Foundation *for* Healthy Communities

Barriers to People Receiving the Right Care

December 2020

Foundation *for*
Healthy Communities

Barriers to People Receiving the Right Care

December 29, 2020

Executive Summary

Ideally, any person needing health care should receive it in the setting most appropriate to meeting their individual needs. Unfortunately, in New Hampshire, there are many patients who no longer require acute care in a hospital setting and who are medically cleared for discharge but who are unable to leave. The delay in discharges is due to a variety of issues, which are often complex "barriers to care". These delays can have a profound effect on patients, along with their families, caregivers, and health providers. This report represents the 4th time data has been collected statewide to highlight the ongoing issues confronting New Hampshire's healthcare systems. Previous reports were published in 2015, 2016 and 2017.

The approach to data collection in 2019 allowed for a greater number of "barriers to care" categories, reflecting the increasing complexity of caring for vulnerable populations. Data analysis required more clarification and review of over 400 comments, making it more challenging and delaying publication of results. When the analysis was completed, NH was facing the COVID-19 Pandemic and its profound effect across the entire healthcare system. Although the data and analysis in the body of this report reflect data pre-COVID-19, it is imperative to acknowledge the additional challenges and barriers to discharge that have arisen since March 2020. During this outbreak there have been significant impacts to the ability of patients to move appropriately along the continuum of care. This study offers some insights to these new barriers to discharge, although it must be acknowledged that the listing of all possible extenuating factors remains incomplete.

<u>COVID-19 Associated Barriers to Care</u>

- COVID-19 has had a significantly disproportionate impact on older adults and those with disabilities. The increasing social isolation from the outside world of community support resulted in a decline in the safety of the home environment. When an acute illness occurred, hospitals became the safety net because returning to isolation at home was not a feasible option.

- General travel restrictions and required quarantines limit an out of state family's ability to support older and / or disabled relatives, resulting in hospitals becoming long-term safety nets.
- Increased incidence of homelessness with a reduced capacity at shelters resulted in limited options of housing for this population.
- Visitor restrictions have limited the ease of interactions and scheduling of family meetings with the health care teams to comprehensively assess patients and determine the best plan of care and appropriate discharge disposition.
- Staffing shortages and challenges impacted all nature of healthcare and support organizations: hospitals, long-term care (LTC), facilities, home health, community programs and State of NH Long-Term Supports and Services (LTSS). The incidence of COVID-19 among healthcare workers affected the ability to operate at 100% capacity while workloads were increasing.
- Constantly changing recommendations, guidelines and regulations as the pandemic evolved resulted in facilities having contradictory policies and a lack of uniformity, which led to significant misunderstandings of the hospital discharge process.
- Temporary discontinuation of LTC conference meetings with hospitals, and the closure of regional offices altered workflows and created communication challenges which caused inefficiencies in the application processes for LTC Medicaid approval.
- 'Stay at Home' executive orders reduced a family / guardian's ability to retrieve required documents necessary for determining financial eligibility for LTC Medicaid benefits.
- The COVID-19 testing requirements for patients being considered for discharge to LTC also led to delays as the initial testing capacity was inadequate to meet the needs of this population. Facility specific testing policies, driven by Corporate decisions did not align with public health guidance, further contributing to confusion.
- All patients discharged to LTC were required to be on quarantine for 14 days. Accommodation of quarantine requirements and the need for private rooms for isolation impacted capacity and census at many facilities.
- The number of NH facilities able to accept COVID-19 positive patients has been very limited.
- Facilities deemed to be in 'outbreak' status are not allowed to admit patients per Federal rules. Over 70 facilities have been affected by outbreaks since March.
- Placing patients with dementia or behavioral health diagnoses present additional challenges due to the inability to quarantine these patients in a private room with a closed door.
- Although many waivers were put in place for easing patient discharges to LTC, the Medicare Advantage plans were not bound by the waivers of Medicare regulations thus creating additional confusion, inconsistency and barriers.

Barriers to People Receiving the Right Care

This report provides a snapshot of the barriers to care preventing timely hospital discharge experienced by patients in all 26 acute care hospitals and 1 specialty hospital in New Hampshire between August 1 and October 31, 2019. Each one of these patient experiences contributes to a significant cumulative financial and human cost during this three-month period. Although this data pre-dates the COVID-19 public health emergency, it remains not only relevant but continues to underscore the urgency needed to address long-term as well as newly highlighted issues.

Key Findings

- 643 individuals were delayed in discharge, 60% were aged 65 or older, 45% had Medicare as their primary insurance, and 82% were New Hampshire residents
- 1,037 barriers to care were reported. (More than one barrier could be identified for each patient.). Barriers were divided into 5 major topic areas:
    - 38% Housing: unable to access a place to live with appropriate supportive care
    - 26% Insurance: difficulty with Medicaid application process or under-insured
    - 18% Assistance Needed: unable to access needed mental health care, transportation or specialty care
    - 10% Decision-Making: Person lacks decision-making capacity and/or needs a guardian
    - 8% Other: other barriers including history of IV drug abuse, sex offender or criminal record
- On average, a person spent 17 extra days in the hospital after being medically discharged. 65 patients experienced delays > 40 days, and 18 patients had delays > 100 days, including one individual spending an additional 495 days in the hospital.
- A total of 10,598 additional, medically unnecessary patient days were reported. This translates to an estimated $27,028,722[1] in additional *unreimbursed* acute care costs for NH hospitals in this three-month period.

Methodology

New Hampshire hospitals were invited to submit several data elements for each patient unable to be discharged despite medical clearance between August 1 and October 31, 2019. A list of the participating hospitals is in Appendix A.

Data collection was modified from past iterations of this report. Instead of submitting individual entries into SurveyMonkey, hospitals submitted all patient data (scrubbed of Protected Health

[1] Total costs were determined by using the average daily cost for an acute care bed in a New Hampshire hospital according to the Kaiser State Health Facts which incorporates 2017 AHA Annual Survey data.

Information) from the three-month date range in an excel file with each row representing one patient. This file was built by the Foundation for Healthy Communities with input from the Case Management Directors Networking Group. It provided drop down options under each of the 5 major barrier types to encourage uniformity in responses among the hospitals. This tool also provided a comment section to supplement the "Other Barriers" type. Over 400 comments were submitted providing details and shedding light on the layers of complexity of the barriers faced by patients and hospitals. These comments facilitated some recategorizing and restructuring of barrier categories to better reflect the patient experience.

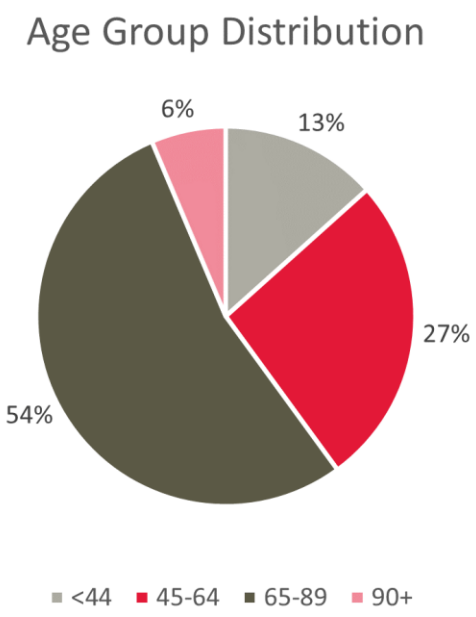
All 26 acute care hospitals and 1 rehabilitation hospital in the state participated in data collection efforts. Dartmouth-Hitchcock Medical Center in Lebanon, the state's largest hospital and only tertiary care facility, contributed the highest percentage (25%) for any one hospital. The next largest contributors included Portsmouth Regional Hospital (16%), Lakes Region General Hospital (12%), Wentworth-Douglass Hospital (10%), and Catholic Medical Center (7%). These 5 hospitals combined represent 70% of the data in the study. Two hospitals, Alice Peck Day Memorial Hospital and Androscoggin Valley Hospital, had zero patients that met the barrier to discharge criteria during the timeframe of this study.

Demographics

Age Distribution of People Experiencing Barriers

Over half of the people unable to leave the hospital were age 65 years or older with 54% ages 65-89 years old and 6% age 90 or older. 27% of the people were between the ages 45-64 years old, and the remaining 13% were age 44 or younger. Figure 1.

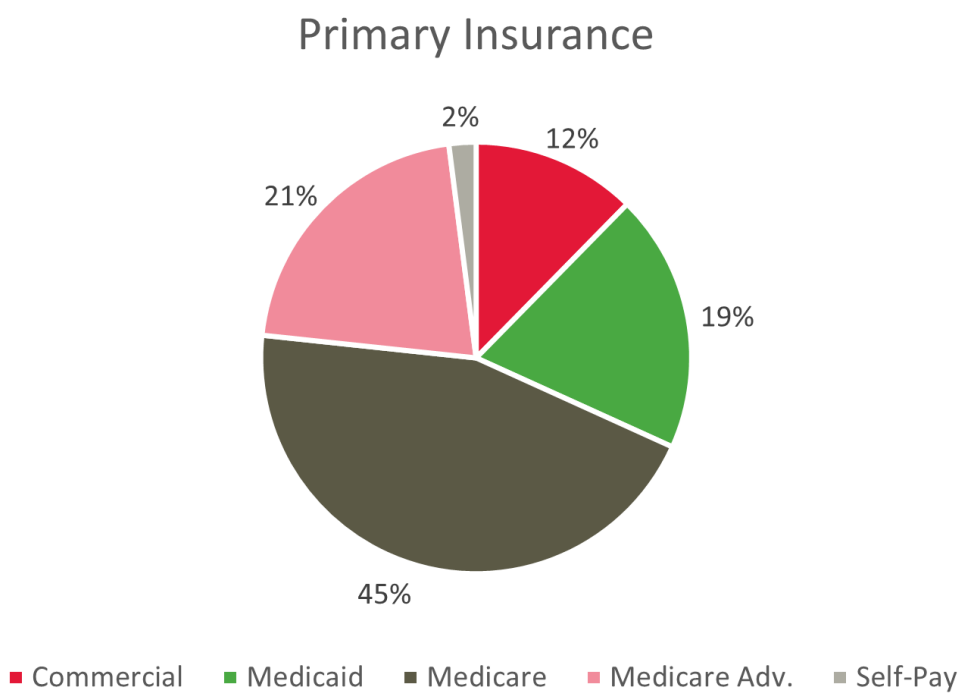
Figure 1



Insurance

Figure 2 identifies Medicare as the primary medical insurer for most people (45%) in the study. Medicare Advantage was the next largest (21%) source of insurance coverage, followed by Medicaid (19%), private/commercial insurance (12%), and uninsured (2%).

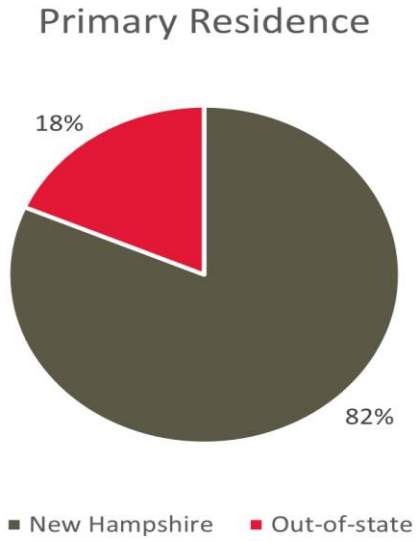
Figure 2



Primary Residence

A majority (82%) of the people in the sample have their primary residence in New Hampshire.

Figure 3



Discussion of Findings

Delays in discharge after medical clearance impact patients in a miriad of ways. Timely discharges to the appropriate settings, either home or a less-acute care setting, offer individuals the independence and support levels that maximize well being. Patients held in acute hospitals longer than necessary occupy beds that could be needed by others with acute health care needs who may be diverted to hospitals further from home.

Unnecessary Acute Patient Days and Associated Cost

Patients in this study spent a total of 10,598 additional days in the hospital when acute care was no longer medically necessary. The average number of additional days spent in the hospital was 17. There were 65 patients who stayed 40 or more additional days and 18 who spent over 100 days. Out of these 18, 14 patients stayed between 100-299 days and 4 patients stayed 300+ additional days, including one patient at 495 days at the conclusion of the survey period.

The cost of care in an acute care setting is very high in comparison to other settings that provide less intensive, supportive medical care for those with non-acute medical needs. The barriers for these 643 people resulted in approximately **$27 million in additional acute care hospital expenditures** for people with non-acute medical care needs. These additional costs are not reimbursable and are absorbed by the hospitals. ***This study only focuses on a three-month period so the true magnitude of the number of patients experiencing barriers and the overall costs are likely to be much higher.***

Analysis of Barriers

A summary of major barriers preventing people who are medically cleared to leave the acute care hospital is identified in Figure 4. Hospitals responding to the survey were permitted to identify specific factors within the five major categories of barriers: Housing (38%); Insurance (26%); Assistance Needed (18%); Patient Lacks Decision-Making Capacity (10%), and Other (8%).

Figures 5-9 displays the frequency of the specific barrier choices under each Major Barrier category. Out of all of the specific options, the following five were reported the most often:

- Unable to access post-acute care: SNF/LTC/Geropsych/28 Day Rehab (303 patients)
- Insurance Authorization Delay or Denial (115 patients)
- Other Health/Behavioral/Psychiatric Care needed (100 patients)
- Waiting on Medicaid Determination (73 patients)
- History of IV Drug Use / Need for Long Term IV Antibiotics / Current Medication-assisted treatment (MAT) (58 patients)

Figure 4

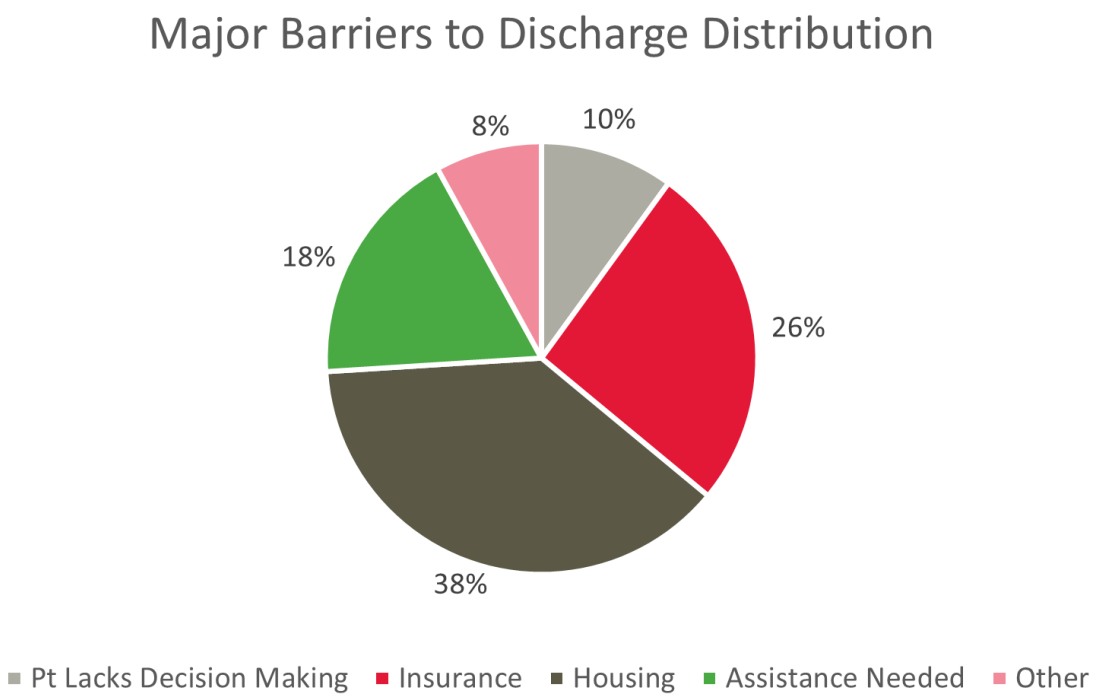


Figure 5

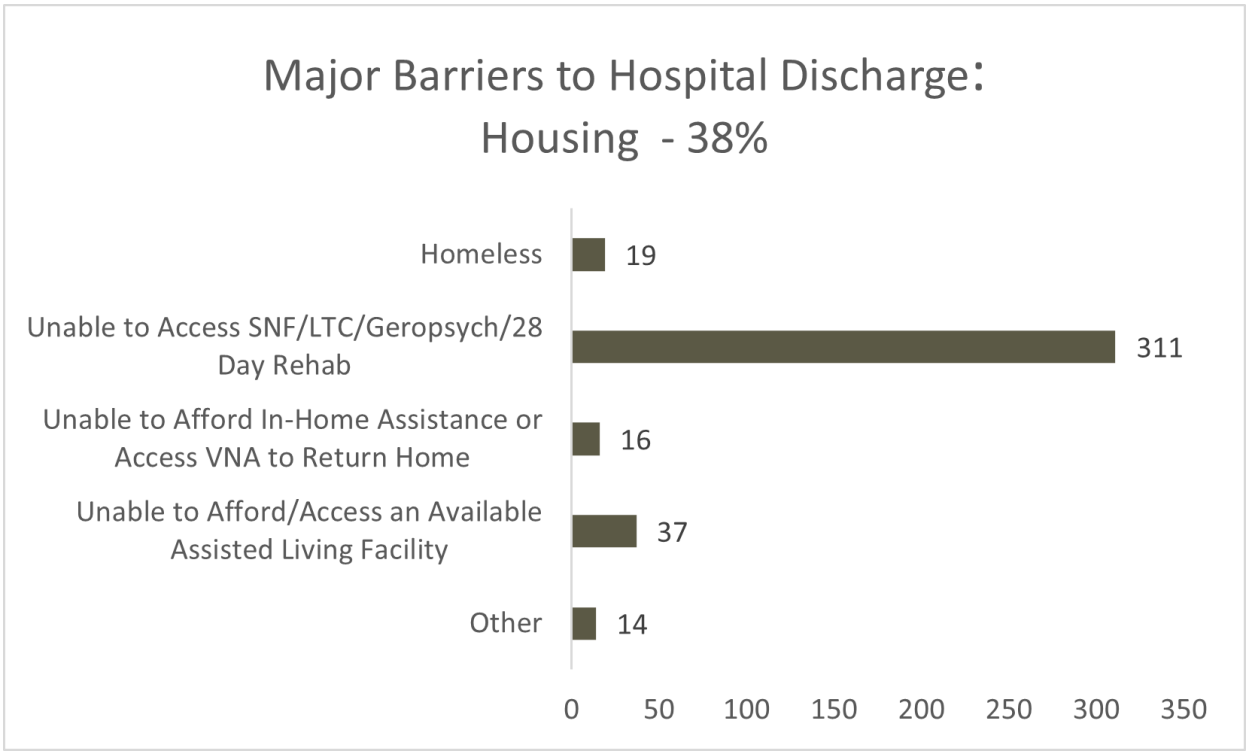


Figure 6

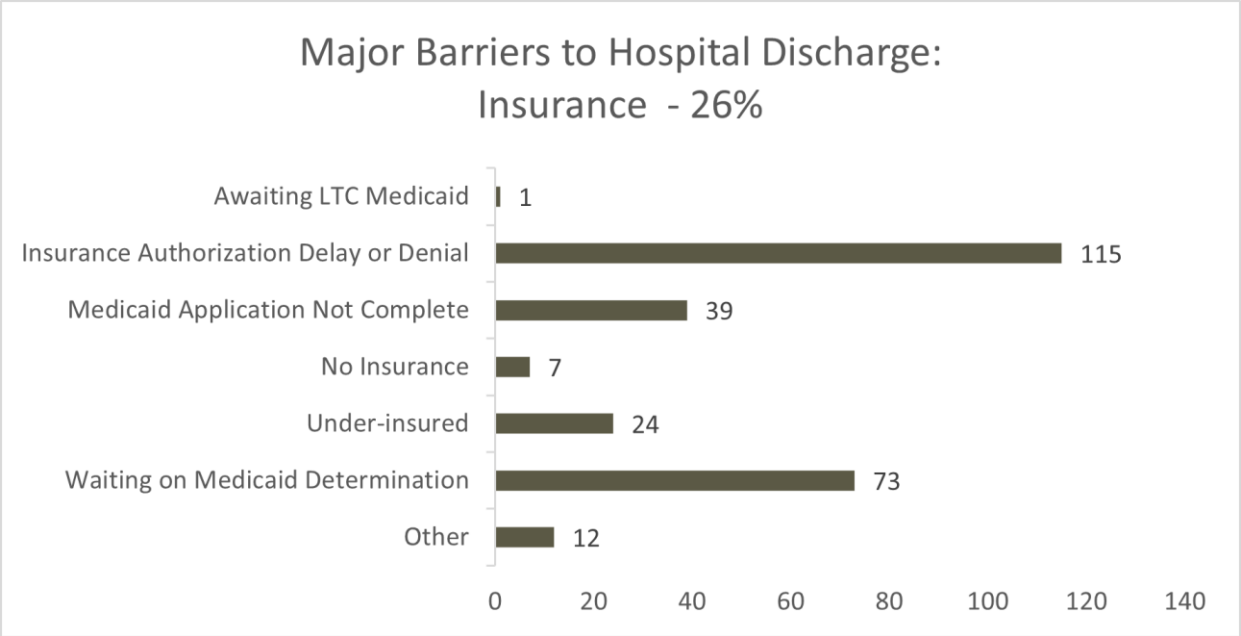


Figure 7

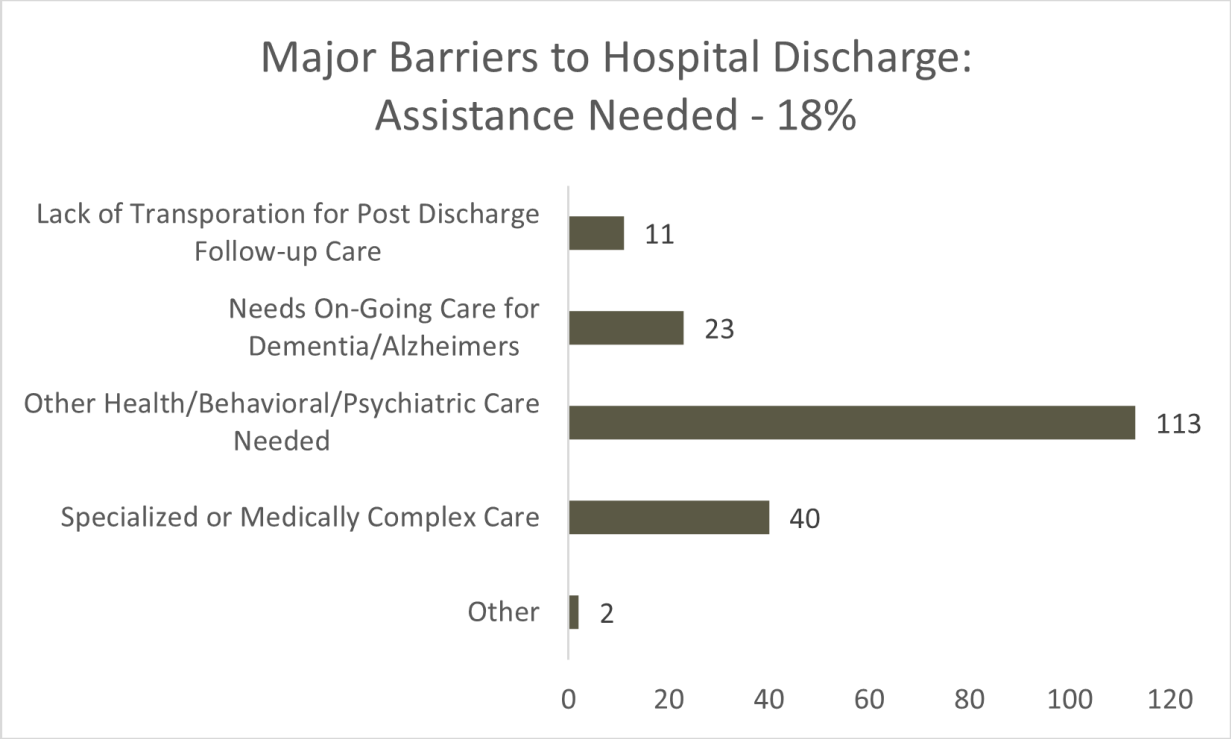


Figure 8

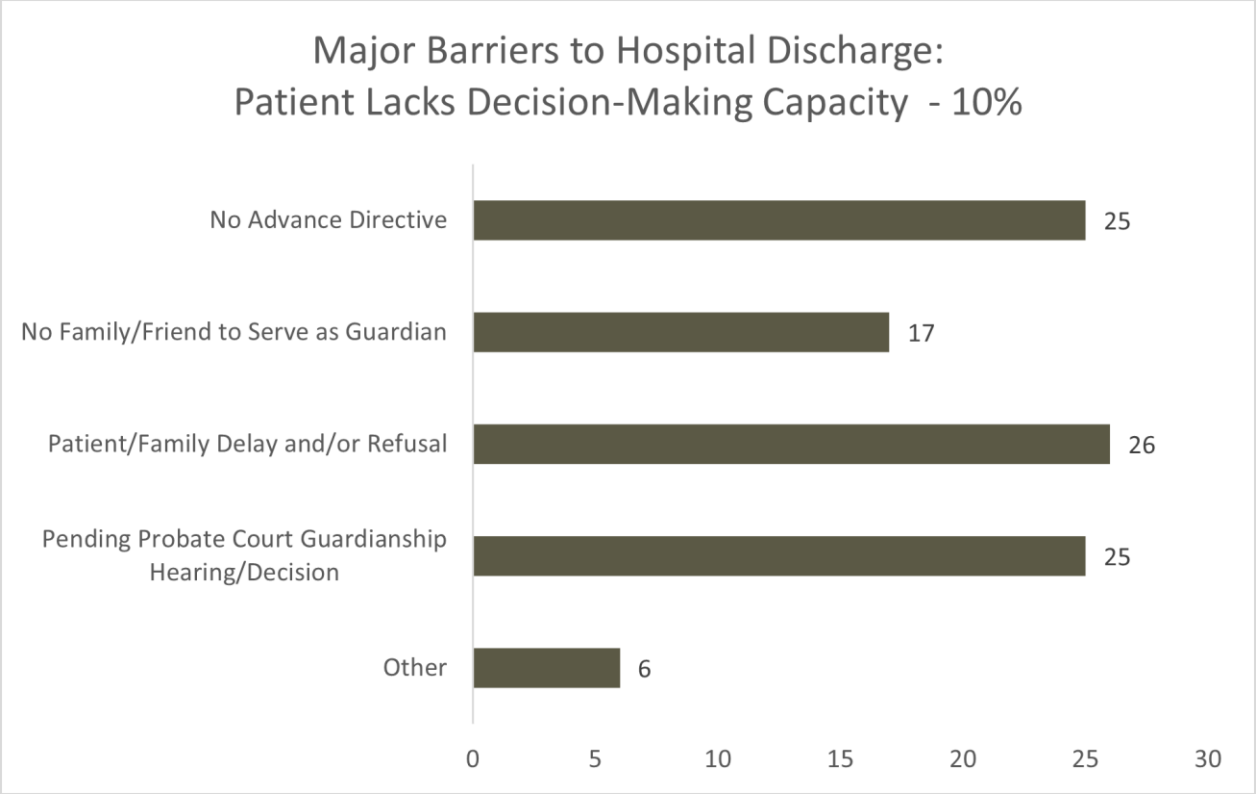
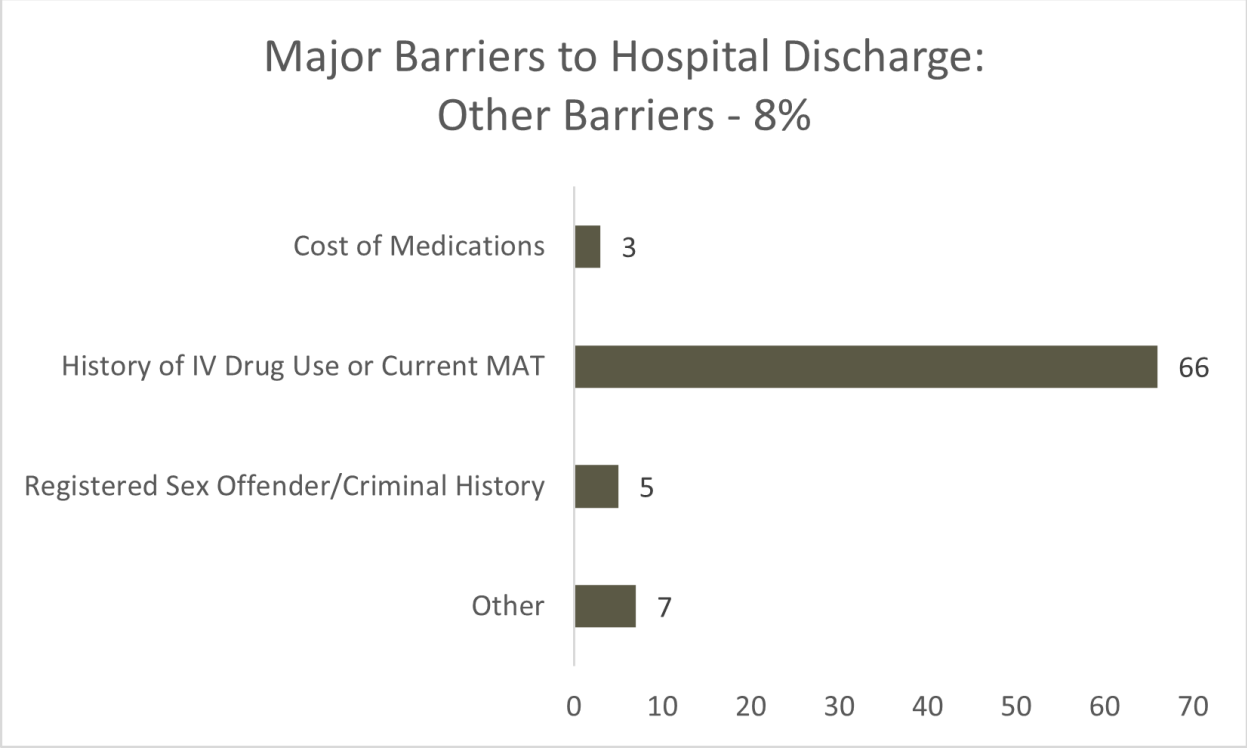


Figure 9



Appendix A. List of Participating Hospitals

Hospital	Location
Alice Peck Day Memorial Hospital	Lebanon, NH
Androscoggin Valley Hospital	Berlin, NH
Catholic Medical Center	Manchester, NH
Cheshire Medical Center	Keene, NH
Concord Regional Hospital	Concord, NH
Cottage Hospital	Woodsville, NH
Dartmouth-Hitchcock Medical Center	Lebanon, NH
Elliot Hospital	Manchester, NH
Exeter Hospital	Exeter, NH
Franklin Regional Hospital	Franklin, NH
Frisbie Memorial Hospital	Rochester, NH
Huggins Hospital	Wolfeboro, NH
Lakes Region General Hospital	Laconia, NH
Littleton Regional Healthcare	Littleton, NH
Memorial Hospital	North Conway, NH
Monadnock Community Hospital	Peterborough, NH
New London Hospital	New London, NH
Northeast Rehabilitation Hospital	Salem, NH
Parkland Medical Center	Derry, NH
Portsmouth Regional Hospital	Portsmouth, NH
St. Joseph Hospital	Nashua, NH
Southern NH Medical Center	Nashua, NH
Speare Memorial Hospital	Plymouth, NH
Upper Connecticut Valley Hospital	Colebrook, NH
Valley Regional Healthcare	Claremont, NH
Weeks Medical Center	Lancaster, NH
Wentworth-Douglass Hospital	Dover, NH