Transitioning from Hospital to Nursing Home

You have been hospitalized following a major surgery or for an illness and you and your family are being told that you will be discharged. You are under pressure to make a decision. How do you know what the best option for you is going to be? Is it home? If so, how will you get the support that you need? Is it a skilled-nursing facility? If so, how do you know which one to pick? And, of course, how will you pay for the care you need?

Recent reports issued by the United Hospital Fund highlight the challenges faced by patients, families, and providers during the transition to post-hospital care. Often patients and their families feel a great deal of stress because they are asked to make such an important choice with insufficient information.

Under federal and Pennsylvania law, all hospitals must have in force a written discharge planning process that applies to all patients. The hospital is required to determine at an early stage during the hospitalization patients who will need discharge planning and to provide a written discharge plan. All patients (or their doctor) have the right to receive a plan. The law requires that hospital personnel give the patient the discharge planning evaluation on a timely basis in order to give the patient time to make appropriate arrangements for post-hospital care and to avoid unnecessary delays. The regulations also require that the patients be given a list of providers to choose from.

Pennsylvania regulations require discharge planning to be an integral part of the hospitalization of each patient and require that discharge planning should start soon after admission. The hospital's written policies on discharge planning must include appropriate referral and transfer plans, methods to facilitate the patient's follow-up care and information to be given to the patient on the patient's condition, health care needs, medications and therapies, and procedures to follow in case of complications.

While it is important that the law recognizes the importance of proper discharge planning, the reality is that patients feel rushed by the discharge process and when they ask for guidance, find that their health care team has limited information to provide about what would be the right place for them to receive post-hospitalization care. As a result, many patients feel like they are left to make these important decisions on their own.

In the "paradox of choice," patients have the freedom to make the decision from a list of facilities, but they feel anxious about making the decision because they do not have enough information and there is little time to do research or talk with others who may have helpful input. This ultimately leads patients and their families to feel unsure about whether they made the right choice. In some cases, there may not really be a choice at all. While there may be a number of facilities on the list, it could come down to which facility has an available bed.

While Medicare rules prevent hospitals from "steering" patients to a specific long-term care facility, if the patient and family are uncertain about the discharge, they should ask for a discharge planning meeting with the patient's doctor and the discharge planner. The doctor should provide an opinion about the specialized services the patient needs and whether it is medically advisable to discharge the patient to home. In addition, the doctor can order home health care and therapy, which should be covered by Medicare. Be mindful, however, that Medicare will not cover non-medical home care to help with activities of daily living, i.e. bathing, dressing, toileting, etc. With non-medical home care services costing on average $20 per hour, the cost alone can be a huge barrier to someone being able to have a successful discharge back to a home in the community.

Be prepared and know your rights:

- Do your research early in the process of hospitalization. Have your family members or authorized representative take tours of different facilities and ask neighbors and others for their opinions. Make sure the facility offers the special services the patient needs. Medicare.gov has a nursing home compare tool that can also be helpful. Anderson Elder Law has a social worker on staff that can provide valuable guidance to our life care planning clients with this process.
- The patient must receive written notice of discharge explaining why the hospital has reached the decision to discharge the patient. The notice must provide the patient with information on how to appeal the decision.
- Confirm that the patient has been admitted to the hospital for at least three days and was not "observation status." Otherwise, Medicare will refuse to pay for rehabilitation care.
- If the notice you receive does not meet the requirements, then you must ask for one that does. Strategically this can give the family extra time to make the right decision.
- If the notice is in the right format, but the patient or his or her family does not believe the patient can be safely discharged from the hospital, then appeal the decision. During the appeal process, the patient cannot be discharged.

Additional information about Discharge Planning is available from the Center for Medicare Advocacy.