Preventing Unsafe and Avoidable Hospitalizations

Understanding the Risk versus the Benefit

Presented by: Dr. Karl Dauphinais

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Kathleen Johnson: Hello and welcome. We're here to talk about the risk versus the benefits of hospitalizations. How do you figure out when the potential benefit outweighs the potential risk of hospitalization? When is hospitalization better than staying and treating in place? How can we tell? I'm Kathleen Johnson, adult nurse practitioner and educator for the national team, and I'm here with Dr. Karl Dauphinais, Optum senior community care medical director for Connecticut, Rhode Island, Maine and New Hampshire, and we're going to address this topic.

Dr. Dauphinais: Hi, thanks for having me here on such an important topic.

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Ms. Johnson: Our agenda for today will focus on the why we are presenting this topic, experiences in the ER and hospital, along with recognizing the risk of complications that can result from unnecessary hospitalizations. There are things you can do to limit these risks and realize the benefits of treating in place when appropriate.

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Sending skilled nursing facility residents to the hospital for treatment of acute care is under scrutiny. Is it really in your residents' best interest to just send them to the hospital when there's a change in condition? Dr. Dauphinais, can you talk a little about why and when you should consider alternatives to hospitalization?

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Dr. Dauphinais: So, thanks for the question. To some, it might seem that the hospital is the natural best place to be. When you can't get the level of care you need elsewhere, the hospital might be just the right place to be. However, there are certainly risks just from being in a hospital setting. As many as 45% to 68% of hospitalizations are potentially avoidable, and most of the acute conditions can be treated in a skilled nursing facility. Hospital environments can be disorienting for frail elders, they can disrupt stable routines, and they can increase the risk of adverse events.

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Ms. Johnson: Well, let's start with what should be relatively easy. When is hospitalization clearly the best choice?

Dr. Dauphinais: Right. So there's certainly some things that you can't do in a nursing home. These include interventions such as placing and maintaining breathing tubes, use of IV medications to reduce or support blood pressure, invasive diagnostics or therapies, and of course, if somebody needs a surgical intervention, that'd be in a hospital. Falls with broken bones or head injuries likely need hospitalization for management or evaluation, but that decision is dependent on the goals of care for that individual.

Ms. Johnson: Yeah. Don't all of these decisions depend on the goals of care and the advanced care plan for the individual?

Dr. Dauphinais: Great, I'm glad you brought that up. Hopefully, although it doesn't always happen, but hopefully a member of the health care team has already explored where the resident wants for treatment over the course of their life and the changes. Of course, it's tough to anticipate all the changes. So we want to keep up with those discussions as much as possible before any events. This type of discussion before things happen, whenever possible, is really helpful.

But what about times like when a 94-year-old resident on aspirin with advanced dementia falls and hits their head? Would they want the same workup and treatment as a younger person with good function? Or how about a resident with advanced Parkinson's disease that's unable to walk but is found to have a hip fracture from a fall? Are they even a candidate for surgery? What benefits does the hospitalization provide compared to workup at the facility under those circumstances? When cognitive impairment, functional dependence, malnutrition and frailty are risk factors for complications, are you sending them because you don't want to make that decision, or is there something that you can do right there and continue to keep them comfortable and manage it right there in place? We want to think about what the workup would look like and what that would put the resident through. This is what we need to measure when we're talking about risks versus benefits.

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Ms. Johnson: So what are some of the other things we need to think about when deciding if we can treat in place or not?

Dr. Dauphinais: So we have here on the slide different treatment options that typically can be managed in a nursing facility. As you see, a majority can be, but when we're looking to treat a change in condition, we need to take into account what's available and when it's available, how quickly is it going to be available relative to how quickly this individual might need an evaluation or an intervention. Questions to ask yourself include, what's in the emergency box? What staff have the skills we need to manage the care? Do we offer things like hypodermoclysis for residents that might not require as aggressive fluid as IV fluids, or if they need some sort of holdover until they can get the IV fluids placed.

Look over previous hospitalization summaries. What was the treatment that they had before? Is this something that you could have offered in the nursing facility? You'll find things like pneumonia, COPD (chronic obstructive pulmonary disease) exacerbation, CHF (chronic heart failure) exacerbations, flu, COVID; they can often be successfully treated in the nursing facility. We look through the treatment guidelines; we know what the nursing facility can provide for treatment that's comparable without putting the resident through the potential pitfalls of an unsafe, potentially avoidable hospitalization. In most facilities, the treatments listed here, as we mentioned, can be done in the facility.

Of course, we need to anticipate how long it might take to get these treatment options in place, and one time, we may be able to treat in place and another time, we may say, hey, it's going to take a little longer than we're comfortable with. We need to send this person to hospital, get things started and then we can continue to evaluate: Can we bring them back sooner and manage them basically in their home and the nursing facility where they're at, where people know them, know what to watch out for, for things like skin breakdown, for their deconditioning, for their eating and what's natural and normal for that?

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Ms. Johnson: Are there particular parts of the ER and hospital experience that can present a particular risk to our patient population that we need to consider?

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Dr. Dauphinais: So the ER experience, it's variable from one facility to the next, right? There are some common experiences in the emergency room that can present a particular risk to an older, more frail individual. Even if they clearly need a hospital level of care, most residents are not directly admitted to the

hospital. So what does this mean for your resident? ER times, ER wait times are at an all-time high. Residents may be on stretchers in hallways for prolonged periods of time, many hours to a day in some situations. They might receive multiple sticks for IVs, labs, Foley catheters for urine samples, not to mention X-rays and other diagnostics that are part of routine ER workup. And they're sitting in the, sitting, waiting for these to happen without somebody who knows them monitoring, are they moving, are they getting up, are they at risk of a bed sore from sitting too long, staying too long in one position? What about their medications that they were supposed to get that they might have missed?

So, shifts change during this time frame. Who's with your resident throughout this? Where's the, is there any consistency in their routine? Is there a staff member available to advocate for that individual, especially if they have any cognitive deficits? Or are they on their own? What about family? Are their family available? Are they able to get in? Are they able to attend at this vulnerable time? Transitions in care and in general, residents changing from one setting or a level of care to another are fraught with potential complications. Medication histories can get confused. It might be a long time between medications that people are supposed to get. Belongings can get lost; members can be immobile for a longer-than-normal period of time. And as we mentioned, who's advocating, who's speaking for them?

Individuals with even mild confusion at baseline tend to get more confused with significant environmental changes that can lead to anxiety, that can lead to agitation. This can lead to things like restraints. This can lead to medications being given that lead to sedation or aspiration events and other bad outcomes for our residents that we really want to protect them against.

Emergency departments and hospitals, they're designed for acute major issues. But there you don't have the staffing structure set up in the same way that we do in the nursing facilities to help with turning individuals who don't readily turn on their own, leading to an increased risk of pressure ulcers if they're not getting turned or monitored for these changes in skin regularly.

We can't forget that individuals go to the hospital because they're pretty sick. That means the hospital is an area where there's a higher concentration of infections, so someone who doesn't already have an infection is certainly at higher risk of exposure to that, those infections in the hospital, leading to prolonged hospitalization course or even carrying that infection back to the facility, leading to a risk of a facility outbreak. So a lot of things we have to watch out for when people go to the emergency rooms.

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Whenever possible, we want to consider other resources that might exist in the community as alternatives. Orthopedic clinics may be a better choice for an uncomplicated fracture or possible sprain. Some communities might have a heart failure clinic or cardiac clinic for CHF exacerbations. For a resident who has recurrent anemia, is there a transfusion clinic that would be able to provide these necessary products? Perhaps there's mobile units and resources for starting pick lines or midlines. These resources vary from community to community, so being proactive and really having a good working knowledge of what's available, and as we mentioned, how long it takes to get those resources really can make a huge difference.

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Ms. Johnson: Dr. Dauphinais, you mentioned the risk of increased confusion with hospitalization. Could you explain a little more?

Dr. Dauphinais: Sure. I mean, stressors such as an unfamiliar environment, repetitive noise, alarms and lights that many of us drown out while we work in the hospital, these things can all cause a significant amount of stress and duress on our residents, even if they're not confused. But if they have a baseline level of confusion and cognitive dysfunction, this can get much, much worse. All of these stressors increase the risk of altered mental status in older adults, especially with those with dementia. Complicate that by many of our residents have issues with hearing or vision, so they're not really sure what all these

noises are when they hear them, and that can become anxiety provoking as well. And I get amazed myself at how many of us would explain the importance of getting rest, and then we put our patients in this situation that makes it really difficult for them to get rest.

The staff in the hospital is going to be unfamiliar with the patient, and vice versa. Confusion, increased anxiety, any acting out because of these feelings increases the risk of polypharmacy, chemical and physical restraints, and that can result in increased risk of injury, falls and injuries from the medications themselves. These issues can lead to additional unnecessary diagnostic testing, prolonged hospitalization, decreased mobility and turning and increased risk of wounds and infection. So a lot of things that can happen to our patients when we're trying to take the best care of them, but they end up in a situation or in a setting that might not be the best setting for them at the time.

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Ms. Johnson: What in particular about the hospital experience makes it a higher risk for complications?

Dr. Dauphinais: Right. So a lot of the things we've just mentioned, right, the alarms, the lights, the overhead announcements, all can be disturbing. They can interrupt sleep. They can cause increased confusion. Ambulating residents isn't a priority, as medical function is the focus, right? We're trying to take care of the acute medical issue in the hospital. So individuals won't be getting up to ambulate or they won't have the staff assisting them in their function, and that can lead to increased deconditioning. Longer stays can mean more loss of function in an ambulatory resident, who previously was only getting up from the bed to chair…they were getting up a little bit more, but they're getting up now just to the bed to the chair while hospitalized. A decrease in the amount of movement and function in general.

For our older, more frail individuals, this can make it much harder to get back to their prior activity function once they're discharged, and sometimes it's not even possible. This doesn't even take into account yet things like adjusting to new routines. Our residents are used to the routine that they're in, so new routines, new settings, meals, toileting schedules, other changes that can be particularly challenging for a resident who's already decompensated. Somebody who previously had a little bit of confusion can become agitated or aggressive and we've already mentioned a few of the complications that can lead to.

Often the medical focus also means that maintenance medications can be put on hold. New medications might be added, some might be temporary, and that can cause confusion for the staff at the nursing facility once the individual is discharged. There could have been changes because of a formula; that can create some confusion. Medication reconciliations could be a particular challenge. When we get a list, and we might not have a full explanation. So examples might include a hospitalized patient with the flu who required a pacemaker because the beta blocker dose was misinterpreted, and the resident received three times the usual dose. Another hospital resident once came back, and the discharge instructions inadvertently left out a blood thinner that was required. And these are real-life examples that we see on a periodic basis, things that we're very cautious as we watch for, but things we'd love to minimize the risk of even having them occur in the first place.

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Ms. Johnson: We talk about deconditioning being an issue, but if our patients are already deconditioned, is that really a risk?

Dr. Dauphinais: I love that question. Hospital-associated deconditioning or post-hospital syndrome, it's well recognized as reduced functional performance after an acute hospitalization. And if we think about our residents, the most vulnerable are our frail, elderly residents. Think about it. If you only have function that allows you to stand, to transfer from a bed to chair, it really doesn't take a lot to lose that last bit of functioning. So they may not be functioning and doing much or moving much, but any little bit puts them further behind and that makes it harder for them to be, to take care of themselves or be cared for by somebody else. They don't just lose function. There's also cognitive decline, where reserves they have to

deal with the loneliness, the confusion, the loss of the familiar, those all get pushed aside even further. So they have very few reserves right to begin with, and this last little bit can push over the edge. So as well trained as the hospital is, they're often not able to focus on these geriatric needs for our older patients that can lead to significant morbidity in a very short period of time.

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Ms. Johnson: What do individuals and facilities need to be looking out for to see the real risk from unnecessary hospitalizations?

Dr. Dauphinais: So these are things that if we watch enough, we start to see what's happening. We'll see that as our patients come back, there is that risk of the worsened depression or isolation, loss of confidence. Often, we'll see patients come back and there may, there's changes in bowel or bladder habits, increased issues with constipation or decline in ability to care for themselves. We had an individual, unfortunately, recently, who had some mild low blood pressure, so slight reduction in blood pressure. It was warm out. They hadn't gotten enough fluids, so their blood pressure went down because they were slightly dehydrated. They needed some IV fluids. They ended up getting sent to the hospital. They got the IV fluids, they were doing better, getting ready to come back and they had a fall in the hospital. Now, they could have had a fall either place, but this led to a fall in the hospital. They then picked up an infection. So these are things that we watch out for, and we say look at what happened while that individual was in the hospital.

What else is going on? So watch what happens. Do they, do you see your residents coming back? Usually there's a loss of function. Frequently people need to go through some sort of additional rehab training as they come back to the hospital, from the hospital, or they might need a little additional assistance. They may need additional assistance in their activities of daily living. Remember, the hospital focuses on the disease state, not the functional state, not the state of how confused they are, they might become if their surroundings aren't quite the same.

And what if they're up all night and now they're more lethargic during the day? They're up all night because of the testing. It's noisier in the hospital than the nursing facility. They have more things going on. Delirium as a result of hospitalization actually carries an increase in mortality rates if it's not addressed. If you've seen this, you know it's not an overnight fix. It takes a while to get these patients back to where they were beforehand. Did the nursing facility perform a thorough skin exam upon their return? This is crucial. We see a lot of individuals come back with increased wounds, wounds that have previously healed that have now opened up again. So we use this, we think about these things to weigh the risks versus the benefits of the residents.

The decision to send to the hospital is similar to any decision for any treatment options. It should be based upon understanding and weighing the potential benefits versus the potential risks. If you can perform the appropriate and equivalent monitoring and interventions at a nursing facility, then the risk of sending someone to a hospital may very well outweigh any potential benefits.

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With familiar surroundings, your residents can often be treated with the same interventions often offered in the hospital. For our frail elderly residents, this can lead, this can be therapeutic, and it can be much more comforting for the individual. There's less chance for delirium, less chance for confusion in general, less chance for pressure ulcers, less chance for loneliness and isolation. The familiar surroundings and caring staff really can make a difference. Think about what you would prefer in a situation like that.

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Ms. Johnson: Okay, so there are definitely reasons we might want to try to avoid going to the hospital, but sometimes it seems like a patient just gets worse and then gets to a level of care that's greater than what

we can handle in the nursing facility. What can we really do to help avoid getting to that point if someone really needs to go to the hospital?

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Dr. Dauphinais: Great question. Sometimes it feels [like] there's not much we can do, right? We get to that point that things have started to spiral. And of course, the key to decreasing the risk of unnecessary, preventable hospitalizations is early identification of changes in condition and early interventions, recognizing what's different with the patient early. These signs can be subtle, but we can pick up a lot if we know what we're looking for.

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Staff who know the residents' behaviors, habits and activities are often the first to pick up on this. So clearly, if you have stable staff, that really helps. But if you have some way of communicating what's truly normal and not just this patient is confused at baseline. But what's normal? What are their normal activities? How do they normally respond? What types of words do they use? That can help anybody who's covering know how to interpret normal versus abnormal for the person.

But of course, our vital signs are always important to look for: changes in heart rate and blood pressure, oxygen levels, high or low glucose levels, physical changes like weakness, where someone being, having some swelling in the hands or feet, increased falls; we have to look at that as a sign that something wasn't quite right. Was it because someone slipped or was it because they were lightheaded or was it because of increased confusion? Or maybe there is, they had gotten up too quickly when they had their blood pressure earlier, and maybe we even need to make some adjustments to blood pressure medications at this point.

Is there changes in their toileting behaviors or their needs for their pads? Sometimes it can be difficult to tell this. If somebody's having any urinary issues, that could be a sign of a urinary tract infection, but it could be as simple as they were, they've been requiring more changes to their pads or less changes to their pads in the last few days. So if we know about these things in advance, as they're occurring, we can intervene much more quickly. It's, sometimes it's very subtle behavior changes that will make the difference. We can watch that over a period of time. We can start getting interventions. We can start getting tests; we can increase the times that we're having vital sign checks. All of these will result in an earlier identification of potential illness. This allows us to catch it earlier when the interventions have the greatest impact. It starts with all staff, everybody that works with the resident noticing and reporting these subtle changes and recognizing that no call is too small in these situations.

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By acting early, we can intervene early, and we can have better and faster results. Our goal is to keep our residents as healthy as possible, and we all need to work together to do that. If you know the resident, whether you're bringing them their meals every day or assisting them with activities or in any role in the nursing facility where you get to know the residents, you may be the first person to notice if something is off. You know what they like. You know what they usually do. You know how they act. So the individuals that see these changes, if you can let the nursing practitioner or the nursing staff know, they can take a closer look, things as simple as someone sitting funny in a wheelchair today. Mrs. Smith just isn't herself. We can then start exploring what is not herself, what's different? We want to know and, of course, we're very grateful for getting this information so we can take the best possible care of the individual.

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Ms. Johnson: In terms of family, doesn't everyone just want to send their family member to the hospital?

Dr. Dauphinais: You know, that can vary, but families are often relieved to find an alternative to hospitalizations and just, they think, you know, someone is sick. That's the place they should be, without going through what we were talking about earlier about the risk, potential risk versus the potential benefits. When they can see that the potential benefits are not really that much different but the potential risk can be significantly higher. They're often relieved to be able to keep mom or dad in place in a location that they know the facility, they know the environment, and [they're] less likely to have any of these adverse events. They need to know what we can offer, why we're recommending that course, for example, of action, and what would happen if things change, if things aren't getting better. What is the point when we say you know what? Now the potential benefit of the hospital is a little higher than what we can do here, so let's go to the hospital at this point, if it comes to that, and frequently if we intervene early, it doesn't come to that.

So, types of discussions we'll often hear that are very effective. Nurse practitioner: I have reviewed your loved one's case. We plan to treat her problem here. This is her home. She feels safe here and we can deliver the needed treatments in the facility. Dr. Smith, the Optum NP and I have reviewed the case. She suggested a set of orders that we can carry out here in the facility, where your dad is comfortable and keep his normal routines. And if there's a concern, we can follow that up with, if there's additional changes, then we'd continue to reevaluate at that time.

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Ms. Johnson: So Dr. Dauphinais, what does success look like in regards to preventing unnecessary hospitalizations and ensuring that those who need to be hospitalized do get there?

Dr. Dauphinais: The greatest success is the success where we don't see the complications, so it can be hard to tell sometimes because we don't see the problem. We avoided it. And that's what we're trying to do. So it can be really tough sometimes to see, but what we need to look for for success is, is somebody staying more comfortable? Are they avoiding the complications of nosocomial or hospital-acquired infections? Are they maintaining their skin? Are they able to maintain what's quality of life for them? So we think about what this means for each individual resident so they can receive treatment at the bedside as opposed to having to go through an extensive aggressive emergency room workup and subsequent hospitalization.

Once they begin to improve, activity can be promoted more rapidly. They can start physical therapy or occupational therapy more rapidly on site in surroundings that they're most comfortable in. When you have successfully treated a resident in the nursing facility and seeing the turnaround and your staff also sees the effect, don't be surprised when someone tells you down the road, hey, I think we can treat this person here. We can keep that same quality of life. We can keep them in their home and decrease the risk of any complications for them.

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Ms. Johnson: How about the success for someone whose disease trajectory has them nearing the end of life or is not likely to get better from their acute illness?

Dr. Dauphinais: So there's certainly times when palliative or hospice care should be considered. If you have a resident who you feel may qualify for either of these resources, we want to arrange an overview in an interview so they can learn what's available for now, for the possible future, and we want those informed decisions. Remember, when offering these services, we're not withholding treatment, we're changing the focus of treatment for a more comfort-based approach that includes its own set of interventions and medications. Palliative care may be a separate entity offered in the community or in some nursing facilities that may have their own palliative care team or palliative care model. This model has a focus on comfort and less treatment for diseases and conditions. Residents that still want to have curative treatments find the palliative care helpful.

Hospice is a well-known end-of-life care alternative with the emphasis strictly on comfort. Frequently, hospice isn't offered until the last few days of life, when studies show that improving someone's quality of life, living with end-stage disease is improved at hospices initiated as much as six months beforehand. Our Optum APCs (advanced practice clinicians) are also valuable resource for defining residents' and families' goals of care and setting a course of direction.

As we mentioned earlier, these are ongoing discussions looking at what would somebody truly want, what would meet their goals based upon what is of value to them. So please use this skill set of these resources, the Optum APRNs (advanced practice registered nurses), APCs, the palliative care and hospice care when it seems appropriate for these challenging situations.

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Ms. Johnson: Thank you, Dr. Dauphinais. We appreciate your input on this really important process. Thank you. Have a great day.

Dr. Dauphinais: Thanks. Here's some basic references from what we were talking about here today. And thank you all for coming today.