Long-Term Care Survey Alert

Case study: Simple Strategies Rein in SNF Rehospitalization Rates

A team approach to SNF discharge planning and disease management programs can pay off.

Keeping people out of the hospital ranks as a high priority for Metropolitan Jewish Health System in Manhattan, N.Y., which has some tried-and-true practices to share with long-term care providers looking to do the same.

The organization provides SNF care, short- and long-term home health, medical model adult day programs, and adult and pediatric hospice and palliative care, among other services, reports **Lydia Galeon,** VP of long-term care and business initiatives at MJHS.

MJHS "can easily transition a patient from acute care to the chronic phase of their disease and then back to the community," she says. "The ultimate positive result is a reduction in hospital readmissions."

Transition Program Helps SNF Patients Go Home Successfully

"Within 72 hours of admission, the resident meets the home care planner who introduces herself and works with the case manager or social worker in developing a plan" to go home, says Galeon. The home care planner subsequently collaborates with the resident and his family, and the case manager or social worker to prepare for the resident's transition home. "We also use the time when the person is in the SNF as a wonderful window to teach, for example, a new diabetic how to use the [insulin] pen," Galeon reports. "That's easier for the person to learn while in a 21-day or so stay in the SNF than when he or she is at home alone."

The SNF staff also encourages residents or their family/caregivers to use the primary care physician as a "quarterback" by keeping him informed about all of their specialists and medications. And they advise departing residents to use a single pharmacy, which can avoid duplicate medications or drug-drug interactions, reports Galeon. (MJHS nurses in the community also teach healthcare recipients this concept.)

Key: To help residents transition to the home or community, if they can function at that level, MJHS keeps tabs on what's available in the community and works with or partners with those services, Galeon says. "It's very, very important to listen to the patients" about their wishes to go home and help those who can be supported at home.

MJHS also refers SNF residents after discharge to its disease management programs for people with congestive heart failure, diabetes mellitus, or organ transplants. "We teach clients of these programs how to manage their chronic disease at home," Galeon says. Participants are taught to identify the first signs of problems -- "and who to call and how to reach them," she adds. "That way, we can avoid rehospitalization or shorten hospital admissions."

As for the organization's payer sources: Medicaid covers the long-term home health program and the medical model adult day care program. The payer mix for SNF services includes Medicare, Medicaid, and private pay.

In addition, "MJHS has a Medicaid managed long-term care plan designed for Medicaid-eligible adults 18 years and older with chronic and disabling conditions," says Galeon. And the organization has a "Medicare Advantage Special Needs Plan that covers hospital stays, physician visits, prescription drugs, at-home chronic care and many other services, as well as an integrated Medicare Advantage plus Managed Long Term Care (MAP)." The latter plan caters to dual-eligible individuals (Medicare and full Medicaid) who are clinically eligible for nursing home care but elect to live at home, she adds.