Dear Dr. Jeff:

I am constantly bawled with materials urging me to keep nursing home residents out of the hospital. They all stress how much money can be saved for Medicare, insurance companies, or hospitals. Why should my patients be denied hospital care to save someone else money or to improve the home’s statistics?

Dr. Jeff responds: They shouldn’t. Too much of the discussion about hospitalization revolves around the notion of frail, elderly patients who have concentrated much of the discussion about hospita-

Losing in Transition

Rehospitalizations that we can all agree should be avoided are those related to poor communication during care transi-
tions. Missing or inaccurate discharge summaries, uncommunicated laboratory or x-ray findings, missing or inac-

By Jeffrey Nichols, MD

Good to Be Home

A general recognition of the benefits of caring for patients in their familiar surroundings and of the risks of hospi-

tal admission for seniors would mean a genuine improvement in the quality of care for residents. Those residents treated in the nursing home avoid the emotional stress of a hospital stay.

Multiple studies have confirmed that nursing home residents with pneumonia but acceptable vital signs are as likely to survive in place as in a hospital, but they are more likely to get out of bed and to take in adequate nutrition, and less likely to lose functional abilities or have skin breakdown. Nursing home resi-
dents are also less likely to be exposed to a urinary catheter or an inappropriate antipsychotic medication. Demented residents surrounded by familiar nurses and nursing assistants are more likely to eat and accept their medications.

Although a UTI might seem to be a random event for a frail elderly woman, infection rates vary widely from facility to facility. Infection control techniques, hand washing, appropriate use of gloves, and avoidance of unnecessary catheter-

ization appear to dramatically decrease UTI rates. Indeed, like pressure ulcer incidence, UTI incidence is a reasonable proxy for nursing care quality. And early recognition combined with communi-
cation and prompt medical attention should allow nearly every infection to be treated in the nursing home.

The basic level of geriatric care in nurs-
ing homes vastly exceeds that in most hospitals. The latter continue the routine use of medications that are risky or contraindicated for the elderly, embrace polypharmacy as a convenience over the careful evaluation of medical symptoms, routinely prescribe dosage regimens that are excessive for the elderly, continue the use of physical restraints, provide inappropriately restrictive diets yielding dangerous weight loss, and utilize silly glucose-control regimens for frail elderly patients. LTC facilities must step forward and point an accusatory fi-
nager at acute care facilities that fail to carry out their responsibility to arrange safe discharges. LTC facilities must step forward and demand the information they need to provide appropriate care. The current hospital-reimbursement system has resulted in discharging patients quicker and sicker. Skilled nursing facilities are receiving patients barely out of the oper-
ating room or intensive care unit.

At the same time, nursing homes are competing for many patients for whom they are not prepared to provide appro-

crate care. A facility that has inadequate nursing and medical staffing to monitor unstable patients and promptly address new problems as they inevitably occur should not blame the hospital when these patients wind up back in the emerg-

ency room. It is the responsibility of the medical director and the director of nurs-
ing to evaluate exactly which patients can be safely admitted to their facility.

The majority of hospital admissions from nursing homes are emergency admissions for respiratory or urinary tract infections (UTIs). Many or most of these admissions are appropriate when they occur, but potentially preventable.

For example, an elderly, demented nursing home resident might develop lethargy, an increased respiratory rate, a fever, and cough or sputum. Early recognition and evaluation of this change in status might lead to the identification of a viral illness that could respond to increased fluids and symptomatic treatment. Failure to address this change in status could lead to hospital admission for “bronchitis” and dehydration. Alternatively, prompt evaluation might identify an early pneu-

mocystoma that could be treated with oral antibiotics and “as needed” oxygen to prevent complications requiring hospital care. Improving the assessment skills of nursing staff and improving communi-
cation among nursing assistants, floor nurses, and practitioners can help.

The malignant effects of a money-

A tragic cause of preventable hospi-
talizations is the continuing failure of nursing home providers to discuss the natural history of disease with residents and their families and to obtain advance directives. Far too many frail seniors wind up spending their last few months in a round of recurrent, minimally effec-
tive hospital stays accompanied by mul-
tiple painful, invasive procedures before their predictable and inevitable demise. Even a written do not resuscitate (DNR) order will not protect against a hospital transfer, intubation, and intensive care admission for respiratory distress.

Along with neurologic decline, recur-

rent infection is a marker for terminal disease in dementia patients. Yet many facilities believe that the end of life has been addressed if DNR has been dis-
cussed and proxy decision makers have been identified. Unfortunately, that leaves the really important decisions undiscussed.

Panicked families may press for hos-

pital transfer of a resident who is irre-

versibly dying, or, worse, facilities may call 911 before a hasty discussion of the risks and benefits of hospital transfer ever occurs. Realistically, for residents with advanced disease, DNR orders are largely about treatment of the body after death. The key questions relate to treat-

ment while the patient is still alive.

The Interventions to Reduce Acute Care Transfers (INTERACT) program is a qual-
young improvement program developed with support from the Centers for Medicare & Medicaid Services and designed to decrease unnecessary hospitalizations. The authors’ research suggests that as many as 60% of hospital transfers from nursing homes might be preventable.

Although some of the INTERACT materials are under copyright, their overall processes are available with-

out charge on the program’s website (http://interact2.net). Because these are largely systems problems, not isolated care lapses, they are ideal for a quality improvement approach that analyzes a facility’s strengths and weaknesses.

In the confused welter of financially dictated care, regulations, and fam-

dy preferences, we must advocate for quality care and the needs of our patients. Prevention of medical errors and iatrogenic disease, improved com-
munication among caregivers, careful evaluation and early intervention when a resident’s medical condition declines, and compassionate care with recogni-
tion of the disease as well as the possi-
bilities of modern medical care, are all elements of quality care. As it happens, they will also prevent unnecessary hos-
pitalizations.

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