

HEALTH CARE POLICY AND LAW

The Need to Realign Health System Processes for Patients Discharged From the Hospital—Getting Patients Home

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In this issue of *JAMA Internal Medicine*, Werner and colleagues¹ compare the experiences of Medicare beneficiaries discharged to home with home health services with those discharged to skilled nursing facilities (SNFs). The authors report that, when comparing similar patients, those dis-



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charged to home had slightly higher rates of rehospitalization but lower 90-day Medicare costs than did those transferred to a SNF. Almost twice as many Medicare beneficiaries were discharged to a SNF than to home with home health care. Although those discharged to a SNF were, on average, older, sicker, and more frail than those discharged to home with home health care, the overlap between the 2 populations is substantial, raising the question of why more patients do not go home after discharge. To answer this question, one can examine patient factors such as financial concerns, preferences, fear of the complexity of their care requirements, and the availability of social support. Alternatively, one can focus on system factors such as continuity of care, rushed discharge planning, and financial incentives.

Unfortunately, there are limited data on patients' preferences for being discharged to home to receive postacute care, although we assume that, since dying patients want to be home, other sick patients might as well.² Qualitative studies asking about patients' preferences to go home reveal concerns about being abandoned at home, fear of managing their own care, and generally acquiescing to professionals' opinions; in other words, ceding the decision regarding where they should receive care to the health system representatives.^{3,4} Whether caregivers, who necessarily must assume the bulk of the work when patients return home, are prepared and willing to assume that responsibility is open to question. Because Medicare beneficiaries receiving home health care have no copay requirement, the apparent preference for discharge to a SNF may not be rooted in patients' financial concerns. Even in the face of copay requirements, present in some Medicare Advantage plans, Li and colleagues⁵ found that demand for postacute home health care was insensitive to the level of copay in place. Thus, not being discharged to home is not about the patients' money.

Most of the variation in regional Medicare expenditures has been repeatedly attributed to variation in the pattern and volume of the use of postacute care. Recent examina-

tion of the geographical variation in the use of home health care, SNFs, and hospitals among Medicare Advantage and fee-for-service beneficiaries finds the highest level of variation to be present in the use of home health services.⁶ Across virtually all regions of the country, after hospital discharge, Medicare Advantage patients are less likely to use either home health care or SNFs than are fee-for-service beneficiaries. Greater use of SNFs rather than home health care is seen in both Medicare Advantage and fee-for-service beneficiaries.⁶ This geographical variation is obscured in the article by Werner et al¹ since they standardize across all hospitals using a fixed-effects design, thus adjusting for the influence that local health systems have on which patients receive home health care vs institutional care and how this decision is associated with expenditures and outcomes. Nonetheless, there are virtually no areas in the country in which Medicare beneficiaries are more likely to receive home health care than to enter a SNF, suggesting that this observed pattern reflects generalized hospital practices.

Qualitative research findings across multiple health systems among patients needing postacute care suggest that patients are offered choice among providers after it has been determined that the discharge destination is home or a SNF.⁷ This pattern seems to be as applicable to Medicare Advantage beneficiaries as it is to fee-for-service patients discharged from the same hospital.⁷ Although hospital officials seem to give precedence to patients' "choice" of which SNF or which home health agency they might select (to the point that officials offer no information about provider quality), we know little about whether and how patients are informed about the differences between home and institutional care.^{8,9}

During the past 2 decades, the number of hospitals owning their own SNFs has declined, particularly in the years after the introduction of SNF prospective payment in 2000, a phenomenon that has been associated with increasing rates of rehospitalization.¹⁰ Since the introduction of the Patient Protection and Affordable Care Act, both penalties (rehospitalizations) and financial incentives (accountable care organizations and bundled payments) have been instituted that were designed to make hospitals accountable for their patients after hospitalization. Rehospitalizations have declined since the penalties were introduced and there is some evidence that accountable care organization membership and participation in bundled payments has further reduced rehospitalization since 2013.¹¹

What is happening in hospitals that predisposes them to discharge patients to SNFs? Because only a small proportion of all SNFs are hospital based any longer, we know that it is not simply because hospitals own SNFs.¹⁰ Hospitals are under enormous competitive and regulatory pressure as inpatient admissions decline, medical reviews disallow hospital admissions, and readmission penalties bite into the bottom line.¹²⁻¹⁴ The rise of the hospitalist movement, which has largely replaced community physicians visiting patients in the hospital, may have inadvertently resulted in even greater institutional bias, as hospitalists push for rapid discharge, consistent with hospitals' fiscal motivation. Consistent with this perspective, there is some evidence that primary care physicians who follow their older patients into the hospital are more likely to discharge them to home than are hospitalists.¹⁵ This difference may be because community attending physicians know about their patients' social situations, family support, and how strong their preference is for being independent. However, because only a small minority of all hospitalized Medicare patients are followed up by their primary care physicians and the trend toward hospitalist care is unlikely to reverse, some other strategy is needed to introduce information about patients and their home situation into the discharge planning equation.

Indeed, what separates clinically similar patients going home from those going to a SNF probably comes down to the intangibles: the unmeasured factors of family support, living arrangements, the number of stairs in the home, and patients' insistence on independence. The long literature on factors associated with institutionalization clearly identifies social support as the most important protective factor and it is likely among the most influential in choosing home as the discharge destination.¹⁶ Because the discharge process can be chaotic and rushed, it is likely that the information base used by hospital clinical staff to make the discharge placement decisions varies substantially across hospitals and may be influenced by ease of transfer to a SNF relative to the time needed to make arrangements for home placement. Although various hospital-based interventions designed to facilitate transition to home have been shown to be effective, outside of a focused quality improvement program embraced by committed hospitals, expeditious

transition management of patients with complex medical needs is facilitated by transfer to a SNF.¹⁷

It is interesting to note that, among commercially insured patients leaving the hospital for postacute care, most use home health care, perhaps because available social supports are stronger.¹⁸ In an era in which hospitals are penalized for higher than expected 30-day rates of rehospitalization, there may be greater comfort sending patients to SNFs staffed with medical personnel who can manage medications and keep patients safe. Hospitals increasingly rely on preferred provider networks to which they discharge their SNF patients, further smoothing inter-institutional arrangements.¹¹ The finding by Werner et al¹ that similar patients discharged to home health care vs a SNF were more likely to be rehospitalized may reinforce the institutional bias that appears to be present already. Combine the ease and standardization of transferring a patient to another medical facility with the administrative complexity and effort required to coordinate simultaneous delivery of medications, equipment, and multiple staff to a Medicare beneficiary's home and it becomes clear why there is a structural preference for discharge to a SNF.

Perhaps the most intriguing finding in the study by Werner et al¹ is the apparent tradeoff between increased risk of rehospitalization and significantly reduced Medicare expenditures. This finding raises important questions that require further exploration. Most of the differences between the SNF and home health care in the adjusted rates of rehospitalization are attributable to discretionary transfers, suggesting inadequate quality monitoring that might be amenable to more skilled home health input. Alternatively, it may be that more rehospitalizations due to inadequate home health care services is the price that must be paid to prevent needless institutional care and lower Medicare postacute expenditures by \$4500. This is a very important question since it may be that a small improvement in clinician quality, better training to improve family engagement, or better targeting of who can use home health care might eliminate excess rehospitalizations without reducing the cost savings. That will require careful study, flexible policy, and committed providers cooperating with one another. Let's hope this is possible to help people get home where they want to be.

ARTICLE INFORMATION

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