Dear Dr. Jeff,

We have had a strange problem on our post-acute unit. Residents are fighting against and appealing discharge dates. Sometimes these are the same patients who had been most dissatisfied at the hospital's original decision to transfer them to us. All have met the rehabilitation goals established on admission. This phenomenon has increased the average length of stay on the unit, which our administrator follows closely. Do we just have difficult patients or are we doing something wrong?

Dr. Jeff responds:

Your problem is neither unique nor strange, and may not even be a problem. Certainly, a facility whose residents don’t want to go home must be doing something right, and must be meeting residents’ needs as the residents perceive them. If a resident might benefit physically or emotionally from a slightly longer stay, and can get their insurance to pay for it or is prepared to pay personally, that doesn’t seem so terrible.

Patients are understandably fearful about proposed transfers from the hospital to a post-acute facility. Discharge planners in the hospital try to provide reassurance that a skilled nursing facility isn’t a nursing home, while families who have promised never to send Mom to “one of those places” may try to disguise the truth. But seniors still know that they are going to one of those snake pits they have read about in tabloids where confused old people sit endlessly in dirty diapers calling for help that never comes. Spruced-up names abandoning anything that sounds like long-term care and refurbished lobbies with chandeliers don’t fool anyone. The ambulance ride to the nursing home may well take them past a roadside billboard offering legal services for those injured by nursing home neglect.

Those of us who work in long-term care understand the wonderful work that is done every day on post-acute units. But for the general public, the nursing home remains one short step above the county asylum or the U. S. Congress on the list of filthy, dangerous, and frightening places to be avoided. It should be no surprise that patients fight to not become residents.

If these same patients or their families read the medical literature on transitions of care, they might well be even more afraid. Wrong or missing diagnoses, errors transcribing medications, and inconsistent or even missing medication lists plague the transition process. Large numbers of post-acute residents, often one in five or more, rapidly decompensate or develop significant new problems that land them back in the hospital.

Unexpected Surprises

After admission to the nursing home, the picture often quickly changes. Residents discover a caring staff, a gradually improving physical and functional status, and a physical environment designed to meet the needs of a frail patient population. Moreover, their rights as residents often provide services and choices that would not be available to them at home. I vividly remember an elderly wife saying to her husband at his discharge meeting “I’m taking you home, but don’t think for a minute you can choose what you want for breakfast.” Understandably, the balance between the desire to return home as soon as possible and the desire to maximize the benefits of the post-acute stay often shifts.

Although the transition from hospital to post-acute unit appears dramatic to some, it is simply a move from one 24-hour medical facility to another, with comparable services and staffing in place but lacking an operating room and intensive care unit. Not infrequently, the skilled nursing facility is actually part of an attached building or immediately across a street or shared parking lot.

The transfer to home is much more drastic. Routinely available 24/7 assistance from a certified nursing assistant may become 20 hours per week of a home health aide, or less. Any additional care is expected to come from an untrained or minimally trained family member. Often, no home health aide assistance is available for a day or two after discharge, as many insurers or home health agencies will not commit to any services until after the initial nursing assessment at home. Nursing care is no longer available whenever the call bell is pushed. Instead, a limited number of scheduled home visits will be provided, typically for a few weeks with backup from an on-call nurse with an answering service.

Medical care will transfer from an “SNFist” experienced in the medical management of frail patients recovering from an acute illness to a provider who lacks access to the recent medical chart, has not seen the patient since before the acute illness if at all, and is only accessible if the patient’s mobility allows access to the provider’s office. Rehabilitation services are rarely scheduled for the day after discharge, and usually they decrease: from the 8–12 hours per week of combined physical and occupational therapy services provided in sessions 5–7 days per week in the skilled nursing facility to a total of 90 minutes of physical therapy provided in three sessions per week. Faced with these changes, many seniors reassess the functional status they seek before returning home and find themselves suddenly unready to be discharged.

Discharge from the safety of a skilled nursing facility that serves hot meals and offers showers and working toilets may not seem attractive.

Again, their fears are not entirely misplaced. Statistics from home care agencies demonstrate the hospital readmission rates for diagnoses such as congestive heart failure and chronic lung disease are higher than those from skilled nursing facilities.

AMDA – the Society for Post-Acute and Long-Term Care Medicine has a workgroup that addresses concerns regarding transitions of care. They have published a valuable clinical practice guideline and suggested procedures to improve the quality of discharges from a skilled nursing facility to the community, but these cannot compensate for all the gaps within the existing medical system. The Centers for Medicare & Medicaid Services already has funded research using their traditional consultants to address potential quality measures related to the discharge process. These are, by definition, narrowly focused on the process within the nursing home itself.

A multi-stakeholder workgroup recently published a broad overview of the components of comprehensive and effective transitional care including the needs of family caregivers (J Am Geriatr Soc 2017;65:1119–1125). Lead author Mary D. Naylor, PhD, from the University of Pennsylvania School of Nursing and the expert panel from Project ACHEVE (Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence), identified eight transitional care components: patient engagement, caregiver engagement, complexity and medication management, patient education, caregiver education, patients’ and caregivers’ well-being, care continuity, and accountability.

Failures to address many of these components leave residents frightened to return home. For example, many post-acute units begin education regarding discharge medications on the day before or the day of discharge, reviewing them once with the patient and family caregiver.

Even when a teach-back method has been used, patients being discharged from the hospital to a skilled nursing facility were less likely to be able to correctly answer simple questions about disease management for congestive heart failure than those being discharged home.

More time spent completing the education process is associated with better information retention (J Cardiovasc Nurs 2013;28:137–146). Patients discharged from a post-acute unit back to the community need even more time for education. When the medication regimen is extremely complex, with 10 or more medications given on different schedules, even the most competent caregiver is likely to feel unprepared for discharge after a single educational session.

No Place Like Home

For many seniors, home is not a safe place. Dangerous neighborhoods or buildings, food “deserts,” and rural areas that require driving ability to access supplies or assistance are common. Seniors generally live in housing that met their needs many years ago, with half living in the same location for 20 years or more. Many others live in housing with steep stairs, often without railings, or with uneven or cracked floor boards, leaking roofs, exposed electrical wiring, inadequate plumbing, or other hazards. Although orders for a certified home health agency often request a home safety evaluation as part of the initial nursing visit, this evaluation may not accomplish much if no repairs can be made. Consequently, discharge from the safety of a skilled nursing facility (perhaps even air-conditioned, but certainly physically safe and protected with fire sprinklers) that serves hot meals and offers showers and working toilets may not seem attractive.

Discharge decisions are frequently dictated by insurance plans rather than set by a mutual decision among the resident or family, the physician, and the facility. Many managed care plans will routinely deny inpatient services for a patient who can transfer independently and walk 50–100 feet with a walker. This is considered the maximum required to get from the bed at home to the bathroom and kitchen, thus seeming to meet the essential needs of sleeping, eating, and voiding. Unsurprisingly, many residents will not find this an adequate functional recovery to feel safe at home. This meager standard is frequently insufficient to allow access to the physician’s office for the follow-up visit that was appropriately scheduled for 7 days after discharge.

Discharges to an essentially home-bound status are considered safe, but
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Length of stay is a poor measure of quality. This statistic is highly dependent on the complexity of care required by the resident. Increasingly, the simple, uncomplicated admission (e.g., a knee replacement) with an anticipated short length of stay is being directed to intensive home care programs, while more complex patients with severe functional impairments and multiple comorbidities come to skilled nursing care. Since payment systems still pay by the day, there is no true financial incentive to discharge quickly if further care can be justified and the resident continues to improve functionally. Because reimbursement rates under Medicare are set prospectively (for example, the 30-day Minimum Data Set sets the rate for days 30 to 60), even if care intensity declines, there is no financial penalty for continuing treatment a few extra days to ensure a safe discharge or maximize function.

Although a few hospitals and accountable care organizations do track nursing home lengths of stay, at least for bundled payment referrals, even those measuring costs for an episode of illness may ultimately experience savings.

In short, patient-centered discharge planning is not only quality care that enhances patient satisfaction, it is frequently “doing well by doing good.”

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.

JAMDA Welcomes New Editors

A MDA – the Society for Post-Acute and Long-Term Care Medicine and JAMDA – The Journal of Post-Acute and Long-Term Care Medicine announced the appointment of new JAMDA Editors in Chief: Philip D. Sloane, MD, MPH, and Sheryl Zimmerman, PhD. Drs. Sloane and Zimmerman will succeed retiring Editor in Chief John E. Morley, MB, BCh.

Dr. Sloane is the Elizabeth and Oscar Goodwin Distinguished Professor of Family Medicine at the University of North Carolina at Chapel Hill. Dr. Sloane’s impressive and varied career has included service in settings including nursing homes, dementia care units, group homes for persons with disability, hospitals, PACE [Programs for All-Inclusive Care for the Elderly] programs, office practices, emergency departments, and more. He has more than 200 peer-reviewed publications and has coauthored two popular text books.

“I have always admired the Society for its focus on clinical care of frail, vulnerable older persons,” said Dr. Sloane. “I look forward to helping JAMDA further advance its mission.”

Dr. Zimmerman is a University Distinguished Professor, Associate Dean, and Director of Aging Research, School of Social Work, at the University of North Carolina at Chapel Hill. Dr. Zimmerman is past chair of the Social Research, Policy, and Practice Section of the Gerontological Society of America, has published more than 300 peer-reviewed publications, and is the national leader in assisted living research; in 2016, she was recognized as the nation’s top-ranked social work scholar in the field of aging.

“Moving forward, we’ll encourage submissions in an even broader array of long-term care services and supports, and with clear practice and policy relevance,” said Dr. Zimmerman.

“The search committee chose Drs. Sloane and Zimmerman for their extensive experience and knowledge in the varied settings of post-acute and long-term care, their proven track records as mentors and published authors, and their vision for the future of JAMDA,” said Society Executive Director Christopher Laxton, CAE.