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Policy Options to Improve Discharge Planning and Reduce Rehospitalization

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Frail older patients and their families are generally unprepared for the flurry of activity that occurs during a hospitalization and for how quickly they must decide where to go at discharge. Hospital discharge is not the time to undertake the extended process of long-term care planning and goals clarification. The biggest challenge patients and families face as they decide their discharge destination is to establish realistic goals of care in the absence of coherent information about their prognosis and options. This decision is particularly important because of the weighty implications of their choices.

Decades ago patients remained in hospital until they recovered or stopped improving. Introduction of prospective Medicare hospital payment with diagnosis related groups in the United States in 1983 and other industrialized countries in later years changed all that. Hospital stays became shorter and illness episodes more disjointed between acute and postacute care, a process exacerbated a decade ago by payment changes to postacute care and the rise of an industry largely separate from hospital-based and primary care physicians. Although evidence suggests that the hospitalist movement has reduced hospital stays and improved inpatient quality indicators without clear deleterious effects on patient outcomes, some observers have worried that such services may complicate discharge transitions to primary care physicians, particularly for the most frail patients.[1,2] Policy changes in payment for acute and postacute care and their sequelae are widely recognized as contributing to the rising rates of rehospitalization and the increased frequency of transitions among health care settings and teams, particularly during the past decade.[3,4]

In 2006, some 40% of fee-for-service Medicare beneficiaries discharged from the hospital transferred to some form of postacute care.[5] These patients can be grouped into 3 types: those expecting to recover following rehabilitation; those who will require housing, supportive services (eg, nursing home or home care), or both for the long term; and those needing palliative care, including hospice care and management of complex, progressive disease–related symptoms during the end of life. These groups are neither mutually exclusive nor static; what may begin as postacute rehabilitation may rapidly evolve into a

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more complicated set of long-term care support services delivered in a nursing home, at home, or in one of the various alternative settings enumerated by Kane[6] in this issue of *JAMA*. As such, hospital discharge is a critical point in a patient's medical course; however, it occurs when no specific health care professional is accountable for patients' experiences.

The complexity of identifying appropriate goals of care, not to mention the multiplicity of possible service options available, would be difficult to navigate even without the pressure of a hospital discharge deadline. Nonetheless, decisions have to be made quickly with a high degree of ambiguity regarding goals and with even less time to consider the quality of the different options, regardless of type. In the estimated 70% of US hospitals with inpatient services having hospitalist attendings, these decisions generally are made with limited involvement of the primary care physician to advocate for the patient and family's preferences.[1] Indeed, in many communities, urgent hospital admissions occur without the primary care physician's knowledge, complicating communication and care both during and after the hospital stay. Because many older patients have multiple chronic conditions, each managed by a different specialist, it is not always clear which physician should be notified in the event of a hospitalization.

The challenges of transitions among medical care settings and clinicians have received increasing attention. Over the last decade, the Centers for Medicare & Medicaid Services has made minor revisions to hospital reimbursement rules designed to penalize hospitals for discharging patients prematurely to postacute settings. However, the length of hospital stay has continued to decrease, and rehospitalization rates have increased.[3,5] It is no surprise, then, that the Affordable Care Act has multiple provisions designed to reduce rehospitalization. In the next year, the Centers for Medicare & Medicaid Services is charged with developing penalties for health care organizations whose patients are rehospitalized "too often." Whether hospitals or the postacute care organizations will be penalized has not yet been specified, but this provision of the law has raised anxiety levels throughout the acute and postacute care sectors. Two strategies are proposed to increase clinical accountability for transitions: one, the creation of accountable care organizations (ACOs), composed of consortia of hospitals, physician groups, and other health care organizations designed to serve populations of patients within a global budget; and the other, "bundling" Medicare acute and postacute payments.[7] Regardless of organizational form, how hospitals, their medical staffs, and postacute referral sources will collaborate to share the payment bundle and reduce rehospitalizations is the subject of considerable speculation.

Even absent policy changes, several evidence-based interventions designed to smooth health care transitions are being implemented. Nurse case managers or other supplemental health care professionals, sometimes referred to as "coaches," introduced either in the hospital or in the community following discharge, have been shown to reduce re-admissions.[8,9] Policy considerations about how such care managers might be reimbursed and whether they would be part of the hospital staff or the primary care physician staff have not been settled. However, unless rehospitalizations are penalized or payment for bundled episodes of care is instituted, hospitals currently have little incentive to reduce rehospitalizations or delay discharge.

Reimbursement policies should provide incentives for health care professionals and settings to work together to achieve positive results for the maximum number of patients. One option is to reimburse specifically for coaching and postdischarge monitoring services in addition to current fee-for-service payments, regardless of who employs such individuals. However, this creates a new class of ancillary professionals, with all the associated incentives to increase billing. Alternatively, bundled payments, or global budgets for ACOs, effectively make health care organizations clinically and fiscally responsible for their patients' care and outcomes without increasing spending.

Under optimal circumstances, ACOs or properly designed bundling policies should set the stage for local health care systems to determine the best approach to meet quality-of-care goals, given the available resources. One approach is unlikely to work in all settings; rather, in some areas, hospitals and postacute care settings may choose to form a network that might function as a "virtual" hospital–based skilled nursing facility or home health agency, while in others with more limited postacute care options, care managers might best guide patients to secure the community-based services they will need. Large geographic variation in the supply of acute as well as postacute settings means that solutions will by necessity have to be different. This level of flexibility is characteristic of how ACOs are being discussed, but to date there has been little mention of the roles postacute and other community-based service organizations might play in ACO networks. It is time to begin such discussions to address the dilemma of patients and families being forced to make hurried and potentially poor choices during the most stressful times of their lives.

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