The right stuff? Hospital readmission penalties approaching for nursing home patients

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An older adult. Credit: Julie Turkewitz, courtesy Hartford Foundation

A significant number of older adults are not ready to go home when they leave the hospital. About one-fifth are discharged to one of the nation's

15,000 skilled nursing facilities for rehabilitative care. With new federal legislation set to penalize both the hospital and skilled nursing facility if rehospitalization occurs within 30 days, clinician-researchers from the Indiana University Center for Aging Research and Regenstrief Institute highlight potential problems with the new mandate.

"Hospital Readmission Penalties: Coming Soon to a Nursing Home Near You" by Jennifer Carnahan, M.D., Kathleen Unroe, M.D., and Alexia Torke, M.D., of the IU Center for Aging Research and the Regenstrief Institute appears in the March issue of the *Journal of the American Geriatrics Society*.

Skilled nursing facilities, known as SNFs (pronounced sniffs), are designed for short-term stay following hospital discharge to supply the medical, rehabilitation and other support that family and caregivers are not trained or equipped to provide. In 2012 SNFs received $26.5 billion in Medicare payments.

"By making SNFs more accountable for the care they provide by initiating a 30-day readmission penalty rule, the federal government is advocating for patients," said Dr. Carnahan, lead author of the commentary. "But as physician-researchers, we believe there will be critical problems for patient care that need to be addressed before this provision of the Protecting Access to Medicare Act rolls out in 2018." Dr. Carnahan is an IU Center for Aging Research fellow and a geriatrician with Eskenazi Health.

The JAGS article highlights three areas the authors believe to be of special concern:

- lack of communication between hospitals and SNFs, between hospitals and patients/caregivers, and between SNFs and patients/caregivers

- the potential for SNFs to keep patients longer than may be medically needed if they feel they can do a better job keeping the patient out of the hospital than the patient could do at home
- lack of research evidence to support assumptions of the mandate

A 2013 report from the U.S. Department of Health and Human Services, Office of the Inspector General found that one in three SNFs failed to meet required discharge planning requirements when SNF patients were discharged to home.

"Transition from the hospital to home is complicated—and for those who go to a SNF, we are adding a another set of doctors and nurses with new instructions," senior author IU Center for Aging Research and Regenstrief Institute investigator Alexia Torke, M.D. said. "Good communication between the SNF clinicians, the patient's community doctors and the patient and caregiver are key. It's critical for the SNF staff to provide guidance to any patient going home so they understand things like changes in medications from those taken before hospitalization or prescribed upon hospital discharge, as well as needs for further therapy. To ensure continuity of care, they should also help or at least encourage the patient or caregiver to set up a follow-up appointment with the patient's primary care provider." Dr. Torke is an aging and palliative care researcher. She is an associate professor of medicine at IU School of Medicine.

SNF stays are on the rise due to shortened hospital stays, improved medical outcomes in the hospital, as well as the recognition of the importance of SNF services such as physical therapy, speech therapy and medication management to both health and quality of life. Patients hospitalized for chronic heart failure, hip fracture or stroke are among those frequently discharged to SNFs rather than directly to home.

"We need to evaluate each patient's home environment to improve

transitions of care," Dr. Carnahan said. "These things are nuanced. When is a patient back to pre-hospitalization baseline? Should a patient be kept in a SNF for 20 days simply because Medicare will pay for it? Does having a strong caregiver advocate at home makes it more likely that a patient will return to the hospital or more likely that he or she will remain in their residence?"

Under the Protecting Access to Medicare Act, the new rehospitalization penalty will not vary by age or socioeconomic status of the patient. However the penalty will be less for readmission of a male than a female. Men are historically more likely to be readmitted to hospitals within 30 days than women.

A 2013 National Academy of Medicine (formerly Institute of Medicine) report, "Variation in Health Care Spending: Targeting Decision Making, Not Geography," found that eliminating post-hospitalization care spending variability would cut variability in total Medicare spending by almost three-quarters. Variability is due to various factors including length of stay at a SNF.

SNFs are often co-located with or within long-stay nursing homes. Medicare covers care in a certified SNF for up to 100 days with a formula that calls for a decreasing reimbursement rate after day 20.

"These new rehospitalization penalties add to the growing incentives for SNFs to increase their clinical capabilities to provide a higher level of care in-house," said Dr. Unroe. She is an assistant professor of medicine at IU School of Medicine and is co-director of OPTIMISTIC, a Centers for Medicare and Medicaid Services-funded program to prevent unnecessary hospitalizations of long-stay nursing home residents.

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