WHITEPAPER

Clear the Discharge Bottleneck

How hospitals move medically ready patients home faster, without adding a single case manager

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AT A GLANCE

Get Ready Patients Out the Door, and Keep Every Choice With the Family

Every hospital has them. The patient is medically ready, the bed is needed, and the discharge is stuck on one question nobody on the floor has time to answer. Where does this person go next?

For a large share of older patients, the answer is a senior living community, a memory care neighborhood, or care at home. Finding the right one, at the right price, with an opening this week, is work the family rarely knows how to do and the case manager rarely has hours for.

This paper lays out what those stalled days cost, why placement is so often the holdup, and how a free, family-facing placement partner gives your case management team hours back while keeping every choice in the family's hands.

41%	$1.1B	89%
of Medicare hospital discharges are followed by post-acute care [1]	in avoidable inpatient cost from patients awaiting discharge, in one state in one year [2]	of case managers are registered nurses [3]

THE COST

Every Stalled Day Has a Price Tag

When a patient is ready to leave and can't, the hospital keeps paying for a bed it can't give to the next patient waiting in the emergency department.

Florida hospitals reported about 117,000 patients who stayed more than a day past medical readiness in a single year. That added up to more than 403,000 avoidable days and roughly $1.1 billion in avoidable cost, at an average of about $2,800 per inpatient day. Patients stuck longer than ten days stayed an average of almost 19 extra days. [2]

The pressure is national. Average length of stay for patients discharged to post-acute care rose nearly 24% between 2019 and 2022, according to Strata Decision Technology data published by the American Hospital Association. [7]

The cost doesn't stop at the bed. ED boarding grows, admissions get pushed, and readmission pressure waits on the other side of every rushed discharge. For fiscal year 2026, 240 hospitals faced Medicare readmission penalties of 1% or more, and roughly seven in ten more faced smaller penalties. [5]

THE PRICE OF A PATIENT WHO IS READY TO GO

403,000+	$2,800	18.9 days
avoidable days in one state, in one year	**average cost** per inpatient day	**extra stay** when a delay runs past ten days

Source: Florida Hospital Association, 2025 Patients Awaiting Discharge

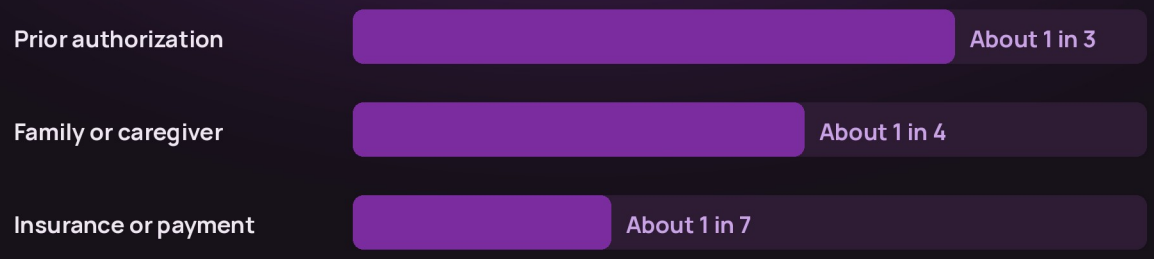
THE HOLDUP

Why Placement Is So Often the Holdup

A study of general medicine patients across 16 U.S. hospitals found nearly one in ten stuck at least a week past medical readiness, and 82% of them were waiting on a discharge resource outside the hospital's control. Those delays took up at least a fifth of all patient-days. [4] In Florida, family and caregiver issues stood behind about one in four delayed patients. [2] Behind most of those numbers is the same problem, a family that needs help finding the next setting.

WHERE STALLED DISCHARGES GET STUCK

Share of delayed patients, by reason



Source: Florida Hospital Association, 2025 Patients Awaiting Discharge

- The family is starting from zero. Most have never compared assisted living, memory care and home care, and they're making the decision in days instead of months.
- Cost confusion slows every decision. Many families assume Medicare will pay for assisted living, and it doesn't. That surprise alone can stall a discharge while the family regroups.
- Openings move fast. The community that fits on Monday may be full by Thursday.

- Tours, paperwork and move logistics fall on adult children who are working, often from another state.

None of this is clinical work, yet it lands on clinical staff.

YOUR TEAM

Your Case Managers Are Nurses. Let Them Work Like It.

Nearly 89% of case managers are registered nurses. [3] Every hour one of them spends calling communities about openings, explaining what assisted living costs, or coaching a family through a tour is an hour away from clinical assessment, care coordination and the discharges that truly need their expertise.

When a placement partner takes the family's search off their desk, the case manager keeps ownership of the discharge plan while someone else does the legwork.

THE PARTNER

What a Placement Partner Does for Your Families

My Senior Care Advisors works directly with families, at no cost to them, to find the right next setting.

- Talks with the family about care needs, budget, location and timing
- Presents multiple matched options from a nationwide directory of senior care communities and services
- Helps families compare assisted living, memory care, independent living and home care
- Guides families through Medicare questions and VA benefits that can help pay for care
- Points families to state inspection records so they can check quality for themselves
- Supports families bringing a loved one home with caregiver training resources

The family gets an advisor. Your team gets a resource it can hand off with confidence.

COMPLIANCE

Built to Protect Patient Choice

Discharge planning rules require hospitals to help patients choose post-acute providers using quality data, and they bar hospitals from steering patients toward particular providers. [6] A placement partner should make that easier, never harder. Here is how MSCA works with that in mind.

- Families always see more than one option, including communities that have no financial relationship with MSCA.
- MSCA is offered as one optional, free resource. It never replaces the hospital's own required provider list.
- MSCA never pays, gifts or rewards hospitals or their staff for referrals.
- Communities in our network pay MSCA when a family chooses them, and we tell families that up front. Families pay nothing.

Your compliance team should review any new resource added to discharge materials, and we welcome that review.

NEXT STEPS

Put It to Work This Week



1. Add MSCA to your discharge resource packet as an optional free resource for families exploring senior living or care at home.
2. Request the free Family Handoff Kit, a printed card with our direct line and a QR code that case managers can hand families at discharge.
3. Give your team one simple line to use. "If you'd like help comparing senior living options, this free advisor service can walk you through them."
4. Call us directly when a family needs help fast.

ABOUT US

About My Senior Care Advisors

My Senior Care Advisors connects families with compassionate, quality care, and never charges families for its advisory services. Families get a real advisor, matched options and guidance on paying for care, from the first call through move-in.

MSCA is an RN Network company, part of the same family as **The RN Network**, which serves nurses and the healthcare organizations that hire them.

REFERENCES

Sources

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[7] American Hospital Association, Issue Brief, Patients and Providers Faced with Increasing Delays in Timely Discharges, Dec. 5, 2022. https://www.aha.org/issue-brief/2022-12-05-patients-and-providers-faced-increasing-delays-timely-discharges

Request Your Free Family Handoff Kit

Call **(614) 818-5150** or visit **myseniorcareadvisors.net**. Families can scan the code to reach a free advisor directly.