DIFFICULT DECISIONS

Health Care Provider Perspectives on Discharge Planning: From Hospital to Skilled Nursing Facility

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Introduction

Discharge planning[i] for hospitalized patients who will need post-acute care (PAC) is a highly complex process involving several actors and steps, all aimed at providing continuity of care and a timely and safe discharge. Yet too often, the needs of patients and family caregivers can get lost in the process, despite the best intentions and conscientious efforts of hospital staff. Discharge planning teams must balance many factors—varied interpretations of regulations that govern what should and should not occur during the process, insurance constraints and authorization delays, patient factors that affect placement into a skilled nursing facility (SNF), coordination across specialties, and communication with patients and family caregivers.

Ensuring an appropriate discharge plan is crucial for older adults with complex care needs who may face adverse outcomes and greater costs if planning for PAC misses the mark and placement does not match their care needs.[1,2] Quality varies across SNFs, and the chance of rehospitalization is related to which SNF is selected—this highlights the importance of making an informed decision about what facility to go to after an inpatient stay. [3,4,5]

To better understand how decisions about PAC occur during discharge planning, the United Hospital Fund (UHF) engaged in discussions with administrators and frontline staff at eight hospitals and administrators at five nursing homes in the New York metropolitan area. (See Appendix A for the methods used.)

DIFFICULT DECISIONS

The **Difficult Decisions** series examines the challenges faced by patients who need post-acute care after hospital stays for major surgery or serious illness. Prepared by United Hospital Fund and supported by the New York State Health Foundation, the reports in this series cover the many factors that go into hospital discharge planning, with context for patients and their families, for hospital teams, and for policymakers.

This report, the third in the series, examines the perspectives of health care providers and the barriers they face when trying to help patients in demanding circumstances; other reports in the series look at patient perspectives on post-acute care, what makes informed decision-making in this area so challenging, and the best practices, innovations, and policy levers that could help support New Yorkers who need to make decisions about post-acute care.

i Discharge planning activities include assessing a patient's medical status and social supports, planning to meet the patient's needs for post-hospital services, completing the evaluation, establishing and discussing an appropriate plan with the patient and/or family caregiver, and implementing the discharge plan.

The Context for Discharge Planning to a PAC Facility

Both the regulatory and the health system environment can influence the choices patients have and the assistance they and their family members receive when faced with a decision about PAC. From the operational perspective of the health system itself, hospital staff involved in discharge planning are often under immense pressure to minimize the length of hospital stays and create room for new admissions.[6,7,8] When deciding on an appropriate PAC setting, staff may take into account a wide range of factors:[9] the patient's characteristics, preferences, functional status, medical history, caregiver support, recovery trajectory, and insurance coverage, as well as various other considerations.[ii] Discharge decisions must often be made when the patients are still quite ill because of the shortened inpatient length of stay and increasing patient acuity. As a result, patients and family caregivers can feel rushed to make decisions.[10,11] PAC choices can be limited by the patient's medical complexity, need for expensive medications, behavioral and psychiatric health history, history of substance use, or need for specialized services and equipment, such as dialysis or ventilators.[12,13,14,15, 16,17] The unfortunate reality is that some patients do not really have a choice of facility—and even when they do, they feel rushed to decide, with limited information and support.

Relevant Regulations

Federal and state regulations have specific requirements that influence the discharge planning process. Discharge planning regulations include provisions to ensure patient choice[iii] and prevent hospitals from steering patients to specific SNFs for their own financial gain.[iv] While these regulations protect the patient's rights and preferences, they have resulted in some unintended consequences that complicate the process for patients and families.

Conditions of Participation for Medicare

The Centers for Medicare & Medicaid Services (CMS), through its Conditions of Participation for the Medicare program (CoPs), requires hospitals to screen all inpatients to determine their need for a discharge plan, to have a discharge plan in place for patients at risk of adverse outcomes following discharge, and to reassess that plan on an ongoing basis.[18,19] However, even with this requirement, there is variation across and within hospitals in how the process actually occurs.[20,21,22,23] The rules require a hospital to provide patients and family caregivers a list of SNFs or home health agencies that participate in Medicare and are in the geographic area where the patient lives or is

ii As described in other reports in this *Difficult Decisions* series, there is considerable variation in what information is available to discharge planning staff as well as to patients and families. There is also variation in how well it is understood and how highly the different factors are prioritized by patients and by providers. Somewhat perversely, all these inconsistencies can make an already stressful moment of decision-making even more complex and difficult to manage.

iii For Medicare beneficiaries, the Social Security Act (42 U.S.C. § 1395a) protects their rights to choose among participating providers.

iv In addition to the CoPs that require hospitals to disclose financial interests, there is a federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)) that prohibits any intentional attempt to solicit or receive remunerations for referrals.

requested by the patient. This list is either developed by the hospital and updated annually (at a minimum) or obtained from CMS websites—Nursing Home Compare and Home Health Compare. For patients enrolled in a managed care plan, the hospital must indicate the availability of services in the plan's network. Any financial interests that the hospital has in a SNF or home health agency on the list must also be disclosed. The staff must also document that they have provided the list to the patient and family in the patient's medical record. In order to prevent hospitals from steering patients to particular facilities for their own interests, the interpretive guidelines for the CoPs state that the "hospital must not specify or otherwise limit the qualified providers that are available to the patient."[24] These guidelines have been subject to interpretation by the hospital's legal and discharge planning staff, which may affect the patients' experience.[25]

New York Codes, Rules and Regulations, Title 10

New York's Codes, Rules and Regulations also set minimum standards for hospitals to address discharge planning and require hospitals to provide discharge plans to all patients and involve patients and families in the selection of the PAC and provide a range of facilities available in their community.[26] These regulations do not require the hospitals to provide performance results on quality measures or other publicly-available, quality information to patients and family caregivers.

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

A proposed rule to amend the CoPs would establish several new requirements related to the discharge planning process, one of which is to require hospitals to provide quality measures about PAC providers to patients and families. This rule was required by the passage of the IMPACT Act, which recognized the key role that hospitals could play to better assist patients and family caregivers in using quality data for selecting PAC facilities. The proposed quality measures differ from the ones already reported on the CMS Compare websites. The quality measure domains include skin integrity, functional status, medication reconciliation, incidence of major falls, and transfer of health information. Despite the proposed rule's release in November 2015, no final rule for hospital discharge planning has been published, and the new requirements have not been implemented.[27] CMS has extended its timeline to publish the final rule until November 2019.[28]

The Hospital Perspective on Discharge Planning for PAC

Discussions with hospital staff highlighted the challenges, constraints, and barriers that the discharge planning teams face when trying to do their best to place patients in PAC under difficult circumstances (see box). They stressed that the constraints created by the discharge planning regulations, which are subject to interpretation, lead care teams to exercise caution and often prevent them from recommending specific SNFs to patients who are looking for exactly this kind of guidance.

Patient Assessment for Discharge

At nearly all the hospitals, the discharge planning process started on admission, and the teams were composed of several disciplines—case managers, social workers, nurses, physicians, physical therapists, occupational therapists. Typically, a multidisciplinary team completes an assessment to evaluate several factors for discharge—such as the patient's functional, cognitive, and psychological status, medications (e.g., IV antibiotics, chemotherapy), home environment (e.g., walk-up), insurance, and support from family or friends. At a few hospitals, teams tried to risk-stratify or identify patients who had more complex medical or social issues to proactively manage their discharge process. Changes in the patient's medical status, which can occur throughout the hospital stay, can add complexities to planning for discharge. As one provider put it, "their medical situation changes from hour to hour, and it's really as it begins to stabilize that one can make a final plan."

Factors That Affect the Discharge Planning Process

- Assessing medically complex patients for discharge and the range of consultations needed while they are hospitalized
- Changing medical status of patient while planning for discharge
- Limited family involvement, distant family members, or differing opinions between patients and family members about discharge needs
- Time pressures to discharge patients
- Delays in insurance authorizations
- Patient-related barriers to SNF admissions due to medical, social, and insurance constraints
- Bed availability at the SNF

Considering Multiple PAC Options

To develop a plan, the discharge teams use the patient assessment and input from team members to discuss PAC options with the patient and family caregiver. PAC discharge options include home, home with home health services, short-term rehab in a SNF, and long-term placement in a SNF. Since the patient's status may change over the course of the hospitalization and the amount of available caregiver support may be uncertain, some teams try to "dual-plan" for certain patients, which entails planning for more than one viable option—such as going to either a SNF or home with home health services.

When considering short- versus long-term stays, most teams try to focus on the patient's immediate needs. Many discharges are for short-term stays, but if it is anticipated that a patient may eventually need a long-term stay, teams try to identify facilities with long-term beds. Staff members mentioned that these beds are often unavailable and that

financial incentives make short-term stay patients more attractive to SNFs because Medicare rates for short-term stays exceed Medicaid rates for long-term stays.

Patient and Family Caregiver Involvement

Teams were aware of the Caregiver Advise, Record, Enable (CARE) Act, which requires hospitals to record the name of a family caregiver, notify them of a discharge, and provide explanation and teaching about care to be delivered post-discharge.[29] While several teams mentioned trying to involve the patient and family caregiver at the outset and recognized that partnering can help make a successful transition, they also highlighted some barriers. One major barrier is trying to discuss discharge when the patient is still trying to recover from their primary medical issue. Other barriers included difficulties trying to reach family members, challenges in communicating with distant family members, patients and family members not prepared to accept the progression of the patient's condition, and differing opinions between family members about the discharge and the patient's post-discharge needs.

"Patients just get here today, and we're going in talking about when they're leaving, so that's not always well received… patients and family members aren't prepared mentally at that point to have those discussions."

The staff we interviewed stressed the importance of aligning around the patient's goals of care while also managing patient expectations. Some discharge planners mentioned explaining to patients the limits of their insurance coverage, which often came as a surprise. Health literacy can also play a significant role in understanding the discharge process, PAC services, and options, as well as insurance coverage and constraints. One example we heard that highlights the complexity of the process and intensity of patient needs is teams planning discharges for admitted patients who are confused and cannot speak English; the teams must think outside the box and extensively research the patient's social and medical history and use translator lines to communicate. Staff also mentioned instances when the goals of the patients and their families differ—patients sometimes feel that they can go home, but family members may not believe that the patient is ready or may not be prepared to help the patient at home.

Information Provided to Patients to Make a Choice

The discussion groups confirmed that interpretations of regulations clearly affect the discussions that hospital staff have with patients and families—they provide lists to patients as required and try to avoid recommending specific facilities to patients, even though all teams mentioned that patients ask for specific advice on where they should go. A few teams were more comfortable providing informal recommendations while others felt a lot more constrained and would only provide patients with a list of SNFs to choose from. Some also did not want to provide recommendations because their perspective on SNFs and priorities may differ from the patient's.

Paper lists were the most common resource available to patients and were often organized by county and list the facility's phone number and address; some contained more details on services available—e.g., vent beds or on-site dialysis. Several hospitals are either exploring or using CarePort, an online tool that enables discharge planners to generate a list of SNFs based on insurance, distance, CMS overall star rating, and other filters. It also provides a description of the SNF and has additional links with more information on the SNF's services and policies, and pictures of the facility. Where preferred provider networks[v] were established, the paper and the CarePort lists indicated whether the SNF is part of the health system's network while still providing the patients with all the other options to choose from.

In addition to providing lists of SNFs, some discharge planners refer patients to the CMS Nursing Home Compare website. While most were familiar with Nursing Home Compare, some noted that the only people who used it were discharge planning staff and the quality team from the hospital itself—not patients or families. Additionally, few were aware of the New York State Department of Health (NYSDOH) Nursing Home Profiles. Staff members said only some patients used Nursing Home Compare to look at the star ratings, consistent with findings in the literature that indicate that it is not as widely used.[30,31] Some discharge planners said that because it can be challenging to place patients in higher-quality SNFs, either because their area may not have any 5-star SNFs or because of medical or insurance barriers, they have to manage patient expectations. Others mentioned that some patients—especially those who are not tech-savvy, have low health literacy levels, or do not speak English—face additional barriers when trying to use CMS Nursing Home Compare.

"There is poor health literacy and education, so even if you did talk about Medicare.gov, the best option is to really go and tour for these family members because, even though we suggest it, I don't really see them using that as the tool to make a decision."

Even if discharge planners believed they were able to make specific recommendations to patients and families, some staff did not have much firsthand information about the differences, strengths, and limitations of various facilities. There was variation among the discharge planning staff about whether they had an opportunity to visit SNFs. Some wanted to visit the SNFs to get a better sense of the facilities, while others were prohibited by the hospitals from visiting because of concerns around compliance with regulations on referrals and the potential for the appearance of improper steering.

Patients and family caregivers are often told to visit facilities to help them decide. Hospital staffs' responses about whether families visit SNFs varied widely, though some noted that they encourage patients to visit facilities because in-person tours can present quite a different picture from information online. Sometimes staff members provide guidance on what to look for when patients visit a facility—e.g., a "sniff test," or a tour

v Preferred provider networks are partnerships created between hospitals and post-acute care providers—e.g., SNFs—to facilitate a smoother transition across settings and optimize health outcomes for patients.

of the rehab floor and the gym. One facility provides patients with iPads to review facility websites and complete a virtual tour when available, which is especially helpful if they have no family available to visit the facility in person.

Confirming the literature, providers said location was one of the most important factors for patients and families—patients want to go somewhere where they or their family members live. Patients care about staffing ratios, number of hours of physical therapy, physicians affiliated with the hospital, appearance of the facility, cultural food preferences, religious services, and private room availability.

> *"For most of our patients, the three most important things they look at for where they pick to go [are] location, location, location."*

Patients rely on their prior experience at a facility to decide if they would go back to it. The prior experience of friends and family members also guides their decision.

Pressure to Discharge the Patient

Several teams mentioned the constant pressures they face to optimize the length of stay and discharge patients that no longer require acute care services. The patients and family caregivers feel this pressure too and sense a rush to discharge. On the other hand, sometimes a patient may be medically ready for a discharge to a SNF but is kept longer so that the SNF stay is covered by Medicare. This is because of the Medicare 3-day rule, which states that a beneficiary (in the Original Medicare program) is eligible for rehab or skilled nursing care at a SNF only when they have been admitted to the hospital for no fewer than 3 consecutive days.[32]

Barriers to SNF Admissions

Across all the hospitals, staff members mentioned several patient-related factors as barriers to admission to a SNF, and many of the factors were discussed at multiple discussion groups. These included:

- Patients with multiple comorbidities
- Patients with dementia (due to wander guard needs or specialized care)
- Patients with behavioral health issues
- Patients with a history of substance abuse or who need treatment (e.g., suboxone or methadone)
- Patients with specialized treatment/equipment needs (e.g., dialysis, ventilator, or bariatric beds)
- Patients on expensive medications (e.g., IV antibiotics or chemotherapy)
- Patients who are young

- Patients who are homeless
- Patients who were living marginally in the community prior to discharge
- Patients who are undocumented

Hospital staff members noted that they are seeing higher-acuity patients with multiple chronic conditions and more complex needs and that it is a challenge trying to place these patients in a SNF, let alone a high-quality SNF. In one instance, they described having to send out a patient's application to all the SNFs in an entire New York City borough.

> *"Dementia, AIDS, psychiatric, substance abuse, anyone who is young, anyone who is on methadone, anyone on suboxone… anyone who is homeless, vent, dialysis, …bariatric… and if you have someone who has at least three of those [issues], … it's impossible [to place them at a SNF]."*

Insurance constraints also make discharge planning complicated—hospital staff members reported taking care of many underinsured patients, uninsured patients, and patients with narrow PAC networks. They reported spending more time trying to help patients navigate their insurance. For example, some patients who qualify for Medicaid start the application while in the hospital—the enrollment process requires substantial financial documentation which takes time to prepare and process. While SNFs historically accepted patients with pending Medicaid applications, the hospital staff members mentioned that they are now less likely to do so. In some cases, hospitals have developed an arrangement with their preferred providers to accept patients whose Medicaid applications are still pending. For patients with managed care plans, discharge applications sometimes require even more documentation to justify the medical necessity of short-term SNF care.

Delays in Insurance Authorizations

All the teams interviewed noted delays in insurance authorizations for SNFs. They indicated that insurers often take 72 hours to review the paperwork, and for example, if a patient's length of stay in the hospital is 4 days and the insurer takes 3 days to review the case—it becomes harder to discharge the patient in a timely manner and the patient may become further deconditioned while waiting. Insurers also request updates on the medical status of the patient because, by the time they review the case, the PT note is "old" and may not reflect the patient's current medical status. While hospitals operate 24/7, the same is not true for most insurers, with little or no action taken over the weekend on pending authorizations, which leads to further delays.

> *"Patients even get their hearts set on certain places … and because of insurance barriers, you kind of have to break their heart in a way…"*

Lack of Available Beds

Often beds are just not available at the patient's choice of facility, which adds even more chaos and rush to this process. Hospital staff members described a circumstance where a family did their research, visited and selected a facility as their first choice, but there was no bed available. Patients feel rushed because if they do not leave the hospital on a certain day, the SNF may not keep the bed available for them. One administrator noted that, sadly, the facilities of higher quality are the same ones that have limited bed availability.

> *"People rarely get their first choice."*

Preferred Provider Networks

A few hospitals we interviewed had developed preferred provider networks, and a few were looking into developing them. The idea behind these networks is to establish a closer relationship between the hospital and SNFs to work together on providing higher-quality care by focusing on transitions of care and reviewing outcomes (e.g., readmission rates, length of stay). These networks are still emerging and can ideally help facilitate smoother transitions, improve information exchange, and reduce errors or adverse events. For example, a hospital and SNF may conduct a root-cause analysis of a readmission to determine if there were systemic issues that if addressed may have been able to prevent a readmission or emergency department visit. Some hospitals are also trying to improve care transitions via warm handoffs, and to develop a shared evidence base of guidelines and protocol—e.g., best practices on transfusions. Efforts are being made to create open channels of communication by providing more direct ways for the SNFs to reach clinical staff at the hospital or providing remote access to the electronic medical records for physicians. Hospital staff members faced hurdles in establishing these networks for larger health systems because it can be difficult to develop systemwide arrangements. With these networks, hospitals cannot recommend certain facilities, but they can inform patients that they work closely with some facilities with the intent to provide shared accountability and improve the quality of care. Interestingly, most discharge planning teams were unaware about what data or information their hospital/health system used to determine what facilities would participate in their PAC network.

The Nursing Home Perspective on Discharge Planning for PAC

To obtain a more complete picture of PAC decision-making, UHF conducted phone interviews with nursing home administrators. The findings from these calls also indicate barriers to admitting certain patients into SNFs, challenges for patients and family caregivers to decide on a SNF and then adjust to the quick transition, and recent progress on improving communications and connections between the hospital and SNFs.

Factors Associated With Accepting a Patient

Nursing home staff members review the Patient Review Instrument (PRI)[vi] and complete a medical review of the patient's history, medications, treatments, and evaluations from hospital staff. Both in the hospital discussion groups and the interviews with SNFs, staff members mentioned that the PRI is an "outdated" tool and they often find the patient's history and physical assessment more useful.

Staff members also complete review of the patient's insurance coverage, medical conditions, social or behavioral issues, medications, need for specialized services (e.g., dialysis, ventilators), family caregiver support, home environment, stability of housing, and demographics (e.g., age). Bed availability is a particularly challenging factor if the patient needs a private room due to isolation precautions. High-cost medications (e.g., IV antibiotics, chemotherapy) came up several times as a serious concern since they are included in the daily rates Medicare pays for SNF care (under Part A), and those costs alone can exceed payment rates. There are further insurance constraints for patients in Medicare Advantage plans because some SNFs do not contract with certain plans.

For patients seeking admission to a SNF for short-term rehab, perhaps the most important factor is the presence of a viable discharge plan; SNFs are hesitant to admit a patient if they do not think the patient will be able to return to the community. It is also becoming less common for patients to go directly into long-term care. Bed availability is one of the reasons—in New York, long-term beds are scarce. Also, patients and families sometimes have difficulty accepting the need for a long-term stay in a SNF, and thus patients are placed in short-term beds if the hospital staff can show medical necessity.

Transition From the Hospital to the SNF

Nursing home administrators indicated that families are often overwhelmed and sometimes even "traumatized" when the patient arrives at the SNF because of the rapid discharge from one setting to the next, not knowing what to expect, and when trying to handle the complexities of insurance. The administrators indicated that improvements can be made by better preparing patients for what to expect at the SNF—some patients think SNFs are simply a continuation of care provided in the hospital and do not understand that there are differences in the level of care (e.g., how often they see a physician or the hours of nursing care they receive). Some of the administrators said they participate in preferred provider networks, which can be very beneficial for patient outcomes; however, they also highlighted that such arrangements can put the SNFs at a disadvantage when risk-sharing, given increasing patient acuity. Some SNFs are trying to build staff capacity to handle more medically complex patients.

vi The PRI is a tool used to evaluate a patient's medical condition, and it helps identify whether a patient is eligible for skilled nursing care; it also determines the level of care and appropriate services to meet the patient's needs.

Factors Associated With Discharging a Patient

Staff members told us that approximately 70 to 95 percent of patients in short-term rehab at a SNF are discharged to home either with family support or home care. Some patients do get transferred to long-term care either at the same SNF or another SNF, and they are provided a list of options to choose from. The SNF staff members review the patient's progress during rehab and similar medical and social factors as those reviewed on admission. Barriers to patient discharges include lack of caregiver support at home, not enough home health coverage, housing (e.g., walk-ups, temporary housing), receiving durable medical equipment on time (e.g., chair lifts, ramps). As we learned during the hospital discussion groups, they also experience delays in insurance authorizations when discharging a patient to long-term care.

Patient and Family Caregiver Preferences for SNF Selection

We asked the SNF administrators about factors that patients and family caregivers consider when choosing a SNF. They said not a lot of families tend to visit, and it is more likely that families visit when the patient is going to a SNF for long-term care. When they do visit, they ask about staffing, rehab, transportation, activities, and cost. They also look at the environment and do the "sniff" test.

Like many in the hospital discussion groups, SNF administrators indicated that location is a primary concern for most families, and they also depend on word of mouth from friends or family for choosing a facility. Also, some patients do look at Nursing Home Compare before deciding on a SNF, but it is often hard for them to understand all the information presented on the website.

Deciding on a PAC Facility: Reconciling the Different Perspectives

Our discussions with patients, family caregivers, and providers illustrate that patient and family caregivers need support to make an informed choice about PAC and that several factors can constrain their choices. There are common themes in both the patient and family caregiver and the provider perspectives.

Patients, families, and providers all felt pressure during discharge because of the tight time constraints. While patients and families wanted recommendations from providers about what facility to go to, providers understood their needs but felt that regulations prevented them from providing advice—or they did not want to be responsible if their perspective on a SNF differed from the patient's experience. It is important that patients are aware of what information and support they can and cannot receive. Similarly, providers should be aware of what information they can communicate within the bounds of the regulations, especially since we found differences in how staff members interpret the regulations.

Providers believe that patients and families should do their own research, recommend that families visit facilities, and, in some cases, encourage them to look at Nursing Home Compare. Yet not all families are able or have the means to visit facilities before

choosing one, so they may have to rely on their own research via Nursing Home Compare and other websites, or on recommendations from their family and friends. Patients and providers corroborated research on the low uptake of Nursing Home Compare among consumers, and some providers highlighted the need to consider patients who do not speak English, have low health literacy, or are not tech-savvy.

It also seemed that hospital staff members may not understand the many factors that matter to patients and family caregivers when making decisions about PAC. For example, while location was important to patients, some patients stated that they would prefer to go to a higher-quality facility even if it was not as conveniently located. Hospital staff members are also balancing patients' medical condition, insurance coverage, and other factors that affect acceptance into a SNF, which patients may not fully understand or know about. When the transition does occur, the nursing home administrators and the patient and family caregiver perspectives indicate that patients and their family caregivers feel unprepared for their transition to a SNF—they are not always aware about what a SNF is, how it is different from a hospital, what the care there might look like, and what their insurance covers. It may be challenging for hospital staff members to balance these factors while trying their best to manage a safe discharge.

Implications and Opportunities for Progress

In what is a critical juncture in a patient's health care journey—the discharge planning process does not fully support patient and family decision-making about PAC. Typically, patients and family caregivers receive lists of SNFs, along with recommendations to review Nursing Home Compare and visit the facilities. Given that patients and family caregivers do turn to their providers for help and ask for recommendations under very challenging circumstances, current regulations designed to protect patients' rights have created unintended consequences that limit support for informed decision-making.

System-level influences also pose constraints when patients are trying to go to a facility of their choice. Discharge planners often find it difficult to place patients in SNFs because of medical, social, insurance, and other factors discussed earlier. At the same time, challenges arise when the SNF of choice accepts a patient, but insurance authorization is delayed and the available bed is offered to another patient instead. There needs to be better alignment between payers and providers and more support for providers to help navigate these constraints and make the process more consistent.

Our findings point to several ways in which discharge planning for PAC might be improved:

- Better preparation for patients and families about what they can expect at a SNF
- Training staff to make it clear what information and support they can and cannot provide to patients and family caregivers

- Increasing staff familiarity with data on quality of SNFs available publicly on CMS Nursing Home Compare and NYSDOH Nursing Home Profiles
- Supporting vulnerable or disadvantaged patients and family caregivers who are not able to visit facilities, are not computer-savvy, have low health literacy, or cannot speak English
- Exploring new decision support tools and resources
- Tackling the causes of insurance authorization delays with payers
- Improving transitions to the SNF via preferred provider networks and other best practices

However, to make real progress and facilitate the best possible decisions about PAC, the underlying processes and support for patients and family caregivers as they make these difficult decisions will need to be carefully examined and better coordinated.

Appendix A: Methods

UHF interviewed hospital leaders and discharge planning staff as well as nursing home administrators to understand the transition to a SNF, and more specifically about how patients and families make decisions about what PAC facility to choose and what information and support is available to them during the process. Described below are the methods we used to gather and analyze this information.

Hospital Discussion Groups

We conducted 90-minute, in-person discussion groups at eight hospitals throughout the New York metropolitan area, including both public and private hospitals, hospitals that were part of large systems, and an independent teaching hospital. They differed demographically in their populations served. The specific composition of the discussion groups varied but broadly included frontline staff and leadership from medicine, nursing, social work, case management, physical therapy, and occupational therapy.

We used a semi-structured discussion guide to facilitate the discussion and elicit responses about the discharge process, evaluation of patients for discharge, involvement of patients and family caregivers, PAC discharge options considered, pressures and barriers faced by staff when planning a discharge, tools and information to support the selection of a facility, regulatory guidance on recommending facilities, perspectives on websites on SNF quality (such as Nursing Home Compare), development of preferred provider networks, and ideas about opportunities for improving the process to better support patients and family caregivers.

We recorded the discussions with permission from the group and agreed that the participants' comments would remain anonymous. We aggregated the notes from the discussion group, coded the themes that emerged during the discussions, and analyzed them using a qualitative software program, MAXQDA 2018.

Nursing Home Phone Interviews

We conducted 45-minute calls with five nursing home administrators—medical director, social work director, and CEO—in the greater New York area.

We used a semi-structured discussion guide to facilitate the discussion and elicit responses around criteria for accepting patients, transition to the SNF, visits by family caregivers and the types of questions they ask, patient preferences for SNF selection, thoughts on websites that provide information on SNF quality (such as Nursing Home Compare), preferred provider networks, and opportunities for improving discharge planning decisions about PAC from a patient and family caregiver perspective.

We took notes during the calls and agreed that the individuals' comments would remain anonymous. We aggregated notes from the interviews, coded the themes that emerged during the discussions, and analyzed them using a qualitative software program, MAXQDA 2018.

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