CHEAT SHEET

for health care leaders

Delays In Transitions to Post-Acute Care

Helping acute and post-acute leaders navigate factors causing delays in care transitions

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Introduction

Hospital systems are increasingly feeling the effects of issues plaguing post-acute care sites, seeing longer patient stays in the hospital due to a lack of available SNF beds. The perfect storm of a significant staffing shortage in the SNF setting and an increase in facility closures has created a significant bottleneck for patients awaiting a transition to post-acute care. Acute and post-acute care facilities alike are being negatively affected financially.

In this resource, learn about the reasons post-acute care sites are struggling to admit patients quickly and efficiently when they are ready for hospital discharge, along with action steps we recommend partners make to help mitigate delays.

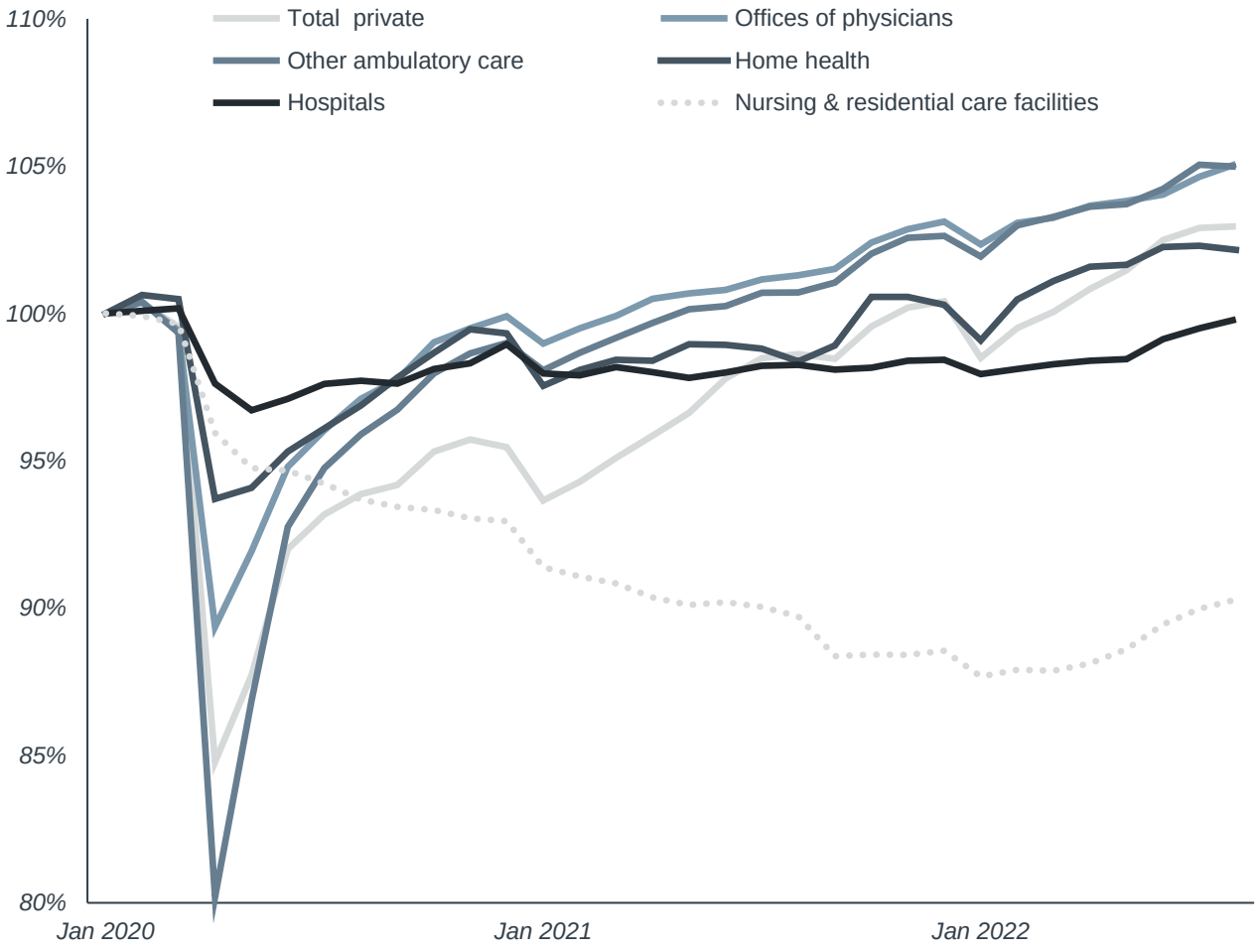
FACTOR 1

Lack of SNF bed availability due to insufficient staffing and facility closures

SNFs are closing at an alarming rate, with 327 closures, as of April 2022, compared to 776 that closed 2015 through 2019—and 400 more are projected to have closed by end of 2022 alone. Across the industry, facilities have a median operating margin of -4.8% and occupancy rates of only 77%.

Even when SNFs can stay open, they're often unable to fully staff their available beds. As of August 2022, SNF employment was down 10% from January 2020—while nearly every other site of care has recovered or improved their staffing levels.

Workforce recovery by health care sector, January 2020 to August 2022



FACTOR 1

Due to SNFs' reliance on Medicaid and an increase in the percentage of Medicare Advantage patients as a share of Medicare—which pays less than fee-for-service—leaders struggle to increase revenue to allow for pay increases for staff members. These staff members commonly leave to pursue higher-paying work, often outside of health care.

Until the staffing crisis abates at post-acute sites, it is likely that this costly bottleneck will persist. However, there is reason to be hopeful for the future. The data on the prior page for nursing and residential care facilities show a stabilization in turnover rates, which looks to continue through 2023, and could help ease this issue for both sides of the continuum over the coming years. Private equity continues to be a major player in post-acute care, and their continued investments in SNFs will also contribute to keeping beds available.

Actions to take

- Health systems should **partner discharge planners with admissions staff at downstream providers** to ensure all sites of care are effectively communicating about bed needs and availability.
- Health systems should **offer training to SNF staff** to provide additional clinical support as needed.
- SNFs should strengthen the staffing pipeline by **partnering with trade schools, community colleges, and community-based training programs** to host job fairs and interview days, and to promote interest in roles in post-acute care. In some cases, SNFs should even consider offering in-house aide certification.
- Leaders in all parts of the health care industry should **advocate for SNF funding or staffing support** from state Medicaid to help keep beds open.

FACTOR 2

Inability to match patient needs to available beds

Difficult-to-place patients are those who need post-acute care after discharge from the hospital, but are less likely than others to be accepted downstream due to the provider's struggle to safely or affordably care for them. As a result, acute providers find themselves keeping those patients longer, increasing length of stay and preventing them from backfilling the bed with a new DRG.

Patient characteristics that can lead to difficulties finding placement at a post-acute facility can include:

Patient characteristic	Why they are difficult to place
Under- or uninsured patients, or those awaiting Medicaid qualification.	These patients represent a financial risk for post-acute facilities that already struggle with margins. SNFs are paid per diem and don't get additional reimbursements for medications; patients with costly needs may cost more to care for than the SNF will get for the patient's care.
Patients whose care is particularly costly, such as those on expensive medications.	
Patients who need services that would require specialized equipment and/or expertise, such as patients on ventilators, those on dialysis, and bariatric patients.	Specific patient needs may go beyond the expertise, staffing, and/or technological capabilities available within a post-acute facility, limiting the facility's ability to safely care for these patients.
Patients with complex behavioral health needs or active suicidal ideation.	The safety concerns associated with these patients can simultaneously make them difficult to care for and increase risks to staff and other patients.
Patients with a history of addiction or violent behavior.	

Actions to take

- Health systems should **standardize clinical guidelines** to identify difficult-to-place patients early in their stay so care coordination staff have plenty of time to plan for discharge.
- Health systems should **ensure social work staff have the support and knowledge** they need to efficiently help those with disabilities or complex health needs.
- Post-acute providers should work with acute care discharge teams to **identify and collaboratively develop care capabilities** for patients that hospitals struggle to place in downstream sites of care.

FACTOR 3

Insurance preauthorization

Preauthorization is the requirement by health plans for patients to obtain approval for care before the care is provided, enabling the payer to evaluate whether care is medically necessary and therefore covered. According to a 2021 KFF issue brief, 99% of Medicare Advantage enrollees are in plans that require prior authorization for at least some services.

Preauthorization delays have historically been fairly localized, as patients enrolled in traditional Medicare do not require preauthorization for post-acute services, but these concerns are spreading as Medicare Advantage usage grows. 46% of Medicare enrollees as of October 2022 are MA beneficiaries, and MA is expected to cover 52.9% of all Medicare beneficiaries by 2031.

The preauthorization process itself includes numerous steps with opportunities for delays across all participants involved. Post-acute providers receive the referral from the acute care provider and initiate the preauthorization process. Once the preauthorization is transmitted, delays are common—especially if it's a weekend, when most payers are unresponsive. At this stage, there is the chance the payer denies the preauthorization or requests additional information in order to move forward. Finally, preauthorization is appealed and approved, clearing the transition for the patient.

Working with post-acute providers on an expedited preauthorization process has notable benefits. Collaboration cuts down on length of stay, avoiding an unnecessary hospital stay; improves downstream throughput; and helps mitigate the many opportunities for discharge delays. Knowing that this process is unlikely to change outright, it's vital that hospitals assist in making the process more streamlined. Post-acute providers themselves should ensure they understand the payer's preauthorization criteria and plan accordingly.

FACTOR 3

Actions to take

- Health systems should **streamline discharge planning** to send referrals to post-acute care providers as early as possible in a patient's acute stay, giving them ample time to complete requests for preauthorization.
- Health systems should **implement data-sharing capabilities** with post-acute partners to keep track of capacity visibility across the preferred provider network and cut down on hospital length of stay.
- Post-acute providers should **ensure that staff are completing documentation fully and accurately** to increase the likelihood of successful authorization on the first submission.

FACTOR 4

Clinical complications at the point of discharge

Patients who are deemed ready for discharge at the hospital may still experience urgent clinical needs such as abnormal test results or new clinical or psychosocial complications, which can contribute to a delayed discharge to post-acute care.

Not all clinical complications can be foreseen, and some delays are therefore inevitable. However, others can be surfaced earlier. Health systems have made significant progress in starting discharge planning at the point of hospital admission, but there is still more to be done.

Hospital care teams should schedule regular, early meetings with physicians to discuss discharge needs. Work to remove any barriers to efficiency in the in-house lab so that new lab results can give a full picture of the patient's clinical status as early as possible. Then send reports to the respective discharge staff.

Ensure huddles have a comprehensive agenda to discuss every patient's discharge plan and areas of potential complications. Implement interdisciplinary rounds between care teams to ensure those patients don't face further barriers to discharge. Additionally, post-acute organizations should educate health system partners on their specific capabilities so discharge planners feel more comfortable transferring patients.

Actions to take

- Health systems should **implement regular team huddles** to discuss potential patient complications so the care team is informed and can proactively address concerns.
- Health systems should **partner with post-acute sites to provide training** for clinicians to help them feel more comfortable with the most common conditions and complications they may encounter.
- Post-acute providers should **inform acute providers about their clinical capabilities,** so hospitals feel confident transitioning patients with reasonable complications who are ready for discharge.

FACTOR 5

Misaligned discharge and intake times

Patients can't be discharged if no one is available to take them—and acute discharge times don't always align with when the post-acute provider can accept admissions.

Historically, hospital discharges occur later in the afternoon or evening, often on a Friday or the weekend. SNF intake staff most commonly work Monday through Friday during regular business hours. Considering the current staffing shortage, this issue has only been exacerbated in recent years.

Hospital discharge teams should incorporate the post-acute perspective into their workflow when sending a patient downstream. Strengthening communication with post-acute sites to better coincide discharge times is a vital step to ensure both providers stay aligned. Similarly, post-acute providers must understand that many discharges don't happen during standard business hours and should get creative to staff accordingly to meet the needs of hospital partners.

Actions to take

- Health systems should **set goals for discharging patients** by a time of day that post-acute partners are most likely to be able to quickly accept admissions**. Hold discharging staff accountable** to those aligned discharge and intake times whenever possible.
- Health systems should **educate post-acute partners on when the most common discharge times** are so they can be better prepared and staff accordingly.
- Post-acute providers must **staff admissions to coincide with hospital discharge times**.

FACTOR 6

Lack of available transportation

Even after the patient is officially ready to make the transition, one final barrier often remains: a lack of transportation to get the patient from the hospital to their next site of care.

Transport by ambulance is a possibility, but ambulances are often overburdened by volume and may not be able to commit to expected discharge times.

Family or caregiver transport isn't always the best option either. Even as the rise of remote work has enabled some family caregivers to be more available to assist, many are unable to pick up their family members at the anticipated time—and very few are able to wait for what can be highly unpredictable discharge times.

In addition, patients who are not clinically stable enough to be transported without support, or who are unable to sit up in a traditional car seat, cannot simply ride in a car to their discharge destination.

While a few post-acute organizations own their own fleet of vehicles to provide patient transportation, many can't afford the high initial cost of investment and have to compete with community ambulances for supply.

There are alternatives. Health systems can partner with rideshare programs like Uber Health or Lyft Healthcare to successfully transport patients to their discharge destination. The downside to this option is the risk that rideshare drivers tend to not be adequately prepared to transport complex patients—some have even shown up to their destination to unexpectedly find it's a hospital.

As an alternative, non-medical home care services typically offer medical transport. However, these services can be expensive and are not covered by insurance. Health systems struggling with transportation can collaborate with organizations that offer these services, either through paid agencies or volunteer services. Community programs like this include New Jersey's EZ Ride Community Cars and Maryland's Partners in Care service.

Actions to take

- Health systems should consider **investing in ambulances, paying for alternative forms of transportation**—such as wheelchair taxis, rideshare services, non-medical home care, or volunteer programs—or **collaborate closely with post-acute providers who have invested** in their own fleet of ambulances.
- Health systems should **collaborate with family** to try to make sure the patient can be discharged at a time a caregiver is available, if relying on the family member for transportation.
- Post-acute providers should **consider which options**—buying ambulances or transportation partnerships—**will best work for their organizations and their patient base**.

What you should do now

01 Health systems should collaborate with their post-acute preferred provider network to stay up to date on bed availability and staffing levels.

02 Health systems should partner closely with post-acute providers in their networks to ensure all parties are aligned on preauthorization processes, transportation options for discharge, and are aware of any other potential barriers that may stand in the way of a smooth care transfer.

03 Post-acute providers should educate acute discharge staff on their facility's capabilities to care for complex patients, and staff their post-acute admissions teams to better align with partners' discharge needs and timing.

04 Post-acute providers should identify private equity opportunities to help improve operating income.

These action items are necessary for acute and post-acute providers to better align, avoiding preventable delays in care and ensuring the patient is able to be at the right care setting for their needs at the right time.

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