Making smarter decisions about where to recover after hospitalization

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Every year, nearly 2 million people on Medicare—most of them older adults—go to a skilled nursing facility to recover after a hospitalization. But choosing the facility can be daunting, according to an emerging body

of research.

Typically, a nurse or a social worker hands out a list of facilities a day or two—sometimes hours—before a patient is due to leave. The list generally lacks such essential information as the services offered or how the facilities perform on various measures of care quality.

Families scramble to make calls and, if they can find the time, visit a few places. Usually they're not sure what the plan of care is (what will recovery entail? how long will that take?) or what to expect (will nurses and doctors be readily available? how much therapy will there be?).

If asked for a recommendation, hospital staffers typically refuse, citing government regulations that prohibit hospitals from steering patients to particular facilities and that guarantee patients free choice of medical providers. (This is true only for older adults with traditional Medicare; private Medicare Advantage plans can direct members to providers in their networks.)

"The reality is that we leave patients and families without good guidance at a really vulnerable point in their care trajectory," said Dr. Robert Burke, an assistant professor of medicine at the University of Pennsylvania's Perelman School of Medicine.

Amid stress and confusion, older adults and their families frequently make less than optimal choices. According to a 2018 report from the Medicare Payment Advisory Commission (MedPAC), an independent agency that advises Congress on Medicare, nearly 84 percent of Medicare beneficiaries who go to a skilled nursing facility (SNF) after a hospital stay could have selected a higher-rated provider within a 15-mile radius. On average, MedPAC noted, hospitals refer patients needing short-term rehabilitation to 34 facilities. (Fewer options are available in rural areas.)

Where older adults go is important "because the quality of care varies widely among providers," MedPAC's report notes, and this affects how fully people recover from surgeries or illnesses, whether they experience complications such as infections or medication mix-ups, and whether they end up going home or to a nursing home for long-term care, among other factors.

A recently completed series of reports from the United Hospital Fund in New York City highlights how poorly older adults are served during this decision-making process. In focus groups, families described feeling excluded from decisions about post-hospital care and reported that websites such as Medicare's Nursing Home Compare, which rates facilities by quality of care and other performance criteria, weren't recommended, easy to use or especially helpful.

What do older adults and family members need to know before selecting a rehab facility after a hospital stay? Recent academic research, policy reports and interviews with experts elucidate several themes.

The Basics

Who needs post-hospital care in a rehabilitation center? Surprisingly, there are no definitive guidelines for physicians or discharge planners. But older adults who have difficulty walking or taking care of themselves, have complex medical conditions and complicated medication regimens, need close monitoring or don't have caregiver support are often considered candidates for this kind of care, according to Kathryn Bowles, professor of nursing at the University of Pennsylvania School of Nursing.

Medicare will pay for short-term rehabilitation at SNFs under two conditions: (1) if an older adult has had an inpatient hospital stay of at least three days; and (2) if an older adult needs physical, occupational or

speech/language therapy at least five days a week or skilled nursing care seven days a week.

Be sure to check your status, because not all the time you spend in a hospital counts as an inpatient stay; sometimes, patients are classified as being in "observation care," which doesn't count toward this three-day requirement.

Traditional Medicare pays the full cost of a semiprivate room and therapy at a skilled nursing facility for up to 20 days. Between 21 and 100 days, patients pay a coinsurance rate of $170.50 per day. After 100 days, a patient becomes responsible for the full daily charge—an average $400 a day. Private Medicare Advantage plans may have different cost-sharing requirements.

Nationally, the average stay for rehabilitation is about 25 days, according to a recent editorial on choosing post-hospital care in the *Journal of the American Geriatrics Society*.

Quality Varies Widely

In its 2018 report, MedPAC documented large variations in the quality of care provided by SNFs. Notably, facilities with the worst performance were twice as likely to readmit patients to the hospital as those with the best performance. (Readmissions put patients at risk of a host of complications. This measure applied only to readmissions deemed potentially avoidable.) Patients at the best-performing facilities were much more likely to be discharged back home and to regain the ability to move around than those at the worst-performing facilities.

In April, for the first time, Medicare's Nursing Home Compare website is separating out performance measures for short-term stays in SNFs, for people who are recovering after a hospitalization, and long-term stays,

for people with severe, chronic, debilitating conditions.

Seven measures for short-term stays will be included: the portion of patients who experience an improvement in their functioning (such as the ability to walk), return home to the community, are readmitted to the hospital, visit the emergency room, get new prescriptions for antipsychotic medications, have pain well controlled, and are adequately treated for bedsores, according to Dr. David Gifford, senior vice president for quality and regulatory affairs at the American Health Care Association, which represents nursing homes and assisted living centers. There will also be a separate "star rating" for short-term stays—an overall indicator of quality.

Questions To Ask

Before making a decision on post-hospital care, older adults and family members should address the following issues:

Your post-hospital needs. Bowles, who has studied what kind of information patients and families find valuable, suggests people ask: What are my needs going to be during the post-hospital period? What kind of help will be needed, and for approximately how long?

Dr. Lena Chen, an associate professor of internal medicine at the University of Michigan who has published research examining wide variations in spending on post-acute care after a hospitalization, suggests asking: What is my anticipated recovery, and what do you think the most difficult parts of it might be?

What the SNF provides. Bowles also suggests people ask why the SNF is being recommended instead of home health care. How will the SNF meet my needs, specifically? What kind of medical care and therapy will I get there? From whom and how often?

Carol Levine, who directs the United Hospital Fund's Families and Health Care Project, suggests that patients and families seek out details about facilities. Is a doctor readily available? (New research suggests 10 percent of patients in skilled nursing facilities are never seen by a physician, nurse practitioner or physician assistant.) What kind of equipment and specialized services are on-site? Can the facility accommodate people with cognitive issues or who need dialysis, for instance?

Getting information early. Dr. Vincent Mor, professor of health services, policy and practice at Brown University's School of Public Health, said patients and families should insist on seeing a discharge planner soon after entering the hospital and start the planning process early. When a planner comes by, "say, 'I don't care about choices: Tell me, what do you think will be best for me?' Be insistent," he advised.

Burke warns that doctors don't typically know which SNF is likely to be the best fit for a particular patient—a topic he has written about. He suggests that older adults or their families insist they be given time to contact facilities if they feel rushed. While there's considerable pressure to discharge patients quickly, there's also a requirement that hospital discharges be safe, Burke noted. "If we're waiting for a family to tell us which facility they want a patient to go to, we can't make a referral or discharge the patient," he said.

We're eager to hear from readers about questions you'd like answered, problems you've been having with your care and advice you need in dealing with the health care system. Visit khn.org/columnists to submit your requests or tips.