Reducing Unnecessary Hospitalizations: Apple Pie!

Karl E. Steinberg, MD, CMD

Dr. Ouslander and colleagues' study[1] in this issue is on a subject near and dear to all of our hearts in long-term care; namely, how to reduce unnecessary hospitalizations and emergency department (ED) visits for the residents under our care. I use the term apple pie because (like Mom and God) everybody loves it: Truly, what's *not* to love about helping avoid transfer trauma, pressure ulcers from lying on a gurney in the emergency room for 12 hours, delirium in an otherwise reasonably well-compensated dementia patient, often unnecessary and ill-advised treatments and medications, IV and Foley catheter placement, and all of those other nasty eventualities that often befall our patients when they get sent to the acute care hospital? The problem is that nobody really knows the right recipe for this apple pie, at least in part because incentives are so disparate. But the interventions promoted in this study are certainly good ingredients; they are simple, intuitive, and sensible.

We know that the annual dollar costs of hospitalizations from skilled nursing facilities (SNFs) are in the multiple billions (not to mention the noneconomic costs of psychological harm to our patients and their families). It's clear from recent activities in Washington that our lawmakers are aware of this. Initiatives like the patient-centered medical home and "bundling" the first 30 days of postacute care to a single cost center (most likely the hospital) are being tossed around along with lots of other ideas in the health care reform movement. I think we all recognize that transitions of care are a tremendous area for improvement, and that the fragmentation of care into silos under our current system—often with little or no communication between care providers—needs to be addressed. Many leaders of the American Medical Directors Association (AMDA) and our Public Policy Committee have attempted to improve some of these problems, but there is no clear solution. AMDA, along with other long-term care stakeholders, clearly needs to remain closely involved in legislative efforts to ensure that the interests of our members, and the patients we serve, are considered in any new programs or measures addressing care fragmentation and related issues.

The intervention applied in Dr. Ouslander and colleagues'[1] admittedly small, geographically limited, nonrandomized prospective study in 3 Georgia SNFs was nothing high-tech or difficult to implement, yet it yielded remarkable results. It even worked pretty well when it wasn't used consistently! The strategy basically consisted of providing some communication and clinical practice tools (INTERACT) to nursing staff, and giving charge nurses access to an advanced practice nurse. These interventions sound pretty intuitive and not so new—Evercare, Kaiser, and other health systems and practices (including my own) have for many years used heightened on-site and telephone availability of clinicians to help assess clinical scenarios and guide (reassure, educate, and so forth) nursing home staff and convince them not to take the path of least resistance and just ship the resident to the hospital. This study is very promising and seems to demonstrate that, at least on a small scale, change can occur without elaborate or exorbitant interventions. This certainly appears to be the type of thing that we could actually do.

Unfortunately, other, more thorny issues and disparate incentives exist concerning SNF-to-hospital transfers that may not be so easily addressed. Clearly, a nursing facility has several actual and potential incentives to transfer a resident instead of diagnosing and treating on site:

1. They are much less likely to be sued if they *do* send a resident who doesn't really *need* to be transferred, than if they *fail* to send a resident who subsequently crashes and has a bad outcome (even if the bad outcome would also have occurred at the hospital).
2. If a long-stay resident gets hospitalized and stays 3 days, he or she can come back and get another Part A stay at many times the custodial per diem charges.
3. Nurses may lack the ability, knowledge, inclination, or time to discuss benefits versus burdens of a trip to the hospital to residents, families, or decision makers.
4. Moreover, even if nurses do have the knowledge, they may prefer to send a resident anyway, because keeping him or her in the facility is likely to result in increased nursing duties (eg, collecting specimens, starting IVs, and so forth).
5. Nursing facility nurses may feel uncomfortable assessing and treating more acutely ill individuals, and hence push the resident, family, and on-call clinician to a decision favoring hospital transfer.
6. Nursing facility nurses may lack the assessment skills to give an adequate history and physical assessment to the on-call, off-site provider, who after a 5-minute conversation where he or she can't really tell what is going on, prudently and understandably decides—to be on the safe side—to ship the resident to the ED.
7. Sometimes the resident is so ill that hospitalization is truly necessary, given his or her preferences for life-sustaining treatment.

Scripps Coastal Medical Center, Oceanside, CA.

Address correspondence to Karl E. Steinberg, MD, Scripps Coastal Medical Center, 2201 Mission Avenue, AD-401, Oceanside, CA 92058. E-mail: steinberg.karl@scrippshealth.org

Copyright ©2009 American Medical Directors Association

DOI:10.1016/j.jamda.2009.08.002

8. Nursing facility nurses may have knowledge deficits or personal values that make it difficult for them to discuss or recommend palliative treatment on-site at the facility, thereby increasing the chance that they will encourage the resident or family to obtain aggressive hospital treatment.

These are just a few of many, many factors that push the default decision to "Send the resident in." On the other side of the argument, the lone rationale seems to be along the lines of "Because it is not always a kindness to transfer a resident to the hospital, and we know the outcomes can be worse for some conditions." There is clearly no financial incentive for "doing the right thing"; on the contrary, with bed-hold compensation in addition to the potential Part A readmission, there are very real disincentives.

Moreover, despite our usual discussions of preferred intensity of treatment on admission to a nursing home, hospitalization is usually not excluded—even for many residents for whom it should be. With wider implementation of POLST (Physicians Orders for Life-Sustaining Treatment) and similar paradigms, it is probable that more residents and families will be given appropriate information on which to make informed decisions about hospital transfer, and with a signed "Do Not Hospitalize" physician's order, it's much more likely that the resident will indeed be treated within the facility.

Add to these influences the common scenarios where a patient or family "insists" on a transfer, or where the on-call physician has no interest in talking to the family, ordering *stat* labs (IVs, antibiotics, other interventions) in response to a change in condition (after all, who wants to be awakened at 3 AM with that pesky urinalysis report?)—why do the extra work, for which there will be no compensation, and on top of that risk being sued for *not* sending the patient in? Merely doing the right thing seems to pale in comparison with those potential downsides. The cards are truly stacked against treating the resident within the facility.

Clearly, there are huge hurdles in creating a culture that rewards keeping the resident at "home" in the SNF to treat acute changes of condition. We have our work cut out for us on this front. But the current study is a ray of light, or a whiff of a delicious pie, whose recipe still remains elusive. The INTERACT tools and improved access to clinicians who understand the nuances of available interventions within the SNF setting (versus the hospital) are certainly a good start, and we look forward with anticipation to the larger iteration of this project, refining the recipe and sharing it with other chefs on a widespread basis.

REFERENCE

1. Ouslander JG, Perloe M, Givens JH, et al. Reducing potentially avoidable hospitalizations of nursing home residents: Results of a pilot quality improvement project. J Am Med Dir Assoc 2009;10:644–652.