Dear Dr. Jeff:

Our skilled nursing facility was recently called in for an unpleasant meeting with our major referral hospital because their statistics showed an unacceptable 30-day readmission rate for subacute patients discharged to us. This came as a surprise because our statistics showed fewer hospital returns. But it appears that many patients we had discharged home wound up back in the hospital. Any suggestions?

Dr. Jeff responds: Most of the focus on problematic transitions in health care has been on hospital discharges. Certainly, tremendous opportunities for improvement still exist here. Anyone who works in long-term care has a horror story of a patient who spent weeks in the intensive care unit and is discharged late Friday night to a subacute facility without even an accurate medication list, much less a discharge summary or a direct professional-to-professional telephone call. The process of transfer back into the community may be worse. Even though the sicker, frailer and more unstable patients are referred to subacute facilities, while healthier and more functional patients are discharged home with home care, the readmission rates for common diagnoses, such as congestive heart failure (CHF), are higher for those referred to certified home health agencies than for those referred to skilled nursing facilities (SNFs).

Unfortunately, the discharge process from SNFs often is no better than the discharge process from hospitals. This represents a significant threat to the long-term viability of such programs and is obviously a major quality-of-care concern.

Increased Accountability

A wide variety of traditional nursing home approaches to care need to be re-examined if residents are to be properly prepared for return home. Of course, the mechanics of the actual discharge require attention, but truly effective change also must include:

▶ A thoughtful reevaluation of the resident’s clinical status and goals of care
▶ New approaches to patient and caregiver education
▶ Rethinking policies on medication self-administration
▶ Simplifying and streamlining medication regimens to encourage compliance
▶ Elimination of procedures and technologies that the patient won’t be able to master after discharge
▶ Effectively communicating significant information to future care providers.

In February, the Office of Inspector General, U.S. Department of Health & Human Services (OIG), issued a 30-page report entitled, “Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements.” Based on a stratified sample of 245 Medicare-covered stays from 2009, the document concluded that 37% of stays didn’t meet care planning requirements, and 31% of SNF stays didn’t meet discharge planning requirements.

Extrapolating these findings to the national experience, OIG calculated that in 2012, Medicare paid $5.1 billion for stays that didn’t meet basic quality-of-care requirements. Almost one-quarter of discharges didn’t include post-discharge plans, discharge summaries, or documentation of discharge status.

Reconsideration of the need for medications often occurs only at discharge, when writer’s cramp leads to doubts about the need for various medications.

Unsurprisingly, OIG asked the Centers for Medicare & Medicaid Services (CMS) to strengthen regulations and oversight, including a request to “increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable.” CMS agreed to these recommendations including linking payments to these quality issues, providing more regulation and guidance, and following up on SNFs that fail to meet requirements.

New payment methodologies, such as bundled payments and Accountable Care Organizations, also will increase pressure on subacute rehabilitation programs to improve the discharge process, as if the threat of survey deficiencies and Medicare audits weren’t enough. As with many other aspects of quality care, meeting minimum requirements is still a long way from best practices.

Regard your meeting with the hospital as a useful wake-up call.

Missing Essential Information

The minimum required elements of a discharge summary should cover the events that occurred during the stay, the patient’s status at discharge and the discharge plan of care. The plan of care should be formulated in collaboration with the resident and the family and should include discharge instructions regarding treatments needed, diet, medications, level of activity, educational needs and how future care coordination will be planned. The discharge summary ideally should be given to the resident and transmitted to future care providers.

All too often, discharge planners mistakenly think they’ve met these requirements by handing the patient a medication list, a sheaf of prescriptions, a list of the equipment ordered, and the name and telephone number of the home care agency. The anticipation is that the home health care nurse will educate the patient, even when the patient is multiple steps away from the actual events of the initial hospitalization with minimal access to any of the findings, underlying prognosis and care plan.

For example, when a home health care nurse first encounters a patient in the community who is breathing rapidly, that nurse needs to know whether or not that is the baseline for this patient. Does the patient need a nebulizer treatment, reassurance or an extra dose of diuretic? If the patient is terminally ill, should the nurse consider a hospice referral? Absent the essential information, the only reasonable solution is a referral back to the hospital emergency department with the inevitable readmission.

Pay Attention to Self-Care

Multiple studies have identified several key factors that predict hospital readmission for medical conditions, such as CHF. Self-care practices play a major role. These include the patient’s ability to maintain physiological stability through adherence to a medication regimen, diet, exercise and symptom monitoring. A patient’s ability to successfully achieve self-care practices could be limited by several factors such as inadequate patient education, cognitive limitations, low health literacy, poor motivation and depression, and inadequate finances to afford elements of the care plan.

Most of these risk factors could be modified, in theory. Yet, despite the tremendous concentration on readmission for CHF, remarkably little change has occurred in CHF readmission rates over the last several years.

Another discharge planning activity that deserves attention is the simplification of drug regimens. Polypharmacy is a known risk factor for drug-drug interactions, falls, excessive exposure to anticholinergic medications and noncompliance. Reconsideration of the need for medications often occurs only at discharge, when writer’s cramp leads to doubts about the need for various medications.

Medication reconciliation is a process commonly misinterpreted to mean one care setting replicating the medication regimen of the previous setting. In the SNF, the receiving practitioners are physicians and nurse practitioners who are experienced in providing quality care to frail seniors, certainly not the norm in the hospital setting. We should not feel obligated to mimic hospital practices for subacute patients.

Build in Time for Education

Provide enough time for education and review of discharge prescriptions to allow for adjustments and monitoring. Offer the opportunity for residents to express concerns regarding the medication regimen several days before discharge.

For instance, a patient who can’t manipulate a metered dose inhaler with a spacer or use a disk medication device properly instead should be trained in the use of nebulizers.

Residents in a nursing home have the right to self-administer medications if they so choose and if judged capable by the interdisciplinary team. Yet, largely for staff convenience, few short-term residents actually self-administer medications. How can we feel comfortable that the patient will be able to take the medications accurately when at home, if he can’t do it under supervision with us?

Additional practitioner education regarding medication cost and drug plan coverage also could encourage compliance in a health system in which many prescriptions are never filled or patient usage is minimized to save money.

Facilitate Follow-Up Appointments

A follow-up appointment with a community practitioner shortly after discharge is another powerful predictor of ability to maintain stable care in the community. It isn’t sufficient to advise residents upon discharge to call their primary care physicians when they get home.

We need to ensure that the appointment is made before discharge, especially for those with multiple medical comorbidities. This allows for the transmittal of the discharge information directly to that provider and identifies a contact practitioner at the nursing home.

Medicare calls its nursing home benefit “extended care services.” But an effective short-term program shouldn’t simply imitate hospital services in a less expensive setting. Nursing homes must learn to provide a safer and better transition back to the resident’s other home in the community.

Dr. Nichols is president of the New York Medical Directors Association. Comment on this and other columns at www.caringfortheages.com under “Views.”