F for the first several decades of my practice in post-acute and long-term care, it was a constant battle to get information or communication from our local hospitals. For all the wonderful, life-saving treatments they provided to our mutual patients, they seemed to have little interest in communicating with skilled nursing facilities to promote smooth, safe transitions of care. We’d get a sick post-acute patient with 40 pages of paperwork, most of it irrelevant — teams of therapy notes, cardiac monitor tracings, a seemingly random medley of records — plus, if we were lucky, the history and physical that had been done five days earlier. But it would almost take an act of Congress (and indeed, this got a lot worse after a particular act of Congress — the Health Insurance Portability and Accountability Act!) to get a discharge summary from the hospital, often days later. Trying to call the hospitalist who had cared for the patient if there seemed to be critical information lacking was a tricky challenge, and other covering hospitalists, when you could reach them after sitting on hold for 10 minutes, often failed to yield the needed data points.

Up until 2012 or so, if a patient was readmitted to the hospital at any time after a hospitalization, it created a new payment under the Diagnosis Related Guidelines (DRGs) and essentially “reset the meter” for hospital compensation. So there was no real disincentive to avoid rehospitalizations, and in fact there was a sort of financial incentive to rehospitalize patients — the more times, the better for the bottom line. Once the Centers for Medicare & Medicaid Services initiated the Hospital Readmissions Reduction Program in 2012, hospitals began to be penalized for excess 30-day rehospitalization rates for certain conditions. For many of us, this program marked the first time in decades that hospitals had expressed any real interest in having a collaborative working relationship with local nursing facilities. Suddenly, we were valued partners in the effort to reduce unnecessary readmissions.

This was a welcome change as our facilities and the local hospital systems worked together to improve the quality of care transitions and medication reconciliation, and even to recommend the “warm handoff.” (I know, “the patient is not a ball.” But we all know what that term means.) We began getting actual, dictated discharge summaries along with the patient. Hospitals began evaluating nursing homes with respect to 30-day readmissions, Five-Star Quality Rating, and other self-defined metrics (such as the use or nonuse of Interventions to Reduce Acute Care Transfers, medical director’s affiliation with a hospital or Accountable Care Organization), and began “narrowing their networks” of preferred nursing homes they recommended to their patients, with the blessing of CMS. Whatever our opinion of making 30-day readmissions such a critical benchmark — and there’s plenty of evidence that it hasn’t really achieved its goal of improving quality of care — we have to acknowledge that communication between hospitals and its nursing home partners has improved substantially. And that is a very good thing.

Obviously, we need hospitals to look after our most seriously ill patients, including those who need pressors, surgical procedures, continuous cardiovascular monitoring, ventilatory support, transfusions, or advanced imaging that we can’t provide on-site in our nursing homes. However, we need to consider that a fair proportion of our residents do not want these kinds of interventions; they may want to concentrate on comfort measures, and we are well equipped to provide comfort care, with or without hospice support, in our facilities.

Short of intensive care unit (ICU) and operating room (OR) services, we can provide many high-level interventions in our nursing homes — intravenous antibiotics and hydration, reasonably high-level wound care, prompt laboratory work, and skilled rehabilitation services. We should try to be selective about what kinds of conditions — and for what patients — we consider a trip to the hospital, and we should handle what we can in-house. After all, in most cases our staff know the patient’s individual needs and preferences; a trip to the hospital will mean dealing with at least two sets of all-new staff, and new doctors in the emergency department (ED) and on whatever unit the patient lands in.

There is good evidence that a trip to the hospital can be harmful for nursing home residents, especially those with dementia. Even cognitively intact patients have a much higher probability of developing delirium — which carries a poor prognostic implication — when they are sent to the hospital, placed in a bright, noisy place, poked and prodded, have lines and catheters placed, and often are given medications like opioids, benzodiazepines, or antipsychotics. These risks can be reduced by having a family member, especially a knowledgeable one, accompany the resident to the hospital.

They may also be diagnosed with a urinary tract infection in the ED when the patient has no criteria beyond some pyuria and bacteriuria with no symptoms, and they may be given unnecessary antibiotics. The hospitalist or intensivist may start them on a proton pump inhibitor or an antipsychotic, and most diabetics wind up on sliding scale insulin even though they may be able to take their oral medications. Those of us with expertise in caring for frail elders know that these types of prescribing decisions, however well intended, are harmful to our residents but happen all the time at the hospital. Improved education of our hospital-based colleagues and communication with them on behalf of our patients can help move the needle on these potentially harmful and unnecessary orders.

Another problem that we observe with hospitalizations is that Physicians Orders for Life-Sustaining Treatment (POLST) forms or similar orders may not be honored at the hospital. A JAMA study demonstrated that some 30% of patients who had documented orders for comfort care on a POLST form in fact received treatment in the ICU. In some cases, patients or their agents may be changing their minds, but in other cases it is probable that the physicians at the hospital are making a conscious decision not to follow valid orders such as do not resuscitate/attempt resuscitation (DNAR).

This lapse occurs in both directions, though. A common lament of hospital-based palliative care clinicians is that they spend hours with a patient and family at the bedside, finally coming to consensus on a “No CPR” decision on a POLST form, only to send the patient out to a nursing home with the POLST and have them land back in the ED two days later with a brand-new, full-code POLST completed at the nursing home because they didn’t bother to look at and verify the recently executed orders, or because they just give every new admission a POLST form and require that it be completed de novo.

Readers, please, if your facility is handing out POLST as part of the admission paperwork, put a stop to it! POLST is not for every nursing home resident and is never mandatory. If a patient comes in with a valid POLST, it is unnecessary and inappropriate.

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