Finding the Right Level of Posthospital Care

"We Didn't Realize There Was Any Other Option for Him"

Robert L. Kane, MD

Many families considering posthospital care options are ill-prepared and in need of guidance. They may not know the range of available options, the relative benefits of each, or have considered their therapeutic goals. Physicians should be informants, advocates, and facilitators of this big leap for their patients. Making a good long-term care decision requires information and structure, but such decisions are often made under great time pressure as part of a hospital discharge. Professional intervention and guidance by an informed but disinterested facilitator may be needed, but hospital discharge planners may not be well suited for this role because their mandate is a rapid discharge. Physicians have 2 crucial roles in these transitions: to ensure the seamless delivery of primary care and to advocate for and facilitate, however possible, better decision making. Physicians need at least a rudimentary knowledge of the array of options and the implications of each. Even if the physician cannot serve as the planning facilitator, the physician should ensure that this task is done well. This review describes the range of options and the implications of each option for long-term care in the United States. It suggests the need for evaluating each patient's care goals, family circumstances and resources, and clinical status to determine if more aggressive medical care might improve an individual's clinical trajectory.

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THE FAMILY'S STORY

Mr and Mrs B lived in suburban New Jersey, where they had raised 3 daughters. Mr B, aged 79 years, had compensated congestive heart failure, diet-controlled diabetes mellitus, and hearing loss remediated with hearing aids. He was physically, mentally, and socially active. Mrs B, aged 78 years, had chronic back pain that limited her activities; Mr B assisted with laundry and food shopping. Nonetheless, Mrs B was still able to engage fully in an independent and active life.

In April 2006 Mr and Mrs B were involved in a severe motor vehicle crash. Mrs B was taken to a hospital, where she was found to have an ankle fracture that required surgery and other minor injuries. Mr B was seen at a different hospital and released to his daughter's home. Three days later, Mr B collapsed; a subdural hematoma was diagnosed and treated surgically, but he remained in a coma in the intensive care unit for more than 5 weeks. Mr B was discharged into an acute rehabilitation facility and thereafter to a skilled nursing facility (SNF). After Mrs B's ankle surgery she received acute rehabilitation and was then discharged to Mr B's SNF.

Mrs B's gradual improvement necessitated finding a new place for her to live. Her injuries ruled out stairs, so her multistory house (hours away from her husband and daughter) was not a viable option. Her daughter's home lacked a ground-floor bathroom and also would not work. Mrs B, with input from her daughter, settled on an apartment in congregate senior housing that provided breakfasts and dinners.

Mr B was evaluated by the assisted living facility that was affiliated with Mrs B's facility but was turned down be-

See also p 302.

CME available online at www.jamaarchivescme.com and questions on p 313.

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cause his care needs were too great. Mr B stayed at the SNF for 2 years. His family hired an aide for 16 hours a day because Mr B would forget that he needed help to walk safely, and he fell frequently. The out-of-pocket cost of the SNF and the aide was approximately $87 000/y.

Two years after the crash, the family learned about an assisted living group home for patients like Mr B and moved him there. The cost of room, board, and care was $7300/mo. Although he has significant cognitive impairment, he is still able to recognize family members. Mrs B visits Mr B every week, and his physician, Dr T, makes house calls. The family has retained a geriatric care manager to assist Mrs B with her ongoing medical needs.

Mr B is incapable of carrying out instrumental activities of daily living (IADLs) (eg, cooking, using the telephone, shopping) and requires assistance with all activities of daily living (ADLs) (basic tasks such as dressing, using the toilet, or feeding oneself), although he can eat by himself with supervision. Mrs B is capable of managing all ADLs, and is largely able to manage her IADLs, with periodic checking-in as to accuracy of medication management by the geriatric care manager and her daughter. The family does not think it possible to find a place that can accommodate the needs of both spouses.

Mr and Mrs B's daughter, Mr B's physician Dr T, and Mrs B's geriatric care manager were interviewed by a Care of the Aging Patient editor between June and November 2009.

PERSPECTIVES

Mr B's Daughter: *My father stayed at the skilled nursing facility for 2 years, mainly because we didn't realize that there was any other option for him. . . . [W]e found out about an assisted living group home. It has 8 residents. My father has his own bedroom and a shared bathroom . . . he can eat what he wants for breakfast and they have people who come in and do activities. It's just much more peaceful for him . . . It's pretty high-level care.*

Dr T: *We've become highly specialized and we can keep people alive for a long period of time, but coordinating care on multiple levels is a problem.*

Mrs B's Care Manager: *Often social workers are really concerned with the immediate discharge plan . . . from their facility's perspective; they're not always as in tune with the future placement options for that resident.*

Unlike most families, the B family had the financial resources to pay for the care they needed at each stage of the long-term care (LTC) journey. Nonetheless, they found it difficult to identify and find the most appropriate LTC options at each care transition. As with Mr and Mrs B, many older persons begin their LTC careers with a hospitalization. Many do not, however, have adequate financial means to pay for their LTC as the Bs did. Generally, Medicare covers the care provided immediately after hospital discharge, called postacute care (PAC). Postacute care, however, is a short-term proposition intended for recuperation; persons needing more care fall into the category of LTC. Overall, about 45% of Medicare beneficiaries discharged from a hospital go to some sort of posthospital care. The number varies by diagnosis. For example, 45% of patients with heart failure receive PAC, compared with 70% of those with stroke and 90% of those with hip fracture.[1] A person surviving to 65 years has about a 40% chance of spending some time in a nursing home before death, and that risk increases with age.[2]

As populations age around the world, more policy attention has turned to providing some form of universal coverage for LTC. Most European countries offer at least some coverage, and many offer quite extensive coverage. The best-known universal LTC programs are probably those of Germany[3] and Japan.[4,5] The former emphasizes community care and allows patients to receive cash in lieu of services. The latter is more targeted at institutional care. The United Kingdom, France, the Netherlands, and most Scandinavian countries have provisions for publicly funded LTC.

Although most physicians will not spend much of their professional lives practicing in LTC settings, they have compelling reasons to become familiar with the LTC landscape. First, they need to ensure safe and appropriate transition of primary care when LTC is required. Second, they should facilitate well-informed decision making when LTC becomes necessary and serve as advocates for their patients so that the patients' best interests and goals of care are achieved when transitions to LTC are made. This review describes the roles physicians can play in caring for patients across the range of PAC and LTC and as they move from one level of care to another. The different levels of PAC and LTC, the outcomes and quality of this care, and the roles of other professionals are also described.

METHODS

Three literature reviews were conducted in PubMed to identify studies published in English between 1990 and November 2010. Additional references were retrieved manually. The searches addressed transitional care, as well as PAC, subacute care, rehabilitation, and nursing home quality. The search strategy and terms are shown in the eAppendix, available at http://www.jama.com.

The Physician's Role in Care Transitions and LTC

Physicians play key roles in managing these types of care transitions (Box 1), which are high-risk events associated with poor outcomes, such as rehospitalizations. The use of hospitalists, by adding another layer of handoffs, may further complicate this transition. Generally speaking, the more transitions required, the greater the likelihood that changes in regimens associated with these moves can lead to medication errors, and this risk is exacerbated by poor commu-

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Box 1. The Physician's Role in Managing Care Transitions and Addressing Placement Options

Manage underlying medical conditions, considering patient goals, life expectancy, and comorbid conditions.
Consider the functional implications of the patient's medical conditions (see Table 1).
Communicate with those working in supportive roles (eg, home care and nursing home staff).
Communicate with families and patients. Use family conferences to discuss end-of-life decisions.
Assess whenever an older person is making a major care transition. Are there any conditions that can be controlled better, any medications that can be reduced or discontinued?
Advocate for patients and families getting an opportunity to make thoughtful decisions.
Facilitate families getting access to their own advocates/case managers.
Be alert for signs of neglect and abuse.
Appreciate the high-risk nature of caregiving.

Box 2. Issues to Be Addressed in Making a Discharge Plan

Identifying the Most Suitable Type of Care

What goal are you trying to maximize?
What options are available? (see Table 2).
How well does each option achieve the desired outcomes? What are the risks associated with the option? Will the patient have to move again? Will the option require a new physician? How big a risk is discontinuity of care in this case?
What are the costs involved in each option? Will third parties pay for some options but not others?

Choosing the Best Vendor

Where is it located? Will relatives be more inclined to visit?
Does it have a philosophy compatible with the patient's and/or family's? Does the vendor have a religious or ethnic overlay desired by (or at least acceptable to) the patient?
Are there policies that restrict the residents from doing what they want? How much risk is the family willing to take?
What is known about the vendor's quality track record?
What does it cost? Total cost? Net costs after third-party payers pick up their share?
What is available now?

Specific Tasks for the Physician

Determining who will assume responsibility for ongoing primary care.
Ensuring a smooth handoff with adequate transfer of salient clinical information

nication.[6-9] Programs that use nurses (or trained "coaches") to work with patients prior to and after discharge can reduce hospital readmission rates by ensuring that patients understand their regimens and can follow through with them.[10-15] However, these programs are currently the exception rather than the rule. Thus, the quality of a physician's documentation at a time of transition may determine whether the patient receives the right medication regimen, gets appropriate follow-up, and gets care that is consistent with the patient's values and goals.

Whenever patients require relocation for more substantial care, physicians should be alert to correctable problems that may have been overlooked or a breakdown in the patient's support system. Assessing the patient for correctable problems also provides the basis for educating the receiving facility about the client's medical status.

Physicians need to communicate with multiple LTC programs. Effective communication between physicians and nursing homes and other elder care programs can result in fewer emergency department visits and better care plans that are more consistent with a patient's goals.[16] New approaches are being developed and tested to support nursing aides in making systematic observations of nursing home resident clinical parameters to create an early warning system about changes in status (eg, INTERACT II[17]). Another approach, the clinical glidepath, structures nursing aides' daily observations of residents' salient clinical parameters to identify early signs of changes that trigger interventions to avoid medical catastrophes.[18] Some managed care plans have established programs specifically designed to manage more problems in the nursing home and avoid hospital transfers.[19]

Physicians should serve as the advocates for their patients and their caregivers, particularly when a discharge (either from the hospital or the nursing home) may not be in the patient's best interest, such as when a caregiver is overwhelmed with the caregiving role. Physicians should argue for more time to make a more thoughtful and realistic discharge decision. They should be sensitive to signs of caregiver fatigue and urge additional supportive care when needed.

Planning Posthospital Care

Mr B's Daughter: *My mother's discharge from the hospital was expected and we had time to consider what the next step would be, but her options were limited since she was discharged to acute rehab. My father's discharge was rather abrupt. He had been in the intensive care unit for 5 weeks and the order was written on a Friday for a Monday discharge. I was not told about the discharge from the doctor, but from other hospital staff. I was completely in the loop with discharge planning. The social worker for the intensive care unit was extremely helpful in giving me options and recommendations for facilities where I could place my father with a respirator and tracheotomy.*

For many patients like the Bs, the transition from independent living to a higher level of care occurs relatively sud-

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denly following an acute hospitalization. Often still grappling with the implications of the illness, families and patients have a poor idea of long-term prognosis when they are pushed into making a long-term placement decision. Most persons experience this introduction to LTC as extremely stressful. Because placement decisions made at hospital discharge can shape the rest of an older person's life, they should be made methodically (BOX 2). Hospitals, however, often prefer the most expeditious discharge route. In clinical scenarios like the B's, families often receive a list of facilities with open beds, rather than encouragement to discuss the full set of long-term options. Rarely is the time and attention paid to the initial planning commensurate with the importance of the decision. Programs should provide adequate time for such decision making; if a hospital bed is too expensive, then a short-term transitional care plan could be created.

With complex cases such as the B's, some trade-offs are inevitable. Is the primary goal to preserve the patient's autonomy and quality of life, or is safety a larger concern? These goals are important to discuss, but such discussions may uncover disagreements and historic tensions within a family. The older person's voice must be heard amidst the concerns of family members. Often, the patient's primary concern is autonomy, while health care professionals and the family are more concerned with safety. Families often benefit from the assistance of an outside mediator and advisor. Although one might hope hospital discharge planners would play this role, they rarely do; it may be necessary to hire an independent case manager.

The first step in determining a care transition is to assess the patient's disease, prognosis, rehabilitation potential, functional status, and decision-making capacity. Many of these data can be collected by nonphysician health care professionals, including physical therapists, occupational therapists, and nurses. TABLE 1 outlines some basic parameters that can inform LTC decisions. Physicians should be familiar with these assessment tools and use them to identify patient needs as a basis for planning LTC. Professional advice should be seen as just that: informed opinion about what kinds of care are likely to work best. In the end, the judgment should rest with the older patient and her family. They need to be helped to determine their care goals. A primary issue to ascertain is the likelihood that the underlying condition can be improved (or even reversed) with active rehabilitation or more aggressive medical care. Conditions like stroke, hip fracture, some hospital-induced debilitation, depression, and delirium may be improved through active care. By contrast, unless extenuating circumstances such as medication adverse effects or infections are identified, patients with dementia or stroke with no further clinical or functional improvement are unlikely to improve after discharge, other than reversal of impairments related to hospitalization itself. In general, heavier needs for care (greater functional dependency) will require more intensive forms of care.

Table 1. Measures Helpful in Planning Long-term Care

Parameter	Components	Examples
Activities of daily living	Bathing, dressing, feeding, using the toilet	Katz ADL Scale[20] Barthel Scale[21]
Instrumental activities of daily living	Cooking, cleaning, using the telephone, paying bills, using public transportation	Lawton IADL Scale[22]
Depression	Feeling sad, blue	Yesavage Geriatric Depression Scale[23] PHQ 9[24,25]
Cognition	Memory, problem solving, orientation, language	MMSE[26] Mini-Cog[27]
Mobility	Walking, getting out of a chair	Get Up and Go Test[28]

Abbreviations: ADL, activities of daily living; IADL, instrumental activities of daily living; PHQ 9, 9-Item Patient Health Questionnaire; MMSE, Mini-Mental State Examination.

Decision-making issues related to LTC options differ from those for PAC. Two schools of thought apply in choosing LTC (as opposed to PAC) options. The first suggests that location of LTC is a continuum, based on the idea that persons whose care needs are greater require a more intense type of care, ie, more professional staff and more active care. The second maintains that almost anyone can be cared for almost anywhere if the planning is right, ie, "aging in place." In reality, payment (or insurance coverage), rather than patient preference, often determines what option a person may "choose." In some cases, as with Mr B, patients are placed in a higher level of care than they need because they are unaware of other options. About 10% of long-stay nursing home residents have only minimal needs that could be readily met in the community.[29] Although community LTC is a mandated service under Medicaid, the majority is provided by special waivers that allow states to use money that would have gone to pay for institutional care to be used for community care.[30,31] States vary widely in their use of these waivers. Too often Medicaid will pay only for nursing home care, when other options might be preferable for both patient and society. Provisions under the 2010 Patient Protection and Affordable Care Act[32] create new voluntary LTC insurance coverage in the Community Living Assistance Services and Supports (CLASS) Act, which will specifically reimburse community care.

The evidence base addressing benefits and risks of different placement options is not robust. Despite a general sense about where patients needing care should be treated, hospital discharge placement is far from an exact science. Multiple types of care can address the needs of persons with a given condition. Recommendations for the best type of care may reflect the health professionals' background. When a group of experts was given patient scenarios describing persons with varying characteristics and asked to recommend the most appropriate care, their recommendations tracked their disciplines and professional experiences.[33]

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Which Programs Are Available?

The experiences of both Mr and Mrs B illustrate how older patients may transition through several stages of care after a hospitalization. Both experienced formal inpatient rehabilitation followed by a nursing home stay and then, in Mrs B's case, a discharge to a less care-

Table 2. Types of Long-term Care

Type	Description	Public Third-party Coverage	Basis for Medicare Payment	Cost Range, $/d	Predominant Physician Type
Postacute care					
Inpatient rehabilitation facilities	Facilities specifically licensed to provide active rehabilitation. Patients must receive at least 3 h a day of PT and/or OT and must show progress to be kept on Medicare.	Medicare (must have a qualifying condition) Medicaid	Prospective payment per episode based on case mix	1000-2000	Physiatrist
Skilled nursing facility	Many nursing homes certified to provide posthospital care under Medicare. Skilled needs include complex medication schedules, wound care, or rehabilitation.	Medicare Medicaid	Daily rate based on case mix (100 d but copayment after 20 d)	150-300	Primary care clinician (physician, nurse practitioner, both), medical director
Long-term care hospital	Facility certified by Medicare to handle complex care (eg, ventilator care and weaning) of patients discharged from hospitals.	Medicare	Variation of hospital payment DRG	1500-3000	Hospitalist
Home health care	Medicare-certified care supervised by registered nurses. Other core staff: physical, occupational, and speech therapists, and social workers.	Medicare Medicaid (limited)	Payment per episode based on case mix	100-300	Primary care clinician
Outpatient rehabilitation	May be certified to conduct active rehabilitation.	Medicare Medicaid	Payment per visit	100-200	Primary care clinician
Hospice/ palliative care	Intended for those at terminal phase of life with expected prognosis ≤6 mo. Hospice care is a specific benefit under Medicare; as such, it is predicated on primarily nonhospital care. Palliative care provides active support like hospice care but without the expectation of avoiding other medical care.	Medicare (hospice; palliative care options vary)	Payment per day	200-300	Primary care clinician or palliative care specialist
Long-term care					
Home care/ personal care	Services to support frail person who needs assistance in meeting various ADL or IADL care.	Medicaid (state plan and waivers)	Payment per hour (sometimes minimum number of hours)	75-150	Primary care clinician
Nursing home	Certified to provide long-term care; some offer specialized units for persons with dementia.	Medicaid	Payment per day	75-300	Primary care clinician (physician, nurse practitioner, both), medical director
Assisted living	Institutional care with self-contained units including living quarters, a private bathroom, and some modest cooking and food storage facilities; heterogeneous and minimally regulated. Serve less disabled clientele than nursing homes. Some offer specialized units for persons with dementia.	Medicaid in some states (waivers)	Payment per day or month	60-300	Primary care clinician
Day care or adult day health center	Care provided in centralized facilities for various periods of the day. Some also have medical or nursing services (ie, adult day health care vs social adult day care).	Medicaid (in some states)	Payment per use	60-120	Primary care clinician
Adult foster care	Small group living settings with care by nonprofessionals; more homelike than larger institutions.	Medicaid in some states (waivers)	Payment per month	50-100	Primary care clinician
Independent living	Room and board and some housekeeping; may have social activities and amenities.	None		50-100	Primary care clinician
Board and care	Variant of independent living, with room and some meals.	None		50-75	Primary care clinician

Abbreviations: ADL, activities of daily living; DRG, diagnosis-related group; IADL, instrumental activities of daily living; OT, occupational therapy; PT, physical therapy.

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intensive location. TABLE 2 and the eFigure summarize the available options.

Postacute Care Options. Many patients can safely return home after a hospitalization with just informal care from families, but some will need additional postdischarge care—ie, PAC—to compensate for shorter hospital stays. Long-term care and PAC often look alike and may even be provided in the same types of places (ie, at home or in a nursing home), but they are quite different, at least in theory. Long-term care implies ongoing support designed to respond to deficits in functioning. Postacute care has a much more active rehabilitative and recuperative goal. Patients undergoing Postacute care can reasonably expect to improve their status, whereas for LTC, success is better measured as slowing the rate of decline. Three primary forms of PAC include inpatient rehabilitation, skilled nursing facilities, and home health care. A fourth but less prevalent option is an LTC hospital. The type of PAC can matter. Some evidence, summarized in TABLE 3, suggests that inpatient rehabilitation is associated with better outcomes for patients with strokes than is nursing home care.[36] In contrast, although rehabilitation for hip fractures is generally associated with benefits,[35] inpatient rehabilitation appears to offer no obvious benefit over nursing home rehabilitation for patients with hip fracture.[37-39] Inpatient rehabilitation for patients with hip and knee replacements was associated with improved function but no improvement in scores on the 12-Item Short Form Health Survey.[40,41]

Inpatient Rehabilitation Facilities. Inpatient rehabilitation facilities (IRFs) are specifically licensed facilities that can provide active rehabilitation. Usually distinct units of a hospital, IRFs may also be free-standing facilities. Care occurs under the direction of a physiatrist. Much of the care is provided by nurses and physical and occupational therapists, although aides may carry out most routines.

Some cases may also involve additional disciplines such as speech therapy. To continue Medicare coverage, patients should be able to tolerate at least 3 hours a day of at least 2 different disciplines of therapy and show signs of progress each week.

Skilled Nursing Facility. Many nursing homes are certified to provide posthospital care under Medicare. Such homes are referred to as SNFs (skilled nursing facilities). The term "skilled," although not well defined, refers in most cases to treatment regimens that began in the hospital and need to be continued. These could include complex medication schedules, wound care, or rehabilitation.

LTC Hospital. Long-term care hospitals are facilities certified by Medicare to provide complex care such as ventilator care and weaning. They can provide rehabilitation in a more medically intensive setting than SNFs.

Home Health Care. Home health care is Medicare-certified care operated under the jurisdiction of registered nurses. Other core staff include physical, occupational, and speech therapists and social workers. Patients usually require some form of active or "skilled" nursing care and supervision. As with SNF care, these needs could include complex medication schedules, wound care, or rehabilitation. Most of the care is directed at recovery after a hospitalization.

Outpatient Rehabilitation. Special outpatient facilities may be certified to conduct active rehabilitation. This can be provided at the same level of rehabilitation provided in IRFs. In general, one might expect that the most severe cases would be treated in an inpatient setting, but there is overlap in the case mix.

Hospice. Hospice care meets the needs of those who have reached the expected terminal phase of life, with a typical prognosis of less than 6 months. Hospice care is a benefit under Medicare. Most hospice care occurs at home; however, some communities have inpatient hospice units, and some nursing homes have designated hospice beds.[42] Hospice goals address the alleviation of uncomfortable physical symptoms (eg, pain, nausea, dyspnea, and constipation) and provide the emotional and spiritual support needed to help the patient and family members face death.

LTC Options

Home Care/Personal Care. As opposed to home health care, home care services are generally "unskilled" services that support frail patients who need assistance in performing various ADL or IADL tasks. Nurses may supervise, but most care is provided by personal care aides or homemakers. In many cases persons may purchase this care directly, contracting with individual aides. Home care, distinct from home health care, is not covered by Medicare but is covered by Medicaid for eligible persons.[43]

Nursing Home. Long-term care nursing facilities are certified to provide LTC, funded either privately or through Medicaid. Nursing homes must provide at least minimal levels of nursing staff and have an infrastructure capable of overseeing the care of frail persons.

Assisted Living Care. Assisted living has effectively lost its meaning after being taken up by so many organizations and companies that offer a wide variety of services and amenities under the same banner.[44,45] Assisted living facilities (ALFs) may serve a wide variety of clients, but usually they serve a less disabled clientele than do nursing homes. Some ALFs offer special units for cognitively impaired residents. Residents live in self-contained units that include living quarters, a private bathroom, and some modest cooking and food storage facilities. Residents may use a common dining room and participate in various organized activities, but they control their own routines. Staffing varies extensively. Most assisted living is paid for privately. Medicaid coverage of assisted living varies by state but is generally limited. Different arrangements exist to pay for care associated with ADL and IADL needs. In some cases there is a base rate and additional care can be purchased in time increments. Other ALFs offer tiers of service packages. Some offer no assistance and discharge residents when they need increased levels of care. Currently, there is very little regulation and oversight of ALFs.

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A review of the correlates of ALF quality points to the problems of having widely varied definitions of such care and few systematic studies of its quality.[46-48]

Day Care or Adult Day Health Center. These programs provide care in centralized facilities for various periods of the day. The goal of this care is 2-fold: first, to provide socialization for older persons otherwise confined to their homes; and second, to provide relief for family caregivers. Some day care programs provide organized activities and may also provide services like assistance with ADLs and even bath-

Table 3. Studies of Postacute Care Outcomes

Source/Study Design, Years of Study/Sample	Rehabilitation Attributes Studied/Outcomes	Results
Buntin, 2010[34] Design: cross-sectional analysis of Medicare administrative data, 2002-2003 Sample: elderly Medicare patients enrolled in the fee-for-service Medicare program and discharged from an acute care hospital between January 2002 and June 2003: 233 986 with hip fracture and 287 115 with stroke	Attributes: IRFs, SNFs Outcomes: mortality, return to community residence, and total Medicare postacute payments by 120 d after acute care discharge among patients for whom there is the greatest clinical uncertainty regarding optimal postacute care	Hip fracture: IRFs vs returning home reduced mortality by 5.1% ($P < .001$) at 120 d postdischarge; SNF vs returning home reduced mortality by 6.3% ($P < .001$) among patients with hip fracture. Stroke: IRFs vs returning home reduced mortality by 2.7% ($P < .001$) at 120 d postdischarge; patients in SNFs vs IRFs were 9.3% ($P < .002$) more likely to have died or been institutionalized at 120 d.
Chudyk, 2009[35] Design: systematic review of studies published 1980-2007 Sample: 30 randomized and 25 nonrandomized trials	Attributes: 6 categories of rehabilitation (care pathways, early rehabilitation, interdisciplinary care, occupational and physical therapy, exercise); 3 settings (acute care hospital, postacute care/rehabilitation, postrehabilitation) Outcomes of hip fracture rehabilitation in elderly: mortality, functional recovery, length of stay, hospital readmission, placement in nursing home	Measures and methods for characterizing rehabilitation interventions and settings not well standardized, hampering conclusions about best practices in hip fracture rehabilitation in elderly patients. Interactions between patient characteristics (eg, sex and psychologic factors) and functional recovery were not consistently reported and may be important. The most frequently reported positive outcomes were associated with measures of ambulatory ability.
Deutsch, 2006[36] Design: cross-sectional, 1996-1997 Sample: Medicare claims for 58 724 Medicare beneficiaries with recent stroke	Attributes: IRFs and SNF subacute rehabilitation programs Outcomes: community discharges, discharge FIM scores, Medicare Part A reimbursement	Rehabilitation in IRFs associated with higher functional outcomes and higher cost. Patients in IRFs had higher adjusted ORs for community discharge among those with mild motor or no cognitive disabilities (2.19 [95% CI, 1.52-3.14]), moderate motor disabilities (1.98 [95% CI, 1.49-2.61), significant motor disabilities (1.26 [95% CI, 1.01-1.57]), and severe motor disabilities (age <82 y) (1.43 [95% CI, 1.25-1.64]).
Deutsch, 2005[37] Design: cross-sectional, 1996-1997 Sample: Medicare claims for 29 793 Medicare fee-for-service beneficiaries with recent hip fracture	Attributes: IRFs and SNF subacute rehabilitation programs Outcomes: community discharges, discharge FIM scores, Medicare Part A reimbursement	SNF subacute rehabilitation programs less costly with similar or better outcomes. Patients with moderate-to-severe and severe disabilities in inpatient rehabilitation facilities discharged to the community less often (adjusted OR, 0.71 [95% CI, 0.55-0.92]). After controlling for covariates, including baseline FIM scores, procedure, prior living arrangement, comorbidity, age, and sex, the difference in change in motor FIM score was not different in IRFs vs SNFs.
Kane, 1998[38] Design: prospective with 1 y of follow-up, 1988-1989 Sample: 487 patients with stroke and 606 with hip fracture	Attributes: posthospital care at home, in rehabilitation programs, and in nursing homes Outcomes: mortality, rehospitalization, discharge to nursing homes, functional improvement	Rehospitalization rates lowest in patients with stroke discharged to home; highest adjusted rehospitalization rates were in patients with hip fracture discharged to home health care, lowest in those discharged to nursing homes. For patients with stroke, posthospital care in rehabilitation facilities or home health care associated with significantly better functional improvement initially, but not at 1 y. For patients with hip fracture, those discharged to rehabilitation facilities experienced the most functional improvement.
Kramer, 1997[39] Design: prospective with 6 mo of follow-up, 1991-1994 Sample: 485 randomly selected patients with stroke and 518 with hip fracture	Attributes: rehabilitation hospitals, subacute nursing homes, and traditional nursing homes Outcomes: community residence, recovery to premorbid levels in 5 ADLs, Medicare costs, number of therapy and physician visits	Patients with stroke treated in rehabilitation hospitals had better outcomes; more patients with stroke were discharged to the community after treatment in subacute nursing homes vs traditional nursing homes. For patients with hip fracture, ORs of community discharge were 4.3 (95% CI, 2.5-7.4) for IRFs vs SNFs, 2.8 (95% CI, 1.6-5.1) for IRFs vs subacute SNFs, and 3.0 (95% CI, 1.7-5.0) for subacute vs traditional SNFs.

Abbreviations: ADL, activities of daily living; CI, confidence interval; FIM, Functional Independence Measure; IRF, inpatient rehabilitation facility; OR, odds ratio; SNF, skilled nursing facility.

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ing. Some day care sites also have medical or nursing services on the premises (often referred to as adult day health care in contrast to social adult day care). Day care programs have drawbacks. For example, some caregivers find it hard to get their charges ready to be picked up or dropped off on time, and long van rides may be disruptive for some. Day care is not a mandated Medicaid service but may be paid for under some waiver programs.

Adult Foster Care. In these small group living settings, nonprofessionals care for older residents, sometimes providing assistance with ADLs and IADLs. Residents may have their own rooms or share them. Some Medicaid waiver programs cover adult foster care.[49]

Independent Living. Independent living facilities, such as Mrs B's, resemble scaled-down hotel services. Most programs provide rooms, some meals, and light housekeeping services but no personal care or assistance. Many have social activities, exercise programs, and other amenities, such as transportation to local grocery stores or banks. Some independent living facilities operate within multilevel facilities that include assisted living and nursing-home levels of care. In some places independent living overlaps with the barest form of assisted living. Both typically offer some level of private accommodation and some capacity to store and prepare food.

Board and Care. A variant of independent living, board and care supplies room and some meals in a setting designed to meet the needs of people living on limited incomes. The extent of housekeeping services may vary. Persons living in this arrangement may also independently receive home care services.

Continuing Care Retirement Communities. Continuing Care Retirement Communities are sometimes called life care communities. Entering one is usually a once-in-a-lifetime decision, which is the appeal. Many have large campuses that include separate housing for those who live very independently, assisted living facilities that offer more support, and nursing homes for those needing skilled nursing care. With all care on the same grounds, people who are relatively active, as well as those who have serious physical and mental disabilities, all live nearby. In theory, residents can move from one housing choice to another as their needs change. While usually very expensive, many guarantee lifetime shelter and care with long-term contracts that detail the housing and care obligations of the continuing care retirement community as well as its costs. In theory, a couple could live on the same campus in different facilities, thereby facilitating visitations to the frailer partner.

Choosing a Quality Facility or Program

Nursing Homes. While the choice of a nursing home is often influenced by location, quality should be considered. The Centers for Medicare & Medicaid Services (CMS) provide an online quality report, Nursing Home Compare,[50] which is derived from several sources that rate aspects of the quality of care in virtually every nursing home in the country. The CMS mandates reporting of each resident's status using the MDS (Minimum Data Set). Nursing Home Compare also includes results of on-site inspections by state surveyors, and data on staffing. The CMS has also instituted a new Five Star quality reporting system for nursing homes that places a heavy emphasis on the results of the annual surveys conducted by field teams. The usefulness of the rating system to families making decisions about LTC has not been determined.

A number of states also have their own online nursing home report cards, some of which offer data on quality-of-life measures and resident satisfaction, as well as quality of care. For example, the Minnesota Nursing Home Report Card provides more quality measures and allows users to sort homes based on individual quality preferences.[51]

Nursing home quality relates to specific characteristics of nursing homes, but no consistent patterns emerge beyond staffing (eTable). Staffing level, especially registered nurse staffing, is a strong predictor of quality, but it is not necessarily causal.[52,53] For-profit nursing homes are generally associated with poorer quality.[54-56] It is much harder to identify similar characteristics associated with quality for other LTC venues. However, nurse staffing has been associated with hospital quality.[57] Nurse staffing should also be related to quality in other settings such as rehabilitation, but ironically, similar quality information is not available for rehabilitation facilities.

Although available quality measures and knowledge of nursing home characteristics may inform judgments about their quality, nothing replaces actually visiting the facility and observing care; the family should be strongly encouraged to do so and if possible talk with others who have firsthand experience with the facility.

Home Health Agencies and Assisted Living. Reports, similar to Nursing Home Compare, are derived from data from the mandatory OASIS (Outcome and Assessment Information Set) forms that home health agencies submit.[50]

By contrast, information on assisted living is very difficult to obtain. No systematic reporting exists, even to identify facilities and what types of care they provide. Some states provide limited information. The local Area Agency on Aging, a federally operated resource run by the Administration on Aging, may be a useful first resource for uncovering what information is available.

Not only is quality information for many forms of LTC difficult to come by, it may prove challenging to identify care providers in the first instance. Hence, a care manager may be especially helpful.

The Role of Care Managers

Mrs B's Care Manager: *I view myself as working in partnership with elders and their families. I sit down with them and get a very good assessment about where the family is in their decision making, exactly what their priorities are, and what, [as] in this case, the parents' lifestyle was before they were ill.*

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My role is to streamline . . . [the . . .] process . . . to help families get focused on just a handful of options. This way they're not overwhelmed with information.

Older persons and their families often need help in planning and implementing LTC. The advocates who assist with this process are typically called case or care managers, but this designation gets used in a wide variety of contexts to achieve a variety of ends.[58] Many are employed by public agencies to facilitate and oversee the use of social welfare funds. Although they seek to help clients make good choices, they are also charged with controlling costs. Others work for health plans to rein in spending for beneficiaries with high utilization. They may do this by improving disease management or suggesting ways to use less expensive care.

The Bs used a care manager late in the game. Had the care manager been involved earlier, she might have expedited Mr B's care and advocated more strongly for a better placement.

A growing cadre of care managers, such as the one retained by the B family, work directly for clients (and their families); they are paid privately at a rate of about $75-$80/h, although in some locations costs run substantially higher. A care manager plays several roles. Most importantly, care managers advocate for their clients. They know how the system works and can anticipate problems. Care managers understand the rights of beneficiaries and can challenge the often authoritative statements of hospitals and health plans. They should be knowledgeable about the array of services available in a community, how to find out more about them, and what coverage is available for each type of service. They should help structure decision making, while providing information about the availability, risks, and benefits (and costs) of various care options. They may serve as a mediator, helping family members resolve or deal with conflicting beliefs about treatment goals. Additionally, they may be decision facilitators, helping families decide on their priorities and weigh available options.

It is important to clarify for whom the care manager works. Although the family pays for the services, the ultimate client should be the older person. Indeed, an important role for a care manager is to preserve the older person's voice in decisions. Finding a care manager is not easy, and physicians can serve their patients well by becoming familiar with some local resources. The National Association of Professional Geriatric Care Managers[59] provides a means for finding a geriatric care manager, but they have no official standing. Membership is determined by paying a fee. A good place to start the search for a care manager is the local Area Agency on Aging.[60] They may either have a staff of care managers or make suitable referrals. Social work departments at many hospitals can often direct families to private case managers. Other resources are the disease-specific organizations, eg, the Alzheimer Association, the American Heart Association, and the Arthritis Association, or local social service agencies such as Jewish Family Services.

CONCLUSIONS

The Bs would have benefited from better support as they considered treatment options at each stage of their recuperation. Mr B could have been cared for earlier in a less restricted setting. The Bs had the resources to pay for their own care, but many older persons do not. Private LTC insurance theoretically could help cover the costs of such care and make more options possible. However, deciding about purchasing LTC insurance requires substantial thought and calculations. Most persons do not buy it until they are at risk of needing such care, and then the cost is high. Buying it early, when the premiums are much less expensive, means spending scarce disposable income on something that will not be used for many years; moreover, the value may be eroded by inflation.[61]

Each decision to move an older person out of a hospital or along the LTC continuum can affect the rest of that person's life. Decisions at each move should carefully weigh the alternatives and determine which choices align best with the patient's most important goals. Physicians have 2 crucial roles in these transitions: to ensure the seamless delivery of primary care; and to advocate for, and facilitate, however possible, better decision making. They need to know at least enough to make useful referrals to persons and organizations that can assist older persons and their families in this important task.

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Resources

ELDERCARE LOCATOR

http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx (or 1-800-677-1116)

Eldercare Locator, a public service of the Administration on Aging, connects older Americans and their caregivers with state and local agencies on aging and community-based organizations that serve older adults and their caregivers. They also provide state reporting numbers for suspected elder abuse.

NURSING HOME COMPARE

http://www.medicare.gov/NHCompare/

This tool provides detailed information about every Medicare and Medicaid-certified nursing home in the country. It also provides links to other resources such as Medicare's guide to choosing a nursing home.

HOME HEALTH COMPARE

http://www.medicare.gov/HHCompare/

This tool provides information on home health agencies. An example of a state-developed nursing home report card is available at http://www.health.state.mn.us/nhreportcard/.

INTERACT II

http://interact.geriu.org

The INTERACT II Program (Working Together to Improve Care and Reduce Acute Care Transfers) strives to improve the quality of nursing home care by providing tools and resources to staff that will help reduce avoidable acute care transfers.

THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

http://www.n4a.org/

The National Association of Area Agencies on Aging Web site helps consumers connect with local Agencies on Aging. The local Agencies on Aging provide information on services necessary to ensure maximum independence and dignity for older individuals and functionally impaired adults.

NATIONAL ASSOCIATION OF PROFESSIONAL GERIATRIC CARE MANAGERS

http://www.caremanager.org

US organization of geriatric care managers; provides a tool to help find geriatric care managers but has no official standing and members must pay a fee to belong.

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