the time between when services are sought by individuals to when they are received (e.g., waitlists for services and benefits). This will provide a better understanding and response to delays in access to care, specifically when done with a focus on the referral and eligibility process.

Local and state agencies should develop explicit timeframes and measures to identify challenges early, request needed resources and track the progress of interventions. These timeframes and measures must be made public at least annually to allow for collaborative development of strategies to address gaps in access to care as they arise.

Our complex case discharge delay data collection pilot's results demonstrate tremendous care gaps for individuals with complex care needs. The healthcare system must be designed for individuals with these care needs as the expectation, not the exception. The need for change is urgent. HANYS looks forward to continuing our work with local, state and national partners to address these gaps and improve access to care for all New Yorkers.

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