Dear Dr. Jeff: I was making rounds last week when I found a newly admitted resident sitting in the hallway in her wheelchair, crying. I asked if I could help, and she replied, “I don’t belong here. I want to go home.” Of course, I tried to reassure her that she was, indeed, in the right place, but it didn’t sound very persuasive to me and certainly did not convince her. I didn’t even try to argue that the hospital discharge planner had evaluated her, that she scored for SNF, or that her managed care company had authorized her stay. So I left a message for the social worker and continued my rounds. I kept thinking about her all afternoon and wondered what else I might have done. What do you suggest?

Dr. Jeff replies: Without knowing the circumstances surrounding her admission and anticipated discharge, it would be very difficult to provide any reassurance to the lady in the wheelchair sitting in that hallway. However, addressing the dual nature of our services might help our facilities devise programs to prevent the kind of distress that’s being experienced by residents like the unhappy lady you encountered.

The two common names for where we work, skilled nursing facilities and nursing homes, represent the two conflicting aspects of the confusing nature of post-acute and long-term care. Skilled nursing facility emphasizes the institutional nature of care and the technical skills of the employees who work there. Nursing home, as implied by the name at least, emphasizes the person-centeredness of a caring environment. Although the Requirements of Participation (usually referred to as ‘the code’) do not recognize a distinction between short- and long-stay residents, our understanding of their status dramatically affects their care plan and management.

How It Used To Be Many years ago, nursing home admissions were much like those of the better assisted living facilities today. Before admission, the potential resident and family could come to take a tour, look at the rooms, and sometimes eat a sample meal. They then could fill out an application and wait to hear about acceptance and bed availability. Applicants could even specify a preferred floor or wing (“Call me if you get a room on the side facing the park”). Many preferred homes had waiting lists, often months to years long, and applicants were encouraged to join the list when they perceived functioning at home was beginning to become a problem, rather than waiting for a crisis to occur that might lead to hospitalization. When a room became available, the waiting list was searched (and there were often rumors that a gift to the Director of Admissions of the facility could help jump the queue), and an admission was scheduled.

Although the Medicare Extended Care benefit existed at that time, Medicare A stays were rare. In that era before diagnosis-related groups, hospital payments were per diem, and hospitals were reluctant to refer patients to nursing homes when a continued hospital stay could be justified. So, for instance, patients with femoral fractures stayed in the hospital for weeks, where they would receive physical therapy before being discharged directly home (the average length of a hospital stay was 23 days). New York actually implemented regulations (the Medicare Maximization Act) that required nursing homes to bill Medicaid and get a denial on all newly admitted or readmitted dually eligible residents before Medicaid payments would be authorized. Nursing home transfers were not entirely without stress, particularly for patients with memory impairment, but the somewhat familiar surroundings and supportive nature of the process eased the pain of moving and minimized transfer delirium. A variety of floor orientation programs — including welcome signs or floor parties to meet new neighbors — were common. With time for advance preparation, the name of the resident and a recent picture were often in place outside his or her room when the new resident arrived. And, of course, formal introductions were arranged to any roommates, who had been previously informed of the impending admission.

How It Is Now In the modern American hospital, patients are informed that they will go from the hospital to a skilled nursing home as soon as clinical circumstances and their insurance plan authorize it. The receiving facility will be the first one to accept the patient, among the multiple applications to facilities from a list often formulated by the family or the discharge planner rather than the patient. The patients are then bundled into an ambulance along with (one hopes) whatever possessions they had in the hospital and a folder of papers they are instructed to give to the nurse when they arrive.

In my experience, it is not unusual for these new “residents” not to know what facility they are being admitted to, much less its location. This is particularly common for residents with visual or hearing impairments, language barriers, or cognitive impairment. The family might have reassured your new resident when she was in the hospital that she was going to “the nice place where Aunt Emily did so well” when, in fact, she wound up in another facility across town.

Post-acute patients who have been rehospitalized and are being referred back to post-acute care usually return to their prior facility. However, a variety of factors — including bed availability on the day of discharge, a disinclination on the part of either institution to return them to where they may have done poorly the first time, or patient/family dissatisfaction with the first facility — may lead to the patient arriving at a new and sometimes unexpected destination.

The frenzied discharge process sometimes even leads to patients being delivered to the wrong facility. Although admissions processes usually identify and correct these errors, it is not unknown for a patient to arrive after the admissions office has closed, carrying their precious packet of papers to be simply admitted. So it is perfectly possible that the sad lady you encountered was in fact correct: She was not where she thought she belonged.

The fluid and transforming nature of post-acute care also makes identifying who actually belongs in a facility difficult. Many conditions that historically represented indications for post-acute care — such as intravenous antibiotics, complex wound care, or a variety of orthopedic procedures requiring physical and occupational therapy — today could potentially be managed at home. Discharge decisions are based on arbitrary limits to the number of therapy visits that might be performed at home. Thus, post-acute care facilities have benefitted from the lack of high-quality, high-tech home services in many communities.

Also bundled payment models and Medicare Advantage plans have encouraged smooth, rapid discharges and have allowed a waiver of the required 3-day stay to trigger nursing home eligibility. Thus, skilled nursing facilities are left with an increasingly medically complex patient population, a direction which new Medicare payment models appear to encourage. Clearly, these patients may not know geographically where they are, but the basis of the need to place them in an institutional setting seems much clearer.

How It Should Be Major hotel chains employ lobby greeters. They set out bowls of fruit, or hot and cold liquids, or chocolate chip cookies near check-in desks. They call you by your name when they’re giving you directions to your room. They always ask whether there is anything more they can do for you.

The nursing home industry has a lot to learn from the hospitality industry. Much more could be done to orient and reassure patients who are newly arrived in the post-acute setting. For example, at the time that an applicant is accepted and assigned a room, the admissions office should generate a name tag for the room, and that tag should be in place before the resident arrives. Ask if there is anyone they want called to confirm that they have arrived safely. Ask if there is anything they need right away. Depending on the time of day, offer the new resident a meal or a light snack.

Essentially, there should be a series of scripted messages for new residents. These could start with a welcome, the name of the facility, something about the physical location, including both the address and some orienting information (“in case you haven’t been here before”). For instance, “We are on the Anderson Road just past the mall,” or “We are right on the lake — you should have a terrific view in the morning when it’s light.” This would segue directly into the mandatory confirmation of a new resident’s name and a request to know what he or she likes to be called. The staff should literally say, “We’ve been expecting you.” And “the hospital sent us a lot of information about your care there. Dr. Blank will be continuing your treatment from the hospital and will be around tomorrow to check on you as well. He/she might have a few extra questions to ask you or details to check with the hospital.”

Through this process, a friendly greeting is completed. You have confirmed that the newly admitted resident is in the right place — which is warm and friendly place — and that the purpose of the resident’s stay is to complete the treatment started in the hospital. Actual transfers frequently occur in the late afternoon or early evening, so much of the burden of welcoming residents will fall on the evening shift, particularly as admitting physicians are generally not physically present in the facility.
Many nursing homes fill all or most of their long-term beds with residents who had been admitted to the post-acute section but failed to make sufficient progress to go home. Other long-term admissions are hospital patients without the skilled care needs to justify a Medicare A stay, or transfers from other nursing homes. Although new admissions from outside might require most of the same welcome elements as for post-acute care, the message is now thanking them for coming to stay with us.

Unfortunately, many facilities treat in-house transfers from post-acute to long-term as though they were simply room changes. They are, of course, major life events: new roommates, new neighbors, new staff, and a totally new situation in life. We might view a transfer from one floor to another in the same facility as a simple change of room number and payment source — but the residents don't actually live in “our facility.” They live on a unit where they know the unit staff, the unit’s routines and schedules, the unit’s “screamer,” and most importantly “their” certified nursing assistants. For them, moving to another floor is almost like moving to another state.

For long-stay residents, we should revisit some of the successful techniques of the past that supported orientation and comfort in transitions. Those techniques were warm and person-centered. The nursing homes that use neighborhood models would find it easier to support such changes, but even a 40-bed unit could be divided into parts to support social interactions.

Every facility needs a Mister Rogers asking residents to be his neighbor, and every facility needs a welcome wagon to help residents recognize that this is a new home. Many of these tasks could, in theory, be done by the other residents with staff coordination.

Our goal should be to move that lady in a wheelchair from wanting to go home to feeling that she already is home.

Dr. Nicholas is past president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringfortheages.com under “Columns.”

By Christopher E. Laxton, CAE

Let’s Work Together to Make This Flu Season a Better One for PA/LTC Residents

Flu season is officially here, and once again I find myself surprised by the tenacity of the old (and new) myths about the flu shot. (For instance, one that recently moved into the “myth” column is that people with egg allergies shouldn’t get the flu shot.) However, unless we’re prepared to have a repeat of last year’s flu season, which was particularly brutal for the frail older adults living in nursing homes and other post-acute and long-term care settings, we need to take steps now to get ready. Improving the rates of vaccination for PA/LTC health care personnel (HCP) would be a terrific first step.

Here at AMDA – The Society for Post-Acute and Long-Term Care Medicine, we recently updated our guidance on flu vaccination for HCP to make it stronger and more specific:

- We support mandatory annual flu vaccination for all PA/LTC HCP — meaning anyone who is in direct or indirect contact with residents such as employees, contract staff, family caregivers, and volunteers — unless there’s a medical contraindication.
- We encourage care communities to provide education for their work force on the efficacy and safety of the flu vaccine, specifically as an important measure to enhance resident safety. Nursing home medical directors can be very effective here by actively promoting the flu vaccination program in their care communities and meeting with workers who may be reluctant to get a flu shot.
- We recommend that employees who don’t receive a flu shot wear a mask when in direct contact with residents during flu season, as well as receive targeted education to encourage vaccination.
- And, finally, we encourage care communities and corporations to make the flu vaccine available on-site and at no cost to employees and volunteers. This has been shown to improve vaccination rates in our setting.

The Society is working closely with the Centers for Disease Control and Prevention (CDC), the Immunization Action Coalition (IAC), and the National Adult and Influenza Immunization Summit (NAIIS), which are also renewing their efforts to improve PA/LTC HCP immunization rates. Why focus on HCP? You may not be aware of this, but while the vaccination rate for HCP in other care settings is over 90%, in PA/LTC it hovers around 68%. And this is in a setting that is particularly vulnerable to flu outbreaks, with the highest incidence and prevalence of mortality from the flu. We need to do better!

Fortunately, we have some inspiring models of success. A number of our Society members are leading the charge when it comes to HCP flu vaccinations. One of these pioneers is Sabine von Preys-Friedman, MD, FACP, CMD, chief medical officer of Avalon Health Care Group. Headquartered in Utah, Avalon has over 50 care communities in California, Hawaii, Idaho, Oregon, Utah, and Washington, caring for between 3,500 and 4,000 patients at any given time.

When Dr. von Preys-Friedman came on board in 2011, there was no organized employee vaccination program at Avalon. That first year, their employee immunization rate was between 20% and 30% company-wide — leading to hospital readmissions and restrictions for admissions to their facilities. “We actually had significant financial losses,” she said. “At that point the chairman of the company said he didn’t want influenza in our facilities. So I said, ‘Leave it to me.’”

The original plan was to make immunization mandatory for all HCP. For a variety of reasons, that turned out to be not possible for the organization. So, she explained, “We decided on a compromise where people would have to mask up during influenza season unless they were vaccinated. We started out by setting a goal and gave our facilities tools to achieve that goal.” Those tools include explanatory letters, posters, checklists, and monthly webinars.

After the first year, vaccination rates increased dramatically — and they’ve continued to climb since. Most Avalon care communities now have an employee immunization rate of between 85% and 90%. And “we’re always trying to see what we can improve,” Dr. von Preys-Friedman said.

Another HCP flu vaccination pioneer is Gregory Gahm, MD, MS, FACP, who serves as chief medical officer for 30 primarily Colorado-based facilities. He helped write the state regulations that now require vaccinations of 90% of employees by December 31 of each year. “Employees” are defined as anyone with a financial tie to the facility, including staff, providers, vendors, and laboratory and hospice personnel, among others. The regulations also note that anyone who’s not vaccinated must wear a mask during flu season, which in Colorado is November 1 through April 1.

Although Dr. Gahm initially wasn’t a fan of the masks, he now sees them as a “scarlet letter that says, ‘I’m wearing a mask because I’m not vaccinated.’” He’s even written orders stating that no staff person wearing a mask during flu season can take care of his patients, and he has found that to be an effective tool for encouraging HCP vaccinations.

However, he said, his edict that “any employee who refuses to get vaccinated has to meet with me one on one has probably been more effective than anything else. They said, ‘I’d rather take the shot than talk to Dr. Gahm.’”

Earlier I mentioned our work with the CDC, IAC, and NAIS. Thanks to that important work, the IAC has set up a specific honor roll to recognize the leadership of all PA/LTC facilities that pledge to adopt a mandatory flu vaccination program for their workforce. So far only seven facilities are listed, but I know that if we work together we can get those numbers up. Improving HCP vaccination rates will reduce flu deaths for our residents and patients. And the pioneering work of Drs. von Preys-Friedman and Gahm shows us how!


Christopher E. Laxton, CAE is executive director of AMDA – The Society for Post-Acute and Long-Term Care Medicine.