

## Medical Ethics



By Jonathan Evans, MD, MPH, CMD

# Hospital Readmissions, Ethical Issues, Unintended Consequences

### The Case

A 78-year-old woman with congestive heart failure was admitted to a skilled nursing facility following a 3-day acute care hospital stay for the condition. She had been hospitalized for heart failure three times in the previous 9 months. Each time, she was discharged directly home from the hospital.

Three days after nursing facility admission, she developed worsening shortness of breath and required supplemental oxygen. Her physician examined her and found diminished breath sounds in both bases, worse on the right. The patient was sent to the emergency room where she was subsequently readmitted to the hospital.

The hospital chief of staff immediately called the facility administrator to complain about the case and then added that the nursing facility had a higher readmission rate than others in the area. This fact would be considered when recommendations for nursing home placement were made in the future.

In the hospital, the patient was found to have a large right pleural effusion. A thoracentesis was performed, and 1,200 mL of exudative material removed.

### Discussion

Up to one-fifth of all hospitalized Medicare beneficiaries are rehospitalized within 30 days of discharge. Medicare has judged many of these readmissions to be avoidable. Published reports indicate that in more than half of all cases resulting in 30-day hospital readmission, patients were never seen by a physician or other practitioner following initial hospital discharge. Hospitalized patients discharged to skilled nursing facilities are virtually all seen by a physician within a few days, and they have access to nursing care around the clock. Therefore, many hospital readmissions from skilled nursing facilities are considered avoidable because of the professionals there.

It is widely acknowledged that the ethics of business, in which profit is considered to be the ultimate goal, differ from the ethics of health care, in which doing

good for others (beneficence) - or perhaps more succinctly "caring" - is most important. Put another way, the primary interest of business is the business, whereas the primary interest of health care is supposed to be the patient. Likewise, given the extraordinary cost of health care in this country, and the need to justly allocate scarce resources, efforts at promoting efficiency and good stewardship of resources are both necessary and laudable.

Nevertheless, the concept of "no margin, no mission" is not only accepted, but largely embraced in U.S. health care. Thus both fee-for-service and managed care models have struggled to overcome conflicts of interest in which patients either receive unnecessary or insufficient care, or both, because a payment system has created incentives that may be at odds with the patient's own best interests. The most frequently heralded solution to avoid the potential conflicts of interest between business and patient is "aligned incentives," in other words to pay providers more for doing that which is in the patient's best interest.

More than 20 years ago, the federal government tried to promote efficiency by adopting a diagnosis-based prospective payment system intended to reward and encourage hospitals to improve processes in order to achieve good outcomes for patients, but more quickly. This was hugely successful at reducing hospital lengths of stay but disastrous at maintaining quality hospital care.

### Another Oops

It was entirely unforeseen that patients would simply be discharged "sicker and quicker." It was simply inconceivable to economists and government planners at the time that professionals would compromise their own ethics and standards by allowing sick patients to be discharged instead of doing the hard work of improving care. The result, obvious now, was the need for more care for discharged patients in settings outside the hospital. This led to the creation of an entire postacute care industry involving skilled nursing facilities, acute rehabilitation units, and home health care agencies, whose primary function was to finish the job that hospitals no longer would and negated much, if not all, of the cost savings anticipated by Medicare.

Disappointed at the enormous cost associated with poor care planning and coordination for hospitalized patients, inadequate follow-up care, and poor hospital decision making regarding discharge, Medicare in 2012 is attempting to align incentives once again by rewarding providers for fewer bounce backs to hospitals following discharge. What could possibly go wrong with that approach?

The case here points out one fairly immediate consequence, in which hospitals blame nursing facilities when patients are readmitted and exert pressure to discourage facilities from sending even very sick patients back. I want to emphasize, however, that 30-day readmission rates should never be zero. That would be a world in which patients are never sick to begin with, so any hospitalization is unnecessary.

## We can reasonably expect unintended consequences from new financial penalties to hospitals and nursing homes for readmissions.

A health professional's tendency to blame others for bad outcomes is natural whenever the person feels that he or she has done the best job possible. But as long as care for a single episode of illness is fragmented across multiple sites, communication, coordination, care planning, and follow-up are probably even more critical than the care that happens at any one site.

### Look Out Below

In the absence of that kind of integration of both care and communication, we can reasonably expect a number of other unintended consequences from new financial penalties to hospitals and nursing homes for readmissions:

► First, blame the victim. Patients and their families may be actively discouraged from seeking hospital or emergency department care, or may be less likely to be offered a hospital bed once in the emergency department. Patients with diagnoses tending to result in hospital readmission (heart failure or disruptive behavior, for instance) and those with histories of recurrent hospitalization may find access to skilled nursing care limited, as facilities try to cherry pick admissions. Most can do this since bed occupancy is over 87% in nursing facilities nationally.

Likewise, pressure to avoid sending patients back to the hospital may create an irresistible temptation for some nursing home administrative personnel to interfere with clinical decision making, resulting in otherwise avoidable and indefensibly bad outcomes. The most vulnerable patients may not even be aware of choices being made for them or able to make their wishes known. The financial interests of hospitals or facilities may supersede the interests of patients and their families.

► Second, blame the nursing facility. Hospitals may assume that "bad"

facilities send patients back while "good" ones do not, regardless of the patient's condition or how appropriate the hospital discharge was in the first place. This may result in facilities being punished by hospitals with holding referrals or by discouraging patients from transferring to those "bad" facilities.

► Third, game the system. If patients readmitted to a hospital from home are excluded from any financial calculus, then more and more patients will be discharged home or to assisted living facilities from the hospital, regardless of their care needs.

A fundamental flaw of aligned incentives is that using money to make business interests more in line with patient and family interests simply takes divergent interests and makes them parallel, not the same. Put another way, no amount of money can make people truly care. Conversely, no amount of caring guarantees making money.

### Try, Try Again

In attempting to reconcile a self-interested business model with an altruistic ethic requiring that "the needs of the patient come first," the best we can hope for as a society is that health care professionals can only do well by doing good. Financial incentives and disincentives are therefore a necessary but insufficient part of quality improvement.

Active involvement of families and consumers, reporting of quality measures and outcomes, and focusing regulation and oversight across the continuum of care are also necessary. Moreover, regulations aimed at improving quality in one setting - such as avoiding unnecessary drugs and physical and chemical restraints, and preventing pressure ulcers and falls - should apply equally to all settings. The standard of care should not be lower in a hospital than a nursing facility.

The goal of avoiding unnecessary hospital readmission is a good one. Financial incentives and disincentives are useful tools to change behavior but are not in and of themselves *adequate to prevent ill-advised hospital discharges or to ensure appropriate access to hospital care for nursing home residents who truly need and desire hospital readmission.* The root problem is not a lack of money but an extension of the fact that the values of the patient and the marketplace are often in conflict. 

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### What's Your Opinion?

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