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Editorial

Can Lawyers Improve Transitions of Care?

Marshall B. Kapp JD, MPH [a,*], Paul R. Katz MD, CMD [b]

[a] Florida State University Center for Innovative Collaboration in Medicine and Law, FSU College of Medicine Department of Geriatrics, and FSU College of Law, Tallahassee, FL
[b] Florida State University College of Medicine Department of Geriatrics, Tallahassee, FL

Post-acute and long-term care medical providers routinely work with teams to ensure the timely delivery of comprehensive, evidence-based care. It is unusual, however, to find lawyers as members of such teams, save for issues related to ethics and risk management. We propose the inclusion of attorneys as members of the hospital discharge team responsible for hospital to SNF transfers. The increasing complexity of such transfers, as well as associated legal and financial dangers, provides the rationale for our proposal. Beginning with an illustrative case example, we highlight medical-legal issues pertinent to both the sending and receiving facilities and offer potential models for incorporating advice and patient advocacy into the discharge planning process. Effectively integrating attorneys into this process while avoiding or mitigating potential conflicts of interest will remain a difficult challenge to overcome.

Illustrative Case

Mrs. Smith is an 88-year-old widow admitted to the hospital following a fall. She lives alone in a two-story single family home and has had a gradual decline in health over the past 12 months. Social supports include a daughter, Linda, who lives locally, and a son, Mark, who resides at a distance. Her income amounts to $3,000 per month, inclusive of Social Security.

Mrs. Smith is followed for a number of chronic conditions, including diabetes mellitus, hypertension, osteoporosis, congestive heart failure, hypothyroidism, and depression. Mrs. Smith is on 10 scheduled medications per day, including insulin.

Evaluation in the emergency department of the hospital revealed no evidence for fracture. Laboratory tests indicated dehydration and a possible urinary tract infection. Mrs. Smith was subsequently assigned to a bed in the observation unit of the hospital and was given intravenous fluids and oral antibiotics. Forty-eight hours following "admission," Mrs. Smith was unable to transfer independently from bed and could ambulate only with assistance. She appeared intermittently confused and disoriented.

Due to persistent functional deficits, Mrs. Smith was discharged to a local nursing home to receive rehabilitation. Mrs. Smith and her family were informed of the discharge just 2 hours before the transport arrived. Mrs. Smith was admitted to the skilled nursing facility (SNF) unit and evaluated by an interdisciplinary team including medicine, nursing, social work, physical therapy, and occupational therapy. On the morning of Mrs. Smith's first full day in the nursing home, she was informed by the social worker that the stay in the hospital did not qualify her for SNF rehabilitation through Medicare.

Since Medicare would not be reimbursing for the nursing home stay, Mrs. Smith and her family were told that the charge for continued services would be $250 per day. Due to lack of affordability, the family decided to return Mrs. Smith to her home the following week. Mrs. Smith's daughter Linda planned to take sick leave in order to care for her mother.

Since there was no formal discharge summary, the attending physician spent several hours attempting to obtain information from the hospital as well as interviewing family to complete an accurate history and reconcile the patient's medications. The physician discovered that the urine culture did not show evidence of infection, and thus Mrs. Smith's antibiotics could be stopped. Lab reports not initially provided also revealed low thyroid function, requiring immediate treatment.

Legal and Financial Issues

A contemplated transfer of a hospitalized patient to an SNF for a period of post-acute care may implicate several medical-legal and financial issues that would be difficult for even a fully healthy and functional person to adequately understand. As observed by one commentator:

> Medicare acute care hospital discharge planning is often seen as offering purely clinical, financial, or legal challenges. But in reality, the re-engineering of Medicare acute care hospital discharge planning requires overcoming all three: it is a legal, financial, and a clinical delivery challenge of the utmost importance. With nearly one-fifth of Medicare patients readmitted to a hospital within 30 days of discharge, the failure of discharge and discharge planning is multidimensional. It represents both a financial disaster for the Medicare program and an exacting burden that extracts a high personal toll on Medicare beneficiaries.[1]

One primary concern is whether the patient is medically ready and hence eligible to be discharged in the first place. When either the

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* Address correspondence to Marshall B. Kapp, JD, MPH, Florida State University Center for Innovative Collaboration in Medicine and Law, 1115 W. Call Street, Tallahassee, FL 32306-4300.
E-mail address: marshall.kapp@med.fsu.edu (M.B. Kapp).

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propriety of the discharge itself or the adequacy of the proffered discharge plan is questionable, Medicare appeal rights are available, as explained in the Important Message from Medicare (IM) that CMS is required to provide to inpatient Medicare beneficiaries once a discharge decision has been made.[2] However, the process for asserting those appeal rights is complicated, time-constrained, intimidating, and financially risky enough that most older hospitalized patients are unlikely to navigate that process successfully and convince the Quality Improvement Organization (QIO) to overturn the hospital's decisions without knowledgeable, timely advice and advocacy.

Assuming the discharge decision is medically appropriate, there are more potential legal and financial concerns for the patient. Attention must be paid from the moment a patient is admitted to the hospital, because hospital admission practices drive eventual discharge decisions, indeed limiting post-acute care options for many older patients.

For one thing, few Medicare patients or their families really comprehend the important distinction between a hospital "admission," on the one hand, and a stay in the hospital under "observation status," on the other.[3] Hospitals are increasingly reluctant to admit patients because of stringent monitoring of hospital discharge data by the Medicare Recovery Audit Contractor (RAC) and the state's QIO; effective September 12, 2016, short inpatient hospital stays are particularly targeted for possible Part A overpayment and/or inappropriate admission.[4] Under the prevailing time-based Two-Midnight Rule, a physician is expected to admit an individual to inpatient status only if the physician believes the individual will need to remain in the hospital for at least two midnights. Other persons are supposed to be classified as outpatients, no matter their condition or present need for services. Additionally, economic penalties imposed on hospitals by the Affordable Care Act for avoidable Medicare patient readmissions (a serious and long-standing problem)[5] incentivizes hospitals to be much more cautious about admitting a Medicare beneficiary to inpatient status in the first place, because there cannot be a readmission without an initial admission.[6] Consequently, hospitals frequently use observation status as an alternative to inpatient admission.

A patient in the traditional Medicare program who is treated under observation status, and whose hospital care therefore is classified as a set of outpatient services and paid for under Medicare Part B, is personally responsible for any charges (such as those for prescription drugs) not covered by Part B. This includes deductibles and copayment expenses (approximately 20% of the total hospital bill). Moreover, a patient who is discharged from hospital observation status to an SNF is not eligible for any Medicare coverage for the post-acute SNF stay, because Medicare limits eligible post-acute SNF services to those provided to a patient immediately after a hospital admission (although some Medicare Advantage plans may waive this requirement). Litigation has been initiated to challenge the "admission" versus "observation status" dichotomy on grounds of due process deprivation of property rights.[7] Legislation has been introduced that would allow the use of observation time to satisfy the 3-day requirement for Medicare coverage of an SNF episode.[8] At present, however, the "admission"/"observation status" dichotomy continues to represent a Medicare policy that threatens the financial and legal well-being of many older patients.

Most Medicare beneficiaries and their families are unaware of the "admission" versus "observation status" dichotomy and its potential ramifications for them. Most health care professionals (physicians, physicians' assistants, nurses, and social workers) do not think about the financial implications associated with observation status, and therefore do not explain these issues in a timely way. The potential sticker shock problem supposedly is addressed by Congressional enactment in 2015 of the Notice Act.[9] The Notice Act requires that the hospital notify, through a written form to be added to the thick stack of other written forms the average hospital patient accumulates, each patient who receives observation services as an outpatient for more than 24 hours about the individual's patient status and its potential financial implications; 1.4 million individuals each year will fall into the required notice category.[10] Because written notices of this sort are easy for the patient or family to ignore, what may be needed is an adequate discussion before the patient receives treatment under outpatient status.

Even if the patient is discharged to an SNF after a hospital "admission" rather than a period of "observation," Medicare Part A pays for the patient's post-acute care only if the hospital admission immediately preceding the SNF admission lasted at least 3 days, including 3 midnights.[11] Many patients and families are unaware of this requirement and are willing to agree to, and often even push for, hospital discharge after a shorter duration admission. When this occurs, the patient's private pay status in the SNF comes as a rude shock (usually learned about once the patient has physically arrived in the facility) to that person and family. If the individual is medically and financially eligible, applying for Medicaid coverage may become a necessary alternative.[12]

Once someone is admitted to the SNF for post-acute care, that new resident gains several legal entitlements, such as the right to be informed about services and fees, the right to keep and use personal belongings and property, and the right to choose one's own schedule and activities. Most new residents and their families are unacquainted with their SNF admission rights, and thus often are less than fully successful in gaining the benefit of them, because they have not been educated sufficiently about this topic during the discharge planning process.

At the same time, many new residents and their families may assume the existence of some rights that, in reality, do not exist. Most fundamentally, individuals who are about to be discharged from the hospital, as well as their families, likely assume that they get to choose the nursing home to which discharge will occur and the specific physician who will care for them in the chosen nursing home.[13] In many instances, however, little or no meaningful choice of either nursing home or specific attending physician is available. The hospital discharge planning process rarely prepares patients and their families for the unanticipated take-it-or-leave-it scenario into which the patient is about to be thrust. In addition, patients and their families are often unaware of the resources available in the nursing home as they prepare for their discharge. This is most problematic on weekends when hospitals often transfer very complex patients to the nursing home, which has even less nursing staff available than is typical during the week, and may offer no onsite medical care. It is uncommon for hospitals to inquire as to the nursing home's ability to care for the medical needs of a given patient but rather depend on the nursing home's admission's office, which is constantly pressured to fill beds at all cost.

Discharge Planning: Current Practice

Discharge planning has a well-established place in the history of American health care.[14]

Society imposes an enforceable discharge planning obligation on hospitals as a matter of the Medicare statute[15] and regulations,[16] state hospital licensing acts, and common law.[17] The Joint Commission accreditation standards include provisions requiring a discharge planning process.

Discharge planning is supposed to be a substantive, constructive component of a patient's coordinated medical experience rather than focused on the hospital's utilization management needs, but unfortunately "it is more commonly used as a way to get patients out of the hospital or facility more quickly."[18] This shortcoming is explained in large part by recognition that, even though discharge planning has