Hospital Discharge Challenges Working Group

Report to the Public Health and Health and Human Services Committees of the Connecticut General Assembly

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Healthcare Workforce Safety Working Group Members

All members appointed by the Public Health Committee

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Table of Contents

Executive Summary

Section 190 of Public Act 25-168 established a multidisciplinary Working Group to evaluate the growing challenges associated with hospital discharge processes and their downstream impact on patient flow across the continuum of care. The statute charges the Working Group with examining current discharge practices, identifying systemic barriers that contribute to delays, and recommending strategies to improve transitions of care while alleviating emergency department (ED) boarding.

Starting on November 17, 2025, the Working Group convened representatives from hospitals, post-acute care providers, community-based organizations, payers, and state agencies to assess the root causes of discharge delays and the operational pressures they create. Early discussions highlighted a complex set of interrelated issues, including limited post-acute care capacity, administrative and insurance-related barriers, workforce shortages, and gaps in care coordination that collectively impede timely discharge.

The Working Group's initial findings underscore that discharge delays are not isolated operational challenges but system-wide constraints that directly affect ED throughput, inpatient bed availability, and overall patient experience. Addressing these challenges requires coordinated action across sectors, improved communication pathways, and policy solutions that support more efficient transitions of care.

This report summarizes the Working Group's analysis to date, outlines the key drivers of discharge delays, and presents preliminary strategies aimed at reducing avoidable hospital days, strengthening care coordination, and mitigating ED boarding. The recommendations are designed to support a more responsive, patient-centered discharge system that enhances flow, improves outcomes, and optimizes the use of limited healthcare resources.

Summary of Recommendations

The Working Group's review of hospital discharge challenges revealed a complex set of interdependent factors that contribute to prolonged inpatient stays, delayed transitions of care, and persistent ED boarding. Addressing these issues requires coordinated action across state agencies, hospitals, payers, community partners, and the judicial system. The following recommendations are organized by strategic priority and reflect opportunities to improve coordination, expand capacity, support innovative care models, and strengthen data transparency.

Improve Interagency and Hospital Communication and Collaboration

Effective communication and coordination across agencies and healthcare providers are essential to reducing delays and improving patient flow.

- *Improve Communication Between the Department of Social Services (DSS) and Hospitals*

  DSS should be directed to implement a structured, statewide process to evaluate and improve communication with hospitals. This process should include: (1) developing and administering standardized surveys and facilitated focus groups in partnership with the Connecticut Hospital Association (CHA); (2) identifying specific points in the Medicaid eligibility and authorization workflow where communication gaps contribute to discharge delays; and (3) publishing a set of recommended process improvements and measurable performance targets.

- *Enhance Collaboration Between the Probate Court and Hospitals*

  The Probate Court should establish a formal, structured engagement process with hospitals to identify and address probate-related barriers that delay hospital discharge. This process should include: (1) convening regular meetings with hospital discharge leaders to review operational challenges; (2) mapping points in the conservatorship and guardianship workflow that contribute to discharge delays; and (3) developing and implementing process improvements, including standardized communication protocols and expedited pathways for hospitalized individuals.

Address Capacity Constraints in Post-Acute, Behavioral Health, and Housing Systems

Discharge delays often stem from insufficient capacity in post-acute care setting, behavioral health services, and housing. Strategic investment in these areas is essential to improving patient flow.

- *Prioritize Medicaid Funding to Reduce Unnecessary Hospital Days*

  The state should prioritize Medicaid funding in areas that reduce avoidable inpatient utilization and support more efficient transitions of care, thereby improving resource stewardship. Consideration should also be given to create a temporary payment method for

post-acute care while applications are processing to precent bottlenecks in hospital systems and encourage patient throughput.

- *Expand Capacity in Known Discharge Bottleneck Areas*

  Continued monitoring and targeted resource allocation should focus on populations experiencing the longest discharge delays, including patients whose social drivers of health—such as housing instability, lack of caregiving support, transportation barriers, or food insecurity—impede a safe and timely hospital discharge.

- *Increase Behavioral Health Investments*

  The state should build on its current behavioral health investments and take additional steps to expand access to care. This includes creating stable, sustainable Medicaid rate structures for new services such as children's behavioral health urgent crisis centers, statewide emergency mobile psychiatric services, adult mobile crisis teams, and other community- and school-based programs. The state should also move forward with Medicaid reimbursement for the Collaborative Care Model (CoCM), as authorized under CGS Section 17b-307a. In addition, the state should allocate targeted funding to support timely, safe discharge for individuals who need home-based, community-based, or outpatient hospital services.

- *Support Workforce Initiatives Affecting Post-Acute Care Capacity*

  The state should continue to assess workforce shortages that impact post-acute care placement and prioritize support for initiatives that strengthen this segment of the healthcare workforce, including but not limited to state and federal initiatives aimed at the shortage included the CMS Nursing Home Staffing Campaign, Rural Health Transformation Program and the Office of Workforce Strategy.

- *Advance Housing Solutions that Support Timely Discharge*

  The Connecticut Department of Housing (DOH) should be directed to establish a formal partnership with hospitals and Coordinated Access Networks (CANs) to expand discharge-appropriate housing options. This directive should include: (1) creating a statewide protocol for identifying and prioritizing medically ready patients who lack safe housing; (2) developing and implementing rapid-placement pathways, including short-term medical respite and transitional housing options; and (3) identifying regulatory, funding, and capacity barriers that impede timely discharge.

Explore Innovative Care Models and Improve Financial Mechanisms

New care models and financing approaches may offer opportunities to reduce inpatient utilization and support more flexible discharge pathways.

- *Evaluate Presumptive Eligibility for Medicaid LTSS*

DSS should be directed to conduct a focused feasibility study on adopting presumptive eligibility for Medicaid long-term services and supports (LTSS), enabling faster placement and reducing avoidable hospital discharge delays.

- *Implement Medicaid Reimbursement for Mobile Integrated Health* (MIH)

  DSS should be directed to establish clear reimbursement pathways for mobile integrated health (MIH) services, enabling alternative care models that lower inpatient use and support timely, safe discharge.

- *Establish a Demonstration Project for Home-Based Discharge Solutions*

  A pilot should be launched to test home-based alternatives to facility placement, with a focused review of reimbursement barriers, Medicare Advantage plan design constraints, and the financial impact on patients. Examples include intensive transitional care at home including non-skilled services.

- *Address Delays Associated with Payer Prior Authorization Processes*

  The State should consider revising CGS 381-591d to shorten the timeframe for health carriers to decide prospective or concurrent review requests, reducing the current seven calendar day period to three business days from receipt of the request.

Strengthening Data Transparency and Systemwide Insight

A consistent theme throughout the Working Group's discussions was the need for more reliable, standardized, and actionable data to understand the drivers of discharge delays and ED boarding. Improved transparency will support better decision-making, resource allocation, and policy development.

- *Analyze the Relationship Between ED Boarding and Hospital Capacity*

  The Connecticut Department of Public Health (DPH) should consider conducting a statewide analysis of how hospital capacity constraints contribute to ED boarding. Particular attention should be given to facilities experiencing disproportionately high boarding relative to available capacity. Statewide occupancy and capacity data reporting standards should be amended to ensure that aggregate occupancy data are separated by clinically relevant bed types. OHS (or equivalent agency) should be directed to include boarding and discharge challenges in its biennial statewide utilization study.

- *Enhance Tracking of Funding-Related Discharge Delays*

  DSS should be required to track and report funding-approval delays specifically for patients awaiting hospital discharge, including the time from application submission to decision, and

to do so in a streamlined way that avoids added administrative burden. The effort should also identify incentives for skilled nursing facilities and short-term rehab providers to accept patients while applications are pending—such as interim payment mechanisms, risk-sharing arrangements, or temporary reimbursement guarantees—to reduce avoidable discharge delays. Consideration should be given to reinstating the program where eligibility services workers were placed in hospitals to expedite application processing.

- *Collect and Report Probate-Related Data for Hospitalized Individuals*

  The Probate Court should collect and report key data for hospitalized applicants—including application type, volume, and time to resolution—to illuminate legal-related barriers that prolong discharge and identify where process improvements are most needed. The Probate Court should include a summary of relevant data, identified challenges, and potential solutions in its biennial report to the Legislature to support informed policymaking.

The above recommendations are not exhaustive, but they offer a solid foundation for tackling hospital discharge barriers and reducing ED boarding through coordinated, system-level improvements. By strengthening data transparency, improving interagency collaboration, expanding capacity in critical areas, and exploring innovative care models, Connecticut can make meaningful progress toward a more efficient, patient-centered system of care. These actions will support improved patient outcomes, more effective use of healthcare resources, and a more resilient statewide healthcare infrastructure.

Background

The impetus for establishing this Working Group emerged from recommendations from a prior working group: The Emergency Department Boarding and Crowding Workgroup. This group was established in 2023 under Public Act 23-97, and administered under the Connecticut Department of Public Health (DPH). This group provided an interim and a final report, which continue to be relevant to the current Working Group recommendations.

Another result of the prior working group was passage of Public Act 24-4, which established CGS Section 19a-490ii and mandates an annual report of emergency department boarding data for each hospital in the state. The 2026 report was submitted on March 1, 2026, and highlights several root causes that hospitals need support from the Connecticut General Assembly to address. As noted in the report, these challenges include but are not limited to Medicaid underfunding and long-term care application processing, housing instability, homelessness, and financial risk, lack of appropriate behavioral health services and the need to enhance overall healthcare delivery system capacity, patients with complex discharge needs, prior authorization, and conservatorship and streamlining proxy decision-making

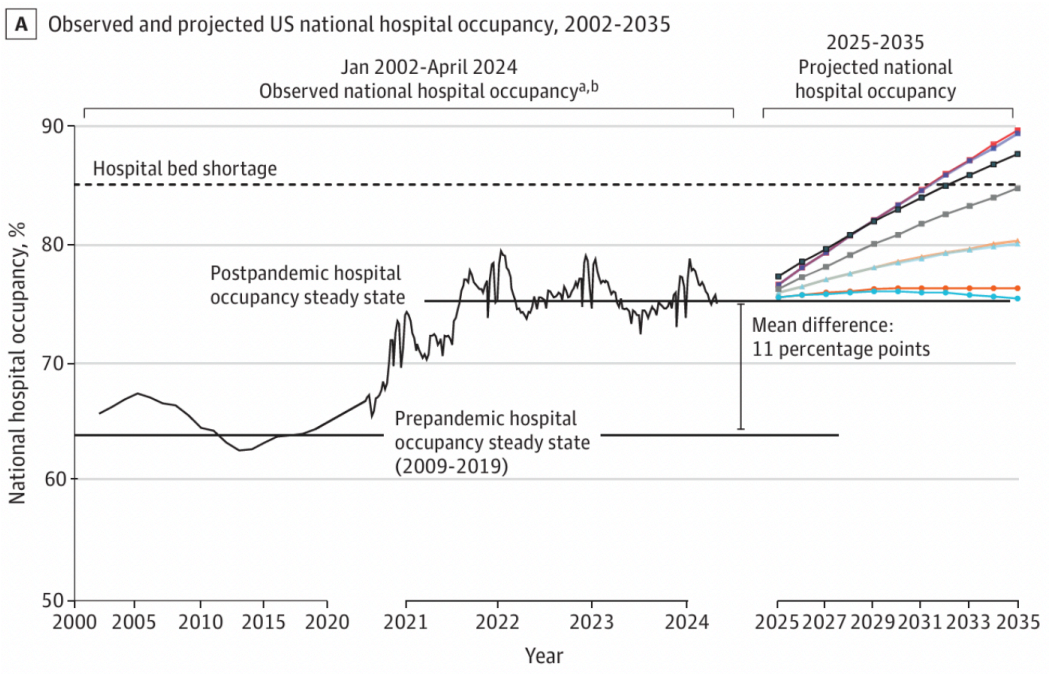
ED boarding in Connecticut, as well as across the country, is substantial and represents a distinct public health issue. While hospital discharge challenges contribute to this problem, they also have distinct operational, patient care, and financial implications. Our Working Group seeks to provide a comprehensive overview of these interconnected issues and to suggest recommendations to inform future policy and system-level improvements.

These issues have prompted similar efforts to address Hospital Discharge Challenges in other states. Notable efforts that we are aware of include the Oregon Joint Task Force on Hospital Discharge Challenges which convened under legislative authority in 2023, with recommendations submitted as a report in fall of 2024.[1] This report resulted in the passage of Oregon SB 296 which authorized immediate action by "declaring an emergency".[2]

[1] https://www.oregonlegislature.gov/lpro/Publications/Joint%20Task%20Force%20on%20Hospital%20Discharge%20Challenges%20-%20Report%20and%20Recommendations%20(2024).pdf

[2] https://legiscan.com/OR/text/SB296/2025

Figure 1. Observed and Predicted Hospital Occupancy

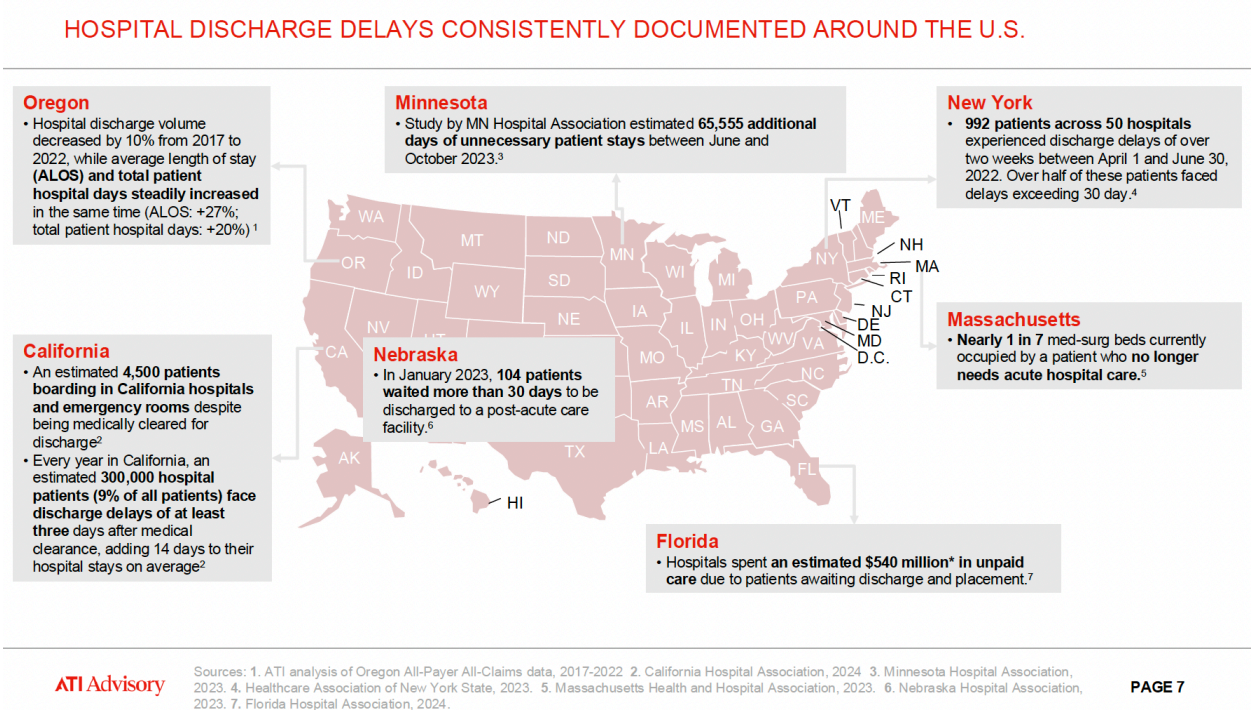


In 2024 Massachusetts recently established the "Transitions from Acute Care to Post-Acute Care Task Force" (TACPAC), which filed a report in the summer of 2025.[3]

Hospital bed availability per capita in the U.S. is among the lowest in industrialized countries, and a JAMA Open piece from February, 2025 predicts significant hospital bed shortages (depending on scenario) as early as 2030 (Figure 1). This is not unique to Connecticut. Data compiled by the ATI advisory group quantifies the issue from states across the U.S. (Figure 2).

[3] https://www.mass.gov/transitions-from-acute-care-to-post-acute-care-task-force

Figure 2. A summary quantifying some of the data from around the U.S. regarding avoidable hospital days (from the ATI Advisory presentation to our group).



There was broad consensus in the Working Group that, as in many other states, hospital discharge challenges in Connecticut represent a significant burden. However, upon querying the Connecticut Hospital Association (CHA), Office of Health Strategy (OHS), and Department of Public Health (DPH), it was determined that there is no systematic, comprehensive, quantitative data available to summarize the number of avoidable hospital days and the specific causes. While it was acknowledged that many hospitals track this data internally, the data is not tracked in a standardized way and is not collected or reported. In the absence of statewide data, the Working Group completed a survey to determine perceived burden and opportunities to address this issue. The results of this survey are summarized in Appendix 1.

Emergency Department Boarding and Hospital Capacity

ED boarding occurs when admitted patients remain in the emergency department due to lack of available inpatient beds. Boarding is associated with delayed diagnosis and treatment, increased mortality, loss of privacy, staff burnout, and reduced emergency response capacity.

In 2025, approximately 1.7 million patients were treated in EDs throughout CT, with 236,123 patients requiring hospital admission. Of this group of admitted patients, *37.9% boarded in the ED for 4 or more hours*, despite needing inpatient care. Boarding is defined as a patient who is held in the ED for four hours or longer after their admission decision has been made, awaiting the availability of an appropriate inpatient bed. The practice of boarding is detrimental to both patients and staff alike and is the primary driver of ED overcrowding.

Previous assessments related to ED boarding have focused on hospital capacity (and increasing it through the ability to discharge appropriate patients) with the basic premise being that when hospital capacity increases it reaches a point where patients board in the ED. Table 1, below, shows Connecticut hospital boarding and occupancy of available beds in 2024.

While literature suggests that hospital occupancy above 85% is associated with increased ED boarding, boarding may also occur when occupancy is lower. In these cases there may be resource decisions at the hospital level that allow boarding to occur that is not associated with overall hospital capacity. Root causes of boarding when capacity is not the issue should be investigated.

Statewide occupancy metrics have limitations for policy purposes. Aggregate bed counts may obscure the capacity constraints most relevant to ED flow; a more meaningful measure would focus on medical-surgical beds and exclude specialty and distinct units (e.g., maternity, NICU, behavioral health and inpatient rehabilitation) that are not interchangeable with beds used for most boarded ED patients. A separate focus on inpatient behavioral health – including the adult, adolescent, and child populations – would also be warranted.

Recommendation:

- The Connecticut Department of Public Health (DPH) should consider conducting a statewide analysis of how hospital capacity constraints contribute to ED boarding. Particular attention should be given to facilities experiencing disproportionately high boarding relative to available capacity. Statewide occupancy and capacity data reporting standards should be amended to ensure that aggregate occupancy data are separated by clinically relevant bed types. OHS (or equivalent agency) should be directed to include boarding and discharge challenges in its biennial statewide utilization study.

Table 1. CT Hospitals – Boarding and Occupancy of Available Beds. This is 2024 data from OHS and the CHA report.

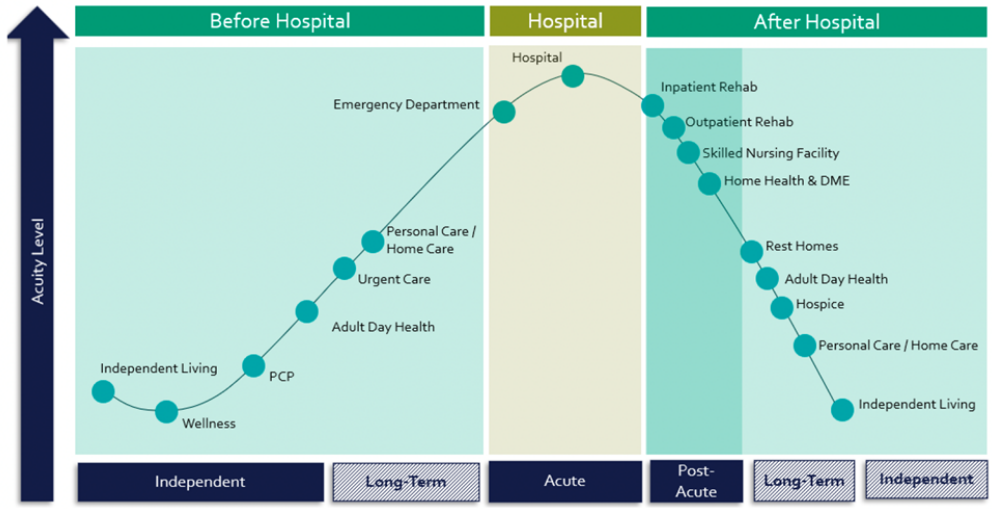
Hospital	Patient Days	Available Beds	Occupancy of Available Beds	Boarding
Hartford	287,294	906	87%	63.1%
Saint Francis	117,801	511	63%	62.2%
Saint Mary's	34,167	190	49%	55.3%
Backus	57,775	205	77%	54.5%
Charlotte Hungerford	28,751	109	72%	53.3%
MidState Medical Center	43,380	156	76%	52.7%
Yale New Haven Hospital	470,998	1,609	80%	46.7%
Day Kimball	13,297	122	30%	40.6%
Rockville	0	60	0%	38.1%
Griffin	32,102	180	49%	33.9%
Middlesex	54,274	235	63%	33.9%
Bridgeport	127,898	460	76%	32.6%
Windham	7,875	81	27%	31.8%
Bristol	25,193	136	51%	30.0%
Hospital of Central CT	81,964	300	75%	29.2%
Manchester	51,276	312	45%	26.9%
Lawrence and Memorial	66,936	259	71%	26.0%
Waterbury	57,621	282	56%	25.6%
Stamford	81,983	330	68%	24.6%
Danbury	94,753	403	64%	22.4%
Norwalk	44,120	230	53%	21.9%
SaintVincent's	94,505	363	71%	21.5%
Johnson Memorial	8,612	63	37%	20.0%
Greenwich	49,628	215	63%	13.6%
CTChildren's	51,787	205	69%	10.5%
Sharon	8,380	65	35%	8.8%
JohnDempsey	62,258	234	73%	8.7%

The Impact of Hospital Discharge Delays

Hospitalization should be reserved for highly ill patients requiring acute medical care. It represents the highest-acuity and highest-cost setting in the healthcare system (Figure 3), and the peak of costs per day. Costs to the hospital per inpatient day vary depending on many factors but are now estimated to exceed $2,500 per day on average.[4]

While hospitals remain essential for acute care, remaining hospitalized when that level of care is no longer required can be detrimental to both patients and hospital systems. At the patient level, prolonged stays increase the risk of hospital acquired infections, falls, delirium, medication errors, and functional decline.[5] Further, literature supports that in addition to most patients preferring to recover in a non-hospital setting whenever possible, it underscores the importance of facilitating discharge once patients are medically stable to improve quality of recovery. At the hospital systems level, unnecessary prolonged hospital stays increase healthcare costs and create downstream capacity constraints that contribute to ED boarding.

Figure 3. Living and care situations and acuity. From the Massachusetts Transition from Acute Care to Post-Acute Care (TACPAC) Task Force Report.[6] These transitions are not necessarily linear, but hospital level care represents the most acute, and most expensive situation.



[4] https://www.statista.com/statistics/630443/inpatient-day-hospital-costs-in-us-by-nonprofit-or-profit/

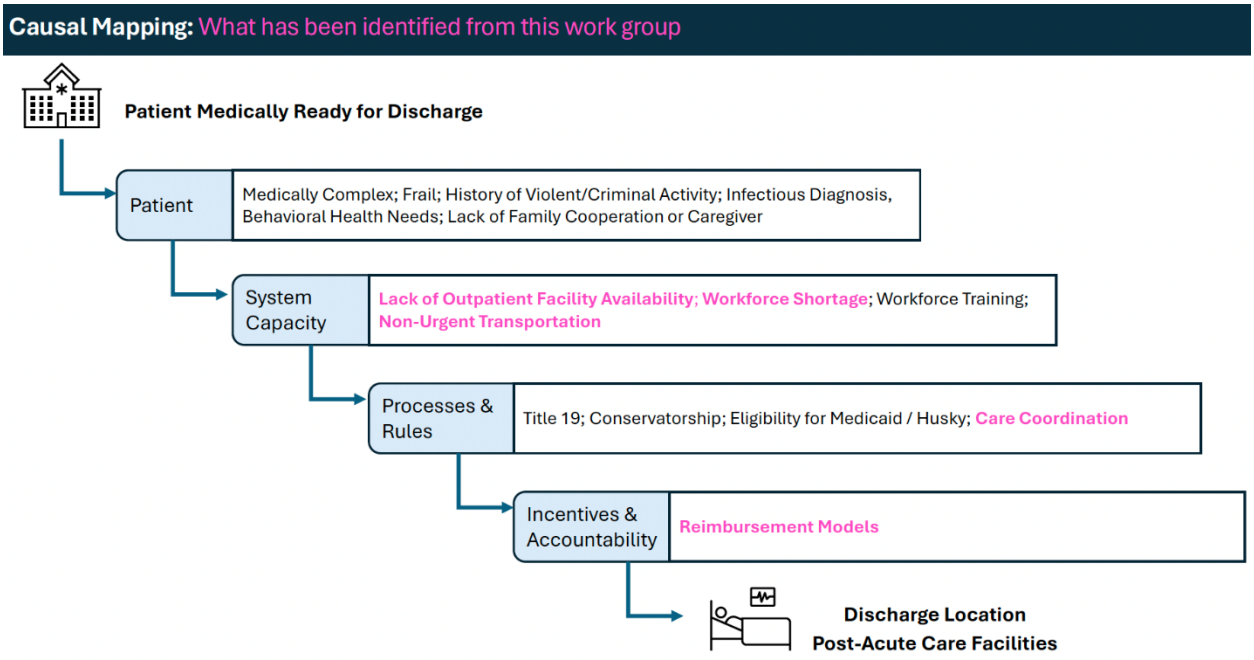
[5] https://pmc.ncbi.nlm.nih.gov/articles/PMC6791742/

[6] https://www.mass.gov/lists/transitions-from-acute-care-to-post-acute-care-tacpac-task-force-report

The challenges associated with discharging hospital patients are complex as they involve multiple layers of factors, ranging from patient-level challenges (medical and social complexities), processes and rules (conservatorship/guardianship issues), system capacity (transportation, workforce and staffing, bed availability) and incentives and accountability (insurance and prior authorization) (Figure 4). However, once a patient is admitted (or even treated as an outpatient in the emergency department), it is incumbent on the hospital to find an appropriate post-acute care placement that is safe for discharge.

The challenges of hospital discharge can be complex, involving patient-level factors, availability of an appropriate situation, capacity and conservatorship/guardianship issues, insurance and prior authorization, and transportation issues (Figure 4).

Figure 4. Causal mapping of delayed hospital discharge.



It should be noted that internal operational inefficiencies such as delayed discharge planning, fragmented care coordination, and administrative bottlenecks also contribute to prolonged inpatient stays for medically stable patients. While these are important and should be pursued by individual institutions, the Working Group specifically chose to focus on external factors that could potentially be alleviated by state-level action.

Avoidable Discharge Delays

An avoidable discharge delay in a hospital is the period of time a patient remains hospitalized after they are medically ready to leave, when the continued stay is caused by non-medical, system-level barriers rather than clinical needs. An avoidable discharge delay occurs when a physician has determined the patient no longer requires acute inpatient care, and the patient cannot be discharged because of external factors unrelated to their medical stability.

Key Elements of an Avoidable Discharge Delay:

- Medically ready for discharge: The patient's acute treatment is complete, and they can safely transition to a lower level of care.
- Non-clinical barrier prevents discharge: The delay is caused by system constraints, not by the patient's medical condition.
- Hospital resources are used unnecessarily: The patient occupies an inpatient bed despite not needing hospital-level care.

Common Causes of Avoidable Discharge Delays:

- Post-acute care placement delays: No available skilled nursing facility, rehab bed, or home health capacity.
- Medicaid or insurance authorization delays: Pending LTSS eligibility, prior authorization, or funding approval.
- Guardianship or conservatorship issues: Legal decision-making authority not yet established.
- Behavioral health capacity shortages: No psychiatric bed or community program available.
- Housing instability: Patient is medically ready but has no safe discharge destination.
- Transportation or logistical barriers: Delays in arranging medical transport or durable medical equipment.

Key Drivers for Discharge Delays in Connecticut and Recommendations

As previously noted, while hospitals report significant avoidable delays, Connecticut lacks standardized statewide data on avoidable hospital days and discharge delays, including the number of patients medically ready for discharge but unable to leave, reasons for discharge delays, duration of avoidable hospital days, and impact on ED boarding and inpatient capacity. The identified barriers and recommendations are based on available data and the collective experiences of the Working Group.

Medicaid Underfunding and Application Approval Delays

Medicaid underpayment has been a persistent and unresolved problem in Connecticut, with significant consequences for the healthcare system and the communities that hospitals serve. In FY 2024 alone, hospitals absorbed $1.46 billion in losses due to inadequate Medicaid reimbursement, straining their ability to sustain services. EDs feel these pressures acutely, as sufficient reimbursement directly affects access to timely care. This longstanding underinvestment undermines multiple parts of the care continuum, including workforce stability, facility operations, and patients' ability to obtain needed services, leaving hospitals to shoulder growing financial and operational burdens.

Medicaid underpayment also influences the number of available post-acute care beds (e.g., skilled nursing facility). Some post-acute care locations limit the number of Medicaid patients they take at any given time to balance financial pressures, limiting the number of beds available. These patients may wait in the hospital for days or weeks before being placed, occupying a bed that could be available to patients boarding in the ED.

In addition, protracted eligibility determinations for Medicaid long-term services and supports (LTSS), including community-based services and programs like Money Follows the Person, can delay the discharge of patients who are medically ready to leave the hospital, forcing them to remain in acute care beds while coverage and service plans are finalized. These administrative delays contribute to constrained inpatient capacity and exacerbated ED boarding by reducing the availability of beds for new admissions and slowing patient throughput. Streamlining LTSS eligibility processes, expanding presumptive eligibility pathways, and accelerating transitions under programs like MFP would help align discharge timing with clinical readiness, improve capacity, and strengthen patient flow.

Recommendations:

- DSS should be directed to implement a structured, statewide process to evaluate and improve communication with hospitals. This process should include: (1) developing and administering standardized surveys and facilitated focus groups in partnership with the Connecticut Hospital Association (CHA); (2) identifying specific points in the Medicaid eligibility and authorization workflow where communication gaps contribute to discharge

delays; and (3) publishing a set of recommended process improvements and measurable performance targets.

- The state should prioritize Medicaid funding in areas that reduce avoidable inpatient utilization and support more efficient transitions of care, thereby improving resource stewardship. Consideration should also be given to create a temporary payment method for post-acute care while applications are processing to precent bottlenecks in hospital systems and encourage patient throughput.
- DSS should be directed to conduct a focused feasibility study on adopting presumptive eligibility for LTSS, enabling faster placement and reducing avoidable hospital discharge delays. The Working Group makes note of Oregon Senate Bill 296 LTSS Eligibility Dashboard as a potential model for consideration.[7]
- DSS should be required to track and report funding-approval delays specifically for patients awaiting hospital discharge, including the time from application submission to decision, and to do so in a streamlined way that avoids added administrative burden. The effort should also identify incentives for skilled nursing facilities and short-term rehab providers to accept patients while applications are pending—such as interim payment mechanisms, risk-sharing arrangements, or temporary reimbursement guarantees—to reduce avoidable discharge delays. Consideration should be given to reinstating the program where eligibility services workers were placed in hospitals to expedite application processing.

Guardianship and Conservatorship Delays

Delays in the probate court guardianship and conservatorship process often impede timely hospital discharge for patients who lack capacity and have no authorized decision-maker, forcing hospitals to retain medically stable individuals in acute care beds while legal authority is obtained. The probate court does not currently identify or track which of their pending applications is for currently admitted hospital patients. These delays, which can take weeks to months even when a willing guardian or conservator has been identified, constrain inpatient capacity, slow patient throughput, and increase ED boarding by reducing the availability of beds for new admissions. Streamlining and expediting the appointment of guardians and conservators for hospitalized patients through statutory or procedural reforms would help align discharge timing with clinical readiness, improve hospital capacity, and reduce boarding in the ED.

Recommendations:

- The Probate Court should establish a formal, structured engagement process with hospitals to identify and address probate-related barriers that delay hospital discharge. This process should include: (1) convening regular meetings with hospital discharge leaders to review operational challenges; (2) mapping points in the conservatorship and guardianship workflow that contribute to discharge delays; and (3) developing and implementing process improvements, including standardized communication protocols and expedited pathways for hospitalized individuals.
- The Probate Court should collect and report key data for hospitalized applicants—including application type, volume, and time to resolution—to illuminate legal-related barriers that

[7] https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureAnalysisDocument/87606

prolong discharge and identify where process improvements are most needed. The Probate Court should include a summary of relevant data, identified challenges, and potential solutions in its biennial report to the Legislature to support informed policymaking.

Prior Authorization Delays

Delayed payer authorizations for post-acute care transfers create avoidable hospital days that drive up costs, reduce bed availability, and worsen patient flow. These delays increase length of stay, contribute to ED boarding, and strain hospital operations. Research shows that avoidable days make up roughly 22% of all hospital days nationally, and prior authorization barriers are a well-documented cause of care delays and higher systemwide costs. Key impacts include financial strain, operational disruption and quality and safety risks. Hospitals absorb higher variable and overhead costs for each excess day, lose revenue when beds cannot turn over, and face millions in annual opportunity losses when actual length of stay exceeds expected length of stay. ED boarding increases, hospitals may divert patients, and throughput slows as case managers spend disproportionate time securing authorizations instead of coordinating care. Longer stays heighten exposure to hospital-acquired infections, falls, and pressure injuries, and increase readmission risk due to delayed transitions and fragmented handoffs. Patients and families face frustration, delayed recovery, and social or financial hardship when discharge is postponed despite medical readiness. Total cost of care rises, post-acute providers face repeated reassessments or bed-holding pressures, and regulators are tightening oversight of prior authorization practices due to documented harm.

Recommendation:

- The State should consider revising CGS 381-591d to shorten the timeframe for health carriers to decide prospective or concurrent review requests, reducing the current seven calendar day period to three business days from receipt of the request.

Post-Acute Care Capacity Constraints Across the Continuum

Limited Behavioral Health Capacity

The behavioral health population faces distinct challenges both inside and outside the emergency department. Limited outpatient capacity continues to drive ED utilization, including repeat visits and readmissions. Discharging behavioral health patients whether from the ED or an inpatient unit requires far more coordination and resources than for other patients, often involving placement in specialized inpatient or longer-term recovery settings. As a result, behavioral health patients experience significantly longer lengths of stay, with even greater delays for children.

In 2025, behavioral health patients spent an average of 30 hours in the ED - 131% longer than non-behavioral health patients. Pediatric behavioral health patients waited even longer, averaging 38 hours, due in part to the limited number of hospitals equipped to admit them and the statewide shortage of appropriate placement options. These delays are further compounded by the additional coordination required among families, schools, and agencies such as DCF, making timely transitions of care especially difficult for children.

Recommendation:

- The state should build on its current behavioral health investments and take additional steps to expand access to care. This includes creating stable, sustainable Medicaid rate structures for new services such as children's behavioral health urgent crisis centers, statewide emergency mobile psychiatric services, adult mobile crisis teams, and other community- and school-based programs. The state should also move forward with Medicaid reimbursement for the Collaborative Care Model (CoCM)**,** as authorized under CGS Section 17b-307a. In addition, the state should allocate targeted funding to support timely, safe discharge for individuals who need home-based, community-based, or outpatient hospital services.

Workforce Shortage Challenges

Workforce shortages slow down the entire discharge process, making it harder for hospitals to move patients out of inpatient units and contributing directly to ED boarding. When there aren't enough nurses, case managers, or post-acute care staff, discharge planning takes longer, beds remain occupied, and patients who are ready for admission from the ED have nowhere to go. Staffing gaps in post-acute facilities add another layer of delay, since many cannot accept new patients without adequate personnel. These combined pressures create longer waits, reduced capacity, and mounting strain on both ED and inpatient teams.

Recommendation:

- The state should continue to assess workforce shortages that impact post-acute care placement and prioritize support for initiatives that strengthen this segment of the healthcare workforce, including but not limited to state and federal initiatives aimed at the shortage

included the CMS Nursing Home Staffing Campaign, Rural Health Transformation Program and the Office of Workforce Strategy.

Housing Instability

Patients who are homeless or experiencing unstable housing often cannot be discharged to lower-acuity settings—such as home care, rehabilitation, or other post-acute services—because they lack the stable living conditions and financial supports needed for recovery and follow-up care. Limited availability of medical respite beds, supportive housing, and community programs that can manage both medical and behavioral health needs further constrain discharge options. As a result, individuals who are medically ready to leave the hospital may remain admitted solely due to the absence of safe alternatives, tying up inpatient capacity and worsening emergency department boarding and crowding. Addressing these barriers will require coordinated, cross-agency strategies that expand community capacity and better align healthcare, housing, and social service resources to ensure safe, timely transitions of care.

Expanding supportive housing, crisis respite, and intensive community care management programs is essential to pairing mental health and substance use treatment with stable, practical housing options. Models such as rapid rehousing and recovery-focused housing treat safe shelter as a core component of the recovery process, ensuring that individuals have the stability needed to engage in care. These programs also give hospitals the ability to develop safe, appropriate discharge plans, knowing that a reliable community safety net is in place to maintain treatment continuity and prevent avoidable readmissions.

Recommendations:

- The Connecticut Department of Housing (DOH) should be directed to establish a formal partnership with hospitals and Coordinated Access Networks (CANs) to expand discharge-appropriate housing options. This directive should include: (1) creating a statewide protocol for identifying and prioritizing medically ready patients who lack safe housing; (2) developing and implementing rapid-placement pathways, including short-term medical respite and transitional housing options; and (3) identifying regulatory, funding, and capacity barriers that impede timely discharge.

- The state should create and expand supportive housing programs, crisis respite, and intensive community care management that offer hand-in-hand mental health and substance use clinical services with practical, safe housing respite.

Need for New and Innovative Care Models

Alternatives to Skilled Nursing Facilities

While trying to address capacity issues can help with the supply side for appropriate hospital discharge options, providing or trying to push for alternate lower acuity options may also help.

Connecticut represents the highest utilization of SNFs in the country, with a 29.7% utilization rate (compared to Alaska, the lowest, at 7.2%).[1] If this care could be provided at home, rather than in a SNF, it could potentially be more economical as well as alleviating facility capacity issues.

Massachusetts is currently several initiatives to establish "skilled nursing facilities at home".[2] There are certainly patients who need a skilled environment, but a portion of those patients could do well at home with the right resources in place.

Recommendation:

- A pilot should be launched to test home-based alternatives to facility placement, with a focused review of reimbursement barriers, Medicare Advantage plan design constraints, and the financial impact on patients. Examples include intensive transitional care at home including non-skilled services.

Mobile Integrated Health (MIH) Programs

A mobile integrated health (MIH) program supported by a state Medicaid agency is a community-based care model that uses mobile clinical teams—often paramedics, nurses, and other licensed providers—to deliver medical and behavioral health services directly in patients' homes or other non-hospital settings. These programs are designed to fill gaps between primary care, emergency care, and post-acute services, and they operate in coordination with hospitals, clinics, and other healthcare providers.

MIH programs provide out-of-hospital care using mobile clinical teams, often led by community paramedics. They support patients with chronic conditions or recent hospitalizations by offering in-home assessments, treatments, and follow-up care that help prevent avoidable ED visits and readmissions. They also deliver urgent or unscheduled care in the home for patients who might otherwise seek emergency services, and coordinate with healthcare facilities to ensure continuity of care and improve outcomes.

When a state Medicaid program funds or authorizes MIH services, it establishes reimbursement pathways for community paramedicine or mobile urgent care visits, and covers in-home clinical services such as assessments, medication administration, chronic disease monitoring, behavioral health support, and post-discharge follow-up. These services help to reduce avoidable ED utilization by paying for lower-cost, community-based interventions that stabilize patients where they live and improve access for patients with mobility challenges, chronic illness, behavioral health needs, or limited transportation. MIH programs help to reduce ED crowding by diverting

[1] https://skillednursingnews.com/2025/07/skilled-nursing-admissions-stabilize-but-growth-of-medicare-advantage-leads-to-5-3-drop-in-ffs/

[2] https://medicareadvocacy.org/skilled-nursing-facility-at-home-care/#:~:text=A%20key%20motivation%20for%20the,nursing%20home%20bed.%20A%202022

non-emergent cases to in-home care and lower total cost of care by preventing hospitalizations and readmissions.

Recommendation:

- DSS should be directed to establish clear reimbursement pathways for mobile integrated health (MIH) services, enabling alternative care models that lower inpatient use and support timely, safe discharge.

Conclusion and Acknowledgements

Hospital discharge delays are systemwide constraints that affect patient outcomes, ED boarding, and the efficient use of healthcare resources. Addressing these challenges requires coordinated, cross-sector action and sustained investment in capacity, workforce, and data infrastructure.

Limited state resources have been directed toward addressing the underlying drivers of ED boarding, even though the issue itself is longstanding. Legislative and agency efforts have largely focused on collecting data about challenges with clearly identified contributing factors that are already well understood, rather than investing in solutions that would meaningfully reduce boarding. Consistent with the recommendations outlined in CHA's 2025 ED Boarding and Crowding Report submitted to the Public Health Committee on March 1, 2026, this Working Group encourages the Connecticut General Assembly to invest state resources into solutions that address the issues identified and the hospital discharge challenges that directly contribute to prolonged ED boarding.

There are few responsibilities of a society that are more important than ensuring access to appropriate healthcare for all our residents. Patients in our emergency departments and hospitals are the sickest of our citizens.

It is the hope of the Working Group members that the recommendations presented can help move us closer to our goal of providing timely, equitable and dignified care to all residents of our state in an economically sustainable fashion.

Collectively as a state, spending resources and funds on avoidable hospital days is not a good use of our resources and we feel addressing this should be a long-term priority for the state. It is also not good patient care, as patients who remain in the hospital longer than they need to face the possibility of increased health complications and a living situation that is not optimal.

The Working Group members would like to thank the Connecticut General Assembly, particularly the Public Health Committee, for their vision in establishing this Working Group. The Working Group members would also like to thank all members of the Connecticut Emergency Department Boarding and Crowding Workgroup who participated consistently over more than a year and donated their time to this endeavor. There are many talented people in our state who remain available to donate their time to a worthy cause should their expertise be asked moving forward. However, it is incumbent on the Legislature and the Executive Branch State Agencies to acknowledge and prioritize solutions to this public health issue.

Finally, the Working Group would like to acknowledge all the people who work tirelessly in hospitals day and night to provide quality care for those who need it most, often in very challenging circumstances.