Hospital Discharge Planning for Older Rhode Islanders

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HARI
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Purpose of Presentation

- Overview of how discharge planning works at hospitals in Rhode Island
- Common barriers to safe and timely transitions
- How hospitals are responding
- Areas where collaboration can improve outcomes

Discharge Planning Begins at Presentation

- Starts when the patient presents for care
- Continues throughout the hospital stay
- Goal: safe, timely, appropriate transition of care
- Process documented in the electronic medical record (EMR)

Multidisciplinary Team-Based Approach

- **Clinical Care**
  - Physicians
  - Nurses
- **Care Coordination & Support**
  - Case managers / social workers
- **Functional & Behavioral**
  - Occupational and physical therapists
  - Behavioral health clinicians (as needed)
- **Patient and family**
  - Central in decision making and planning

Patient Choice Matters

- Patient preferences are central to planning
- If Skilled Nursing Facility (SNF) is recommended
  - Patients receive a list of facilities
  - Includes CMS Star Ratings to support informed choice
- Family or caregivers involved whenever possible

Common Post-Acute Discharge Destinations

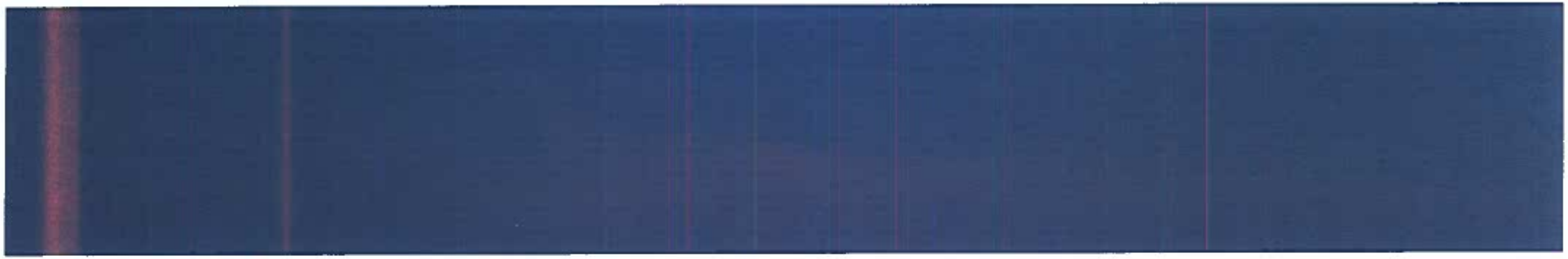
- Patient's home (with or without services)
- Home health care
- Inpatient rehabilitation facilities
- Skilled nursing facilities (SNFs)
- Assisted living
- Group homes or supportive housing

Coordinating the Discharge

Once a destination is identified, teams coordinate with:

- Receiving facility or provider
- Home health agencies
- Insurers / managed care plans
- Transportation and equipment needs
- Medication reconciliation and follow-up care

Barriers to Discharge



Barriers: Guardianship Gaps

- Patients unable to participate in decisions
- No family or legal decision-maker
- Guardianship process is slow and complex
- Often results in extended hospital stays

Barriers: Patients Hard to Place

Common challenges include:

- Uninsured or Medicaid-only coverage
- Need for memory care
- Dual diagnosis
- Med-psych complexity
- Lack of safe, stable housing
- History of behavioral challenges
- Differences in restraint standards between hospitals and SNFs
- Limited placement options for individuals with multiple prior SNF placements

Barriers: System Capacity Gaps

- Limited placements at the state hospital
- Long waitlists for outpatient psychiatric services
- Limited access to non-clinical home care supports
- Referrals frequently delayed due to capacity constraints
- Limited placement options for individuals with multiple prior SNF placements

Barriers: Prior Authorization Delays

- Increasingly common across payors
- Can take 5–6 days (or longer)
- Delays discharge even when patient is medically ready
- Contributes to longer hospital length of stay

Impact of Delayed Discharges

- Extended hospital stays are not good for patients or families
  - Increased risk of decompensation
  - Cognitive and functional decline
- Limits hospital capacity
- Contributes to ED boarding and access challenges
- Increased cost to healthcare system

How Hospitals are Responding

- **Care Coordination & Throughput**
  - Dedicated physician teams focused on payer authorization
  - Complex Care Committees working directly with SNFs
- **Care Delivery Innovation**
  - Mobile Integrated Health for higher-risk discharges home
    - Currently no reimbursement
  - Hospital at Home programs
- **Older Adult-Focused Care**
  - Geriatric Emergency Department Accreditation
- **Legal & Social Complexity**
  - Retaining outside counsel to support guardianship needs
- **Support for Uninsured Patients**
  - Financial counseling
  - Charity Care: In hospital rehab & home care support

Opportunities for Collaboration and Improved Outcomes

- Volunteer or paid guardian program
- Improved collaboration with OHA (address confidentiality barriers)
- Medical-psych reimbursement pathways
- Amendments to the 1115 waiver to allow placement of BH patients in SNFs
- Reduce or eliminate prior authorization for post-acute discharges
    - 7-day guaranteed payment to post-acute providers