

# M E D I C A R E

## To Hospitalize or Not to Hospitalize?

### Medical Care for Long-Term Care Facility Residents

*A Report Based on Interviews in Four Cities with Physicians, Nurses, Social Workers,  
and Family Members of Residents of Long-Term Care Facilities*

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## Executive Summary

The 2010 health reform law included a number of provisions to improve the delivery of care for Medicare beneficiaries, particularly those with extensive medical needs and relatively high costs, yet little attention has been focused on reforms to improve the management of care for people living in long-term care facilities.<sup>1</sup> Residents of nursing homes, assisted living facilities and other long-term care facilities account for a disproportionately large share of Medicare spending, with relatively high rates of inpatient hospital care, skilled nursing facility care and use of other Medicare-covered services by facility residents.<sup>2</sup> Hospitalizations are not only costly, but also associated with disorientation, and often contribute to a decline in cognitive status.<sup>3</sup> Emerging evidence suggests that a substantial share of hospitalizations among nursing home patients can be prevented with adequate care management, additional medical support in the facility, better transitions to and from the hospital, and re-aligned financial incentives.<sup>4</sup>

To understand factors associated with relatively high rates of hospitalizations and other medical services among long-term care facility residents, the Kaiser Family Foundation commissioned Lake Research Partners to conduct interviews with medical professionals, staff at long-term care facilities, and family members to learn how medical decisions are made on behalf of long-term care facility residents. This study reveals many factors that influence decisions about whether or not to send a long-term care facility resident to a hospital from the perspective of those most involved in these decisions. In all, 43 interviews were conducted in April 2010 in the following cities: St. Louis, Miami, Philadelphia, and Phoenix. In each site, between 9 and 15 interviews were conducted with family members and clinical care providers of long-term care facility residents, including medical directors, attending physicians, nurse practitioners, registered nurses, licensed practical nurses, hospice nurses, social workers, and care managers.

### Research Insights

Interview participants indicate that the hospitalization of long-term care facility residents occurs routinely. In many cases, hospitalizations occur with little discussion or active decision-making among facility staff, particularly in cases when a resident has fallen, has an infection, or becomes disruptive or violent due to dementia or behavioral health issues. Interview participants suggest there are no *disincentives* to sending a long-term care facility resident to the ER when there is a suspected medical issue. Rather, they say that hospitalizing a medically compromised resident reduces liability concerns, allows for more timely diagnostic work, often is more convenient for physicians, and frequently is

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<sup>1</sup> The health reform law refers to the Patient Protection and Affordable Care Act [PPACA; P.L. 11-148] as enacted on March 23, 2010 and amended by the Health Care and Education Reconciliation Act of 2010 [HCERA; P.L. 111-152] as enacted on March 30, 2010.

<sup>2</sup> Neuman T, Jacobson G, and Damico A., “Medicare spending for beneficiaries in nursing home and other long-term care facilities: Opportunities for achieving Medicare savings and improving the quality of care,” Kaiser Family Foundation, September 2010.

<sup>3</sup> For example, see Ehlenbach WJ, Hough CL, Crane PK, et al., “Association between acute care and critical illness hospitalization and cognitive function in older adults,” JAMA, vol. 303 (8), p. 763-770.

<sup>4</sup> For example Peikes D, Chen A, Schore J, and Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries. JAMA. 2009;301(6):603-618; Sylvia ML, Griswold M, Dunbar L, et al. Guided care: cost and utilization outcomes in a pilot study. Disease Management. 2008;11(1):29-36.

believed to be financially beneficial for physicians and, in some instances, the facility. Attempting to treat a medical condition or conduct diagnostic testing at the facility, participants suggest, even when the condition is minor and the test is routine, is much more difficult and can be fraught with risk. Nurses and physicians wanting to perform bedside care can bump up against licensing restrictions, anxious families, liability concerns, staffing or skill limitations, delays in obtaining lab results, and a “culture of hospitalization.” One physician pointed out that many nurses and physicians are trained in hospital settings and are less comfortable practicing the “slow medicine” that may be more appropriate for some long-term care facility residents, depending on the circumstances.

Even as they explain the causes of the frequent hospitalizations in their facilities, many of those interviewed acknowledge that revolving-door hospitalizations can be physically and emotionally hard on relatively frail and often cognitively impaired long-term care facility residents and can lead to disorientation and even poorer health outcomes.

Transitions to and from the hospital from a long-term care facility is a particular concern. Social workers, nurses, and physicians say that medical charts and patient information rarely follow the resident to or from the hospital, leaving providers at the hospital and long-term care facility with questions about medications and care instructions. Facility-based nurses say they rarely know what has transpired for their residents during the hospital stay which makes it more difficult to provide appropriate follow-up care. Additionally, they note it is not uncommon for residents to return from the hospital disoriented, on different medications, and with new infections.

Yet, family members interviewed for this study generally indicate that they trust decisions made by the facility staff with respect to hospitalizations, assume these decisions are in the best interest of their family member, and seem to prefer to err on the side of doing more rather than risk the consequences of doing less when it comes to medical care. Although some family members express concern about the disorienting effects of hospitalizations, they seem reluctant to intervene or challenge decisions made by facility staff and physicians, and generally prefer to err on the side of caution in matters related to the health of their loved one.

### **Factors Driving Many Hospitalizations of Long-Term Care Facility Residents**

Physicians, nurses, social workers, and family members interviewed for this study identified the following factors that may drive high hospitalization rates among long-term care facility residents:

1. **Limited on-site capacity at the facility to deal with medical issues.** Physicians and nurses say that long-term care facility staff often lack the skill and training needed to deal with medical issues, particularly those that are unanticipated and more acute in nature. This is attributable to inexperienced and unseasoned staff, partly as a result of high staff turnover rates; a lack of training and no clear policy on how to deal with certain medical situations, including when to hospitalize a resident; insufficient nurse-to-resident ratio which means nurses are often spread too thin; and licensing limitations that do not allow certain medical procedures and tests to be done on-site.
2. **Physician preferences for care in an inpatient hospital setting.** The decision to hospitalize tends to rest with the facility’s medical director or attending physician and, according to some, many physicians feel more comfortable having medical treatment and testing provided in an inpatient hospital setting. Some physicians indicate that it is more convenient for them to see patients at the hospital than the long-term care facility because they often have other patients at the hospital.

Physicians also say they typically receive lab and test results quicker in a hospital setting and have more faith in the medical skills of ER staff to address the residents' needs. Finally, some physicians say that when they receive a call from a facility after hours or on weekends, it is easier to have their patients sent to the ER rather than wait for the outcome of a medical issue at a facility.

3. **Liability concerns for physicians, nurses, and facilities.** Physicians and nurses say they fear lawsuits from families if they do not hospitalize a resident when a medical situation arises. They say families often panic when their loved ones are sick and push for hospitalizations even when unnecessary, and even when the resident has an advance directive that confirms a preference for a less intensive course of action. As a result, some physicians concede that they practice defensive medicine with their long-term care facility residents – conducting more tests and procedures than they might ordinarily, and often in a hospital setting – in order to appease family members.
4. **Financial incentives for physicians and long-term care facilities.** Physicians in the study say they believe they get paid more, and more frequently, when they see their long-term care facility patients in the hospital. One physician reported being hassled by Medicare for submitting claims for multiple visits within a month to see patients in a long-term care facility. Long-term care facilities also benefit financially in some circumstances, say some interview participants, when a patient transfers back from the hospital to a skilled nursing unit, enabling them to charge a higher daily rate than they would receive while the resident is in a non-skilled unit. In addition, long-term care facilities can continue to receive payments from Medicaid and private payers (i.e., bed hold days or reserve bed days), for a limited period of time while the resident is in the hospital.
5. **Type of facility: Physicians and nurses say assisted living facilities are often less able than nursing homes to address medical needs on premises.** Interview participants explain that nursing homes tend to have access to more medical staff and are able to offer limited medical care at the bedside or bring in contracted professionals to do lab work and tests. By contrast, they say assisted living facilities tend to be built around a social model of aging, with less medical care on site. As a result, they suggest that preventable emergency room visits and hospitalizations are more common among assisted living facility residents.
6. **Lack of a relationship between the facility staff, resident's physician, and the resident's family.** According to interview participants, admissions to hospitals are higher in the first months of a resident's stay at a long-term care facility, in part because the staff and physicians assume that the family prefers more aggressive treatment. Physicians say once they are more familiar with the family, and have had time to establish a level of trust, they are more comfortable waiting out certain situations or delaying sending the resident to the ER, a scenario described by one physician as "slow" medicine. Similarly, physicians on call are more likely to have a resident sent to the ER if they do not know the individual or their family, and feel it is "safer" to send the resident to the hospital.
7. **Lack of advance care planning and failure to update care plans as medical needs change, resulting in confusion and panic.** While residents may have a do not resuscitate (DNR) document and other advance directives, interview participants (both family members and medical providers) feel these documents are not well-understood or discussed among families and their medical providers. Often, it is not clear who is responsible for discussions around end-of-life care or for updating advance directives, leading to confusion when there is a medical crisis and a tendency to hospitalize a frail resident when there is a medical issue.

8. **An unspoken preference for sending long-term care facility residents/family members to the hospital to die.** Some staff say that there is an unstated preference among family members and facility staff to have residents spend their final days in a hospital. They say other residents and even staff can find it unsettling when a resident dies at the facility. According to participants, this is not an official written policy, and may at times be more for the family's comfort, particularly if hospice is not involved.
9. **Behavioral health issues.** A number of interview participants say that a frequent cause of hospitalizations is acting out or violence by residents due to dementia or behavioral health issues. Facility staff members say they prefer to keep a calm environment at their facility and that disruptive residents can unsettle others. They also say they lack staff to find alternative ways to settle down these residents or deal with possible medication problems. They feel that ERs can better manage these residents. However, some nurses and social workers say residents who are hospitalized for these reasons tend to fare worse than others, returning to the facility over-medicated, disoriented, and in a state of decline.
10. **Reluctance of family members to intervene and second-guess decisions to hospitalize.** Interviews with family members suggest a fairly strong reluctance to intervene in medical decisions – even when they have concerns about the potential consequences of hospitalizations. Family members express tremendous guilt related to the decision to put their parent, spouse or sibling in a facility, and seem reluctant to do anything that would limit the care their loved one receives. While some question the need for ER visits and hospitalizations, and some recognize the potentially negative effects, they tend to defer to the facility and trust their judgment – not wanting to deny their loved one needed medical care, even if they think it is, or might be, futile. While providers often cite panic and concern by the family as a reason they elect to hospitalize long-term care facility residents, the family members in this study appear to play a more passive role in this decision-making, letting staff and medical professionals determine whether a hospitalization is needed.

### **Transitions To and From the Hospital Need to Improve**

Physicians, nurses, and social workers say better management of transitions to and from the hospital would minimize complications, including some preventable readmissions that result from a lack of communication. Transitions could be better managed by a medically trained patient advocate, a discharge nurse following the patient between transitions, physicians talking more to one another, or another way (i.e., electronic, paper, or person-to-person) in which the information in the medical record follows the resident to and from the hospital. Interview participants noted the importance of transferring medical information, including changes in drug regimens, to and from the long-term care facility in real time, noting that ERs and hospitals are too often a “black hole” of information.

### **Strategies for Reducing Avoidable Hospitalizations of Long-Term Care Facility Residents**

Individual participants offered several suggestions to reduce inappropriate hospitalizations among long-term care facility residents. Their ideas include:

- **Additional support and training for long-term care facility staff.** Physicians, nurses, and family members said more training, additional support, increased hiring (to improve the staff-resident ratio), and less staff turnover would improve the ability of facility staff to handle a variety of medical situations without hospitalizations, if medically appropriate. The training should also address the

special challenges presented by residents with mental and behavioral health issues since many of the hospitalizations occur among these residents.

- **More medical support to back up facility staff during late nights and weekends.** Facility staff members need greater medical support – particularly during nights and weekends – to minimize hospitalizations that result when staff members “panic” without sufficient access to physicians.
- **Philosophy shift in the appropriateness of hospitalizations.** According to some physicians, nurses, and social workers in this study, hospitalizations are often viewed as the “path of least resistance”, and suggest more discussions are needed to ascertain what care can and should be provided in long-term care facilities, rather than in a hospital setting, as well as discussions about the cost implications of frequent hospitalizations.
- **More ongoing advanced care planning and discussions among residents, families, physicians, and staff of long-term care facilities.** Many physicians we interviewed say these discussions and planning typically occur only once, if at all; they also suggest this information needs to be updated as the residents’ health conditions change. Physicians indicated that they were unclear whether it was their responsibility or the responsibility of the facility staff to talk with the resident and family about updating their wishes as their medical situation evolves.
- **Improve capacity of assisted living facilities to deal with the medical needs of residents.** The predominant model for assisted living communities is a social model, not a medical model, but as the aging baby-boom generation gravitates more to this setting for long-term care rather than nursing homes, physicians and facility staff recommend more attention to the medical care and support provided to residents in assisted living facilities.
- **Review the financial incentives for physicians and facility staff.** Although interview participants did not have specific suggestions for changing the financial incentives for physicians and staff, physicians believe it is financially preferable to send residents to the hospital rather than see them in the facility, and confirmed that, from their point of view, there are no financial or other incentives to avoid unnecessary hospitalizations. Therefore, changing the financial incentives or creating disincentives could help to discourage inappropriate hospital admissions.

## Conclusions

Individuals interviewed for this study recognize the vulnerability and medical fragility of residents living in long-term care settings. Many residents have multiple chronic conditions or cognitive impairments, and are at risk for falls and other events that require intensive care that may be most appropriately provided in an inpatient hospital setting. Yet, facility staff and physicians generally agree that hospitalizations are routine, perhaps *too* routine, and often preventable. Study participants generally agree on the need to strike a better balance between providing appropriate medical care to long-term care facility residents and avoiding unnecessary trips to the hospital.

## Introduction

While the 2010 health reform law included a number of delivery system reforms to help improve care and lower medical costs, little attention has been focused on the medical care and medical costs for people living in long-term care facilities.<sup>5</sup> The Kaiser Family Foundation and Lake Research Partners visited four cities in the spring of 2010 to examine how medical decisions are made on behalf of emergency room (ER) use and hospital admissions for residents of long-term care facilities. We conducted interviews with medical professionals, staff, and family members to learn how medical decisions are made on behalf of long-term care facility residents, particularly decisions related to emergency room use and hospitalizations. According to a separate analysis by the Kaiser Family Foundation, long-term care facility residents account for a disproportionate share of Medicare spending due to relatively high rates of inpatient hospital care, followed by skilled nursing facility care, and use of other Medicare-covered services by long-term care facility residents.<sup>6</sup>

This study identifies factors that may drive decisions about whether or not to send a long-term care facility resident to a hospital. These factors were derived directly from the interviews with the long-term care professionals who participated in this project – nursing home medical directors, geriatricians and other physicians who treat patients in long-term care settings, staff at nursing homes and assisted living facilities (e.g., LPNs, RNs, NPs), and geriatric care managers – as well as family members of residents of long-term care facilities.

In addition to a primary interest in providing appropriate medical care to the residents of long-term care facilities, other factors influencing decisions to send residents to the hospital include the following: liability concerns, physicians' preferences to have their patients treated in a hospital setting, limited capacity of nursing staff to deal with medical situations, limited access to medical support for facility staff during nights and weekends, minimal access to diagnostic tests in facilities, family preferences, and lack of advance care planning. In short, the default option and the path of least resistance for long-term care facilities and the physicians making decisions on behalf of residents, is often to send patients to the hospital. In fact, for staff of long-term care facilities and physicians, there are virtually no disincentives for sending patients to the hospital to be seen and treated. Further, there was virtual consensus about the need for improvements in transitional care management for long-term care facility residents who are being transferred to and from the hospital, often leading to medical complications that could be avoided with improved communication and planning.

## Research Methods

Forty-three interviews were conducted in April 2010 in the following four cities: Miami, St. Louis, Philadelphia, and Phoenix. At each site, between 9 and 15 interviews were conducted with medical directors, attending physicians, nurse practitioners, registered nurses, licensed practical nurses, hospice nurses, social workers, care managers, and family members. A mix of long-term care facilities was

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represented at each site – nursing homes and assisted living facilities, for-profit and not-for-profit, highly rated facilities and those with lower ratings, and private-pay facilities and those that accept Medicaid. Interview participants were told they would not be identified in this study to encourage them to speak openly and honestly about their facilities. The family members recruited for this study were screened to ensure that they were the primary family member responsible for medical decisions for their loved one, and that their loved one had at least one recent ER visit so that they could talk about this experience. We did not interview long-term care facility residents directly since our focus was on the experiences of residents who are medically compromised and there were concerns that interviews directly with residents themselves would be a burden and potentially unreliable. (See Table 1)

**Table 1. Profile of Study Participants**

	Nurses			Doctors	Social Workers	Family Members	Total
	LPN	RN	NP				
Philadelphia	—	4	—	1	—	4	9
Miami	3	2	1	2	1	6	15
Phoenix	2	1	2	2	1	2	10
St. Louis	1	2	—	2	1	3	9
Total	6	9	3	7	3	15	43

It is important to note that this is a qualitative study and the sample of participants is small. The purpose was to identify factors associated with frequent hospitalizations among long-term care facility residents, to set a framework for efforts to develop potential interventions to help reduce preventable hospital admissions, while providing quality care to patients in the most appropriate setting.

## Findings

The physicians, nurses, social workers, and family members interviewed in this study agree that hospitalizations are a frequent, everyday occurrence at long-term care facilities. In many cases, these hospitalizations are automatic and occur with little discussion or decision-making among facility staff, particularly in cases when a resident has fallen, has an infection, or becomes disruptive or violent due to dementia or behavioral health issues. Comments made by interview participants suggest there are no *disincentives* to sending a long-term care facility resident to the ER when there is a medical issue. This is often the path of least resistance and a decision that is rarely questioned by facility staff or family members. On the other hand, treating a medical condition at the bedside in a long-term care facility or practicing “slow medicine” on frail residents is much more difficult. There are license limitations, liability concerns, questions about skill levels and training of staff, a lack of medical resources on-site, physician preferences for in-hospital care, concerned and anxious families, and a culture of hospitalization that need to be overcome.

**“ I call them *frequent fliers*, they come and they go. Sometimes I feel that the facilities have something to do with the actual care of the patient, that they’re not given the care that they should be given. And then due to that lack of care given at the appropriate time, then that will basically cause the patient to end up in a hospital.”**

Social Worker, Miami



Possible reasons for these frequent hospitalizations are explored below. What is clear from the interviews is that frail long-term care facility residents can suffer deleterious effects from frequent trips to the hospital. These revolving door hospitalizations can leave residents physically and emotionally exhausted, disoriented, and sometimes in poorer health. Family members notice this “rush to hospitalize” at long-term care facilities and the damaging effects on their loved one but defer to long-term care professionals. A family member in Philadelphia commented, “My mother-in-law is in assisted living. She falls a lot as well. It seems like every time she falls, they send her off to get a check. She is always fine. I guess I don’t know if they are overly cautious and just trying to cover themselves.”

### **Factors Driving Many Hospitalizations for Long-Term Care Facility Residents**

Ten factors that drive decisions to hospitalize long-term care facility residents emerged from the interviews. There does not seem to be any single overriding motivation according to study participants; any or all of these factors could be influencing decisions:

#### **1. Limited On-site Capacity at the Facility to Deal with Medical Issues**

Many of the physicians and nurses in the study explain that long-term care facilities such as nursing homes can have staffing and licensing restrictions that limit their ability to diagnose and treat potentially serious health conditions on premises. Assisted living facilities have even less capacity than nursing homes since they tend to have fewer on-site medical staff. These limitations lead to frequent and possibly avoidable hospitalizations for residents.

According to some physicians and nurses, tests such as X-rays and EKGs are not available on-site and can take hours or even days to order from an outside contractor. Treatments such as IVs, sutures, or even drawing blood can be beyond the skill level of long-term care nurses or require too much time, say a number of physicians and nurses, impinging on their ability to care for other residents. Most of the physicians in the study believe sending a resident to the ER for these tests and medical procedures is quicker and better for the resident. “The problem is the time,” explained a medical director from Miami. He continued, “The patient has chest pains and I need an EKG. I need blood work, I need an echo and I need X amount of tests and that will take a long time in a nursing home. But if we take them to an ER, it takes a few hours.” A family member from Phoenix also made this point: “It was very difficult to get any of the testing done. Anything that needed to be done took forever, and so it was actually much quicker to go to a hospital to have some of the testing done.”

There also may be limitations on the type and amount of medical care a facility can provide because of their license. A Director of Nursing in Miami explained, “It depends on what type of license you have. If you have a standard license you can only do basic things.”

In addition, having less experienced nursing staff at long-term facilities and high turnover of nursing staff can limit the ability to provide bedside care and lead to more avoidable hospitalizations. Some physicians and nurses say unseasoned nurses are more likely to panic and push for immediate hospitalizations rather than wait out certain conditions or attempt to resolve medical situations at the facility. An RN from Philadelphia commented, “The new nurses get nervous and would probably call 911 right away.” One medical director from St. Louis said the problem is that it is difficult to attract highly skilled nurses into nursing home care. “That is part of the quandary, how do I get them better nurses of skill... to avoid that hospitalization they could have managed there?” A physician from that same city said, “My feeling is a lot of the nurses going to the nursing homes don’t feel comfortable with a lot of

the acute issues that you see in the hospital.” Sometimes it is not even a trained nurse making the decision to hospitalize but other caregivers with less training and skill to deal with a medical need.

Inadequate training can also limit bedside care in facilities and lead to more hospitalizations. A few nurses in the study admitted to being overwhelmed at times and ill-prepared for dealing with the medical crises they encounter. At least one nurse talked about wanting a manual or some



**I have caregivers who are very moderately trained. They are not nurses. They didn't go to nursing school. So if a resident is telling them that they are sick and not feeling well and they want to go to the hospital, sometimes they are like, 'They want to go, we are going to send them.'"**

LPN, Phoenix

kind of guidebook that outlines what to do in different situations. A number of physicians also noted a lack of training in some of the nursing staff in long-term care facilities. A medical director from St. Louis said, "I think there is a lack of training and how to do it right."

Adding to this problem is a staff-to-resident ratio in some facilities that is not sufficient to address multiple medical needs, according to some nurses and family members in the study. They feel that nurses are stretched too thin in many facilities. A Director of Nursing from St. Louis explained the challenge: "A lot of times when you are overseeing a larger group, say the 60 beds that you are overseeing, it might take you an hour before you see all 60 of those people. By the time you start with bed 1 and you get to bed 60, that person in bed 60 may have been in respiratory distress or having problems before you even get there." An LPN from Phoenix told about her experience being short-staffed. She said, "There was one incident where [a resident] fell in the evening and all I had on that shift were women and it took every single one of them to get him up. In the meantime, another resident fell and that ended up being a big conflict that we discussed at great length. We couldn't have every single staff member in there [helping the one resident] because they were not answering the other call buttons because they were all assisting him."

## **2. Physician Preference for Care in Hospital Settings**

Some physicians see patients regularly at specific hospitals and prefer to see their long-term care facility patients there, if a medical need should arise, rather than try to deal with the problem in a nursing home or assisted living facility. For these physicians, hospitalizations are more convenient, less time consuming, and potentially better for the patient. An LPN in Phoenix explained, "The doctor will say just send [a resident] to the ER and we could probably do labs here. I think that is because they don't come to the facility. If you send [the resident] to the ER, everything is done... they are going to run the tests, the labs and the x-rays and they are going to get it right there."

Many of the physicians in this study acknowledged that convenience is a factor in their decisions to hospitalize long-term care facility residents. For example, a St. Louis physician commented, "I don't want the headache of the phone call two hours from now, at midnight, from the nursing home... 'Mrs. Johnson has a white count of 14,000. Do you want me to send her to the ER?' As opposed to eight o'clock [in the evening] and I say 'Send them to the ER and we will see what happens.' No phone call at two o'clock in the morning."

A few physicians expressed discomfort with this preference for ER care. One physician conjectured that his peers are not comfortable practicing “slow medicine” on frail long-term care facility patients but prefer more aggressive approaches, including sending residents to the ER. A nurse practitioner in Miami alluded to this when she said, “There are still doctors who want their patients to go to the hospital and we’re thinking, ‘Why? We can draw blood and administer whatever level of medication they need.’ We just have to do whatever the physician wants to do. But...I have felt like this patient should not be going out [to the hospital].”

“**They go to the hospital. I am going to be at the hospital anyhow. I am going to be there from 8:00 am to 2:30 pm. For me to see two more or three more patients at the hospital versus running around at the nursing home... it is going to be logistically easier, more effective, better coordinated and financially profitable. I would have to be a moron to leave the patients that are moderately ill that I have to see daily at the nursing home, right?”**

Medical Director, Philadelphia

A handful of other physicians in this study seemed attuned to the strain of frequent hospitalizations on frail long-term care facility residents, and also to the cost to the health care system of so much expensive care. These physicians attempt to limit unnecessary hospitalizations as a result. They do this by visiting patients regularly in the facility and having the facility or family call them first before hospitalization. “I go by and see the patient and makes sure he’s okay. It’s more work but sometimes it’s better. It’s more rewarding,” explained a physician in Miami. He went on to say, “We can solve problems early on and we can modify their diets and we can modify the way the medications are administered. That would save future problems.” A social worker in Phoenix works with a like-minded physician. She said, “I met with a physician the other day and he said to me ‘I don’t want any of my patients going to the hospital and you call me first before you even think about sending them.’”

### **3. Liability Concerns for Physicians, Nurses, and Facilities**

Fear of lawsuits from residents and families is clearly a factor in decisions to hospitalize, according to physicians, nurses, social workers, and family members interviewed for the study. Liability concerns exist both for the facility and the physicians and nurses who provide medical care. All feel vulnerable if they do not act when they encounter a resident in physical or emotional duress or who complains of pain. A social worker in Phoenix explained, “I think a lot of nurses or even LPNs are afraid of liability, they are afraid of if they don’t send so-and-so to the ER, what if they are bleeding internally? What if they die and then they are getting sued?” A registered nurse from Miami commented, “I don’t think any physician really wants to code a 95-year-old person, but with the fear of if they don’t what’s going to happen... ‘Is the family going to try and sue me because I didn’t send their 95-year-old loved one to the ER?’”

Liability fears not only affect the decision to hospitalize, they also prompt physicians to conduct more tests and procedures on long-term care facility residents than they might ordinarily. A Philadelphia medical director said, “The defensive mode... has accelerated blood tests, heroics and hospitalizations directly related to liability risk.”

Nurses and physicians say families drive their liability concerns. If they are present in the facility and see their loved-one struggle to breathe, for example, they will often push for hospitalization even if shortness of breath is a common symptom of their loved one.

**“ I think liability...drives a lot of what we do. I don't want Mrs. Johnson's family to say that I did not take care [of their mom]. I may do more tests than I would probably do for myself or my son or my wife. If I knew that I wasn't going to be liable for not doing the multiple tests, that in my eyes do not necessarily need to be done, [then I would not do them]. I don't want to be in litigation with anyone over a health care issue.”**

Physician, St. Louis

#### **4. Financial Incentives for Physicians and Long-Term Care Facilities**

It is unclear from these interviews if financial gain is a reason behind the frequent hospitalizations of long-term care facility residents. While the long-term care professionals in this study agree that physicians and facilities make more money when a resident is sent to the hospital, they differed on whether the financial benefit actually drives decisions about hospitalization. They suggest instead that decisions to hospitalize are complex and influenced by many factors – including doing what is best for the resident – and cannot be attributed solely to a desire for higher compensation.

In explaining the financial benefit to physicians of hospitalizing a long-term care facility resident, a medical director in St. Louis explained, “In the hospital, I am billing every day that [my patient] is there.” A physician from Miami said, “While in the hospital, I would be able to do procedures [on the long-term care facility resident], which is billable, which is what puts the cost all the way up there.” An RN from Miami commented, “As long as [the doctor] is treating them [in the hospital], they're making money.”

**“ If I send a patient to the hospital, then I get paid for seven days. If I see them one time in the nursing home for a month, then I only get paid for one visit.”**

Medical Director, Miami

However, some physicians say they do not feel hospitalizations are generally positive for frail long-term care facility residents and so try to avoid them despite the financial incentives to do otherwise. A medical director in Miami commented, “If it is one of the patients that I have at [a nursing home] then I try to keep my patient at the home as much as I can. Not because it isn't financially feasible or advantageous for me to send every patient to the hospital that I can – because it is a business – but you try to do what is best for the patient.” This medical director went on to say, “I don't like to admit patients to the hospital because it is unethical to send somebody to the hospital just because I can make more money that way.”

Some participants suggest there are also financial benefits for long-term care facilities to send residents to hospitals. For example, facilities with both a residential and skilled nursing unit may financially benefit from hospitalizing a resident and then sending them to the skilled unit for rehabilitation where the facility can charge a higher rate; the skilled unit is typically paid for by Medicare at a higher rate than the residential unit, which is often paid at a lower rate by Medicaid. Also, residents and their families often must keep paying for the empty bed in the residential unit to ensure the residents do not lose their space when they are discharged from the skilled nursing unit. A medical director from Miami explained, “The [facility] is getting a bed-hold on a lot of them. The patient is not in the building, they are not caring for them, and they get money [for the patient] every day.”

### **5. Type of Facility: Physicians and Nurses Say Assisted Living Facilities Are Often Less Able than Nursing Homes to Address Medical Needs on Premises**

The type of long-term care facility seems to matter when it comes to hospitalizations. The nursing homes in this study all seem to have a physician medical director and at least one registered nurse (RN), if not more, in the facility most of the time.<sup>7</sup> These medical professionals can provide some bedside care for common conditions and quickly assess when hospitalization is needed.

**“ I find that with assisted living facilities... it is hard to work with them to keep people out of the hospital because... on their staff you have an LPN, not even an RN, who is handling maybe 100 or 120 people and you have caregivers who are not trained medically.”**

Social Worker, Phoenix

Assisted living facilities, on the other hand, seem less structured to address medical needs. According to some of the physicians and nurses in this study, assisted living facilities are based on a social model of aging – one that generally precludes having medical staff and resources on-site. The result, based on these interviews, is more frequent hospitalizations for residents in assisted living facilities. A medical director from St. Louis said, “There is not enough medical help [in assisted living facilities]. They push so hard to be a social model and we are arguing that you are shooting yourself in the foot, you don't want a medical model but you have to have some basic medical help... I think there will be inroads down the road because... [people] will realize you don't need a medical model, you just need some medically-based competencies in your staff.”

Interview participants explain that residents in assisted living facilities often have a personal doctor, but usually these physicians do not visit their patients. Physicians have less ongoing contact with assisted living facility residents and their families, which make them more likely to hospitalize residents when medical care is needed. Some physicians also say their assisted living facility patients just tend to be less prepared for serious medical issues; they often do not have an up-to-date advance directive, nor do they have a plan for their future care. Medical directors and nurses in nursing homes are more aware of their residents' medical conditions and history, which can help avoid unnecessary hospitalizations; for example, they may know that a resident has temporary shortness of breath due to a medication they are taking.

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<sup>7</sup> The Omnibus Budget Reconciliation Act of 1987 [OBRA '87; P.L. 100-203] required all nursing facilities that receive reimbursement from Medicare or Medicaid to have a medical director (effective 1990).

## 6. Lack of Relationship between Facility Staff, Resident’s Physician, and Resident’s Family

Knowing the resident and their family appears to be a good way to avoid unnecessary hospitalizations, according to the physicians, nurses, and social workers interviewed in this study. When providers know the resident and the family, they can more accurately assess the medical need, wait out certain conditions (e.g., labored breathing, not eating) with more confidence, and avoid a panic mindset which can lead to hospitalizations. “I know every one of my people inside and out,” said a social worker in Phoenix. “I can tell you their family members, probably even phone numbers. I think that helps. I don’t have that many hospitalizations. I think having a good case manager on them and knowing what is going on works.”

A number of participants suggest that hospitalizations are higher in the first few months after an individual arrives at a nursing home, when there is less familiarity with the patient and family members. A family member in Philadelphia explained, “In the very beginning, they were more cautious and they would send her a lot [to the ER]. As they got to know her... and she had the tendency to fall... they didn’t send her as much.” Some long-term facilities sell families on the fact that they form close relationships with their residents, which leads to better care and quality of life. A medical director from St. Louis explained, “That is one of the biggest selling points... ‘You trust us, we are taking care of mom. Their nurse here is going to know every change that goes on, [whereas] the nurse in the hospital is clueless when someone is demented [versus when] their behavior is really changing.’”

**“We’re all trained to say, ‘I don’t know this patient, send them to the ER, and call me from there.’”**

Physician, Miami

Another challenge is that, according to many physicians, nurses, and social workers, the bulk of the hospitalizations occur after hours or on weekends when their normal providers are absent. “I get a call, I swear every weekend, that so-so is going out to the hospital. I am like, ‘Are you kidding me?’ Every weekend, never fails,” commented a social worker from Phoenix. A physician from that same city said, “A lot of times patients [have a medical crisis] after hours or on weekends when the primary doctor is not available or on-call. There is someone [else] on-call and/or there is a new nursing staff who doesn’t know the patient’s prior level of function. He panics.”

## 7. Lack of Advance Care Planning and Failure to Update Care Plans as Medical Needs Change

While helpful, advance directives do not necessarily provide enough or the best guidance for dealing with or avoiding hospitalizations. Physicians and nurses in this study say that advance directives are not updated enough, not discussed with family members, and not always fully understood by the residents themselves.

Many feel that DNRs are insufficient in themselves to guide decisions about hospitalizations. “I try to go a step further, when I do an admission because you can have a DNR but like I said, DNRs are only going to cover you once we come in and you are already gone. We are not going to try to restart your heart and we are not going to do CPR. I have more of it laid out... ‘What you want? Do you want to go to the hospital? Do you want IV treatment ...?’” said an LPN from Phoenix.

**“ He has a DNR [but] my immediate reaction is to get him out of pain. He said, ‘I need a doctor, I need a doctor.’ It never occurred to me to ask if they could relieve the pain [at the nursing home]. Now I know that they can and I know that there is no need to send him to a hospital or an emergency room. If they can relieve the pain there, then what will happen, will happen.”**

Family Member, Philadelphia

Interview participants say family members in a panic sometimes change their minds and seek hospital care despite what a resident’s advance directive may say. “Sometimes the family gets worried... they don't feel comfortable. Even if their loved one is a ‘do not resuscitate’ status, or even if they're on hospice sometimes, in fact, a lot of times... they start to panic. They'll [want you to] call 911, and 911 has to come. 911 has to do what they have to do. And then at that point it's out of my hands,” said a nurse practitioner from Phoenix. A social worker from St. Louis said, “Occasionally we will have families who panic and unfortunately we will have hospice patients end up dying in the ER because the family insisted they be sent out.” The problem, according to some participants, is that no one is having ongoing conversations with residents and their families to explain and update advance directives. Some physicians in this study feel they are in charge of having these discussions but often lack time for this conversation. “I think those discussions are not happening. I am not doing them. Sometimes I am inheriting them [the patient and his or her advance directive]. It is there already, but I don’t review it. I think I am definitely guilty of not bringing these things up early on. They probably should be,” said a physician from Phoenix.

#### **8. Unspoken Preference for Sending Residents to the Hospital to Die**

Some nurses said that there is an unacknowledged preference to have residents who are near the end of life sent to the hospital to die. They explain that other residents can find it alarming to observe a fellow resident die at the facility. According to these nurses, nursing homes and assisted living facilities work hard to keep a calm, serene atmosphere and a dying resident can disrupt this. Inexperienced and inadequately trained staff can also find a dying resident to be difficult to cope with and so may be more likely to call 911. It can also be families not ready to lose a loved one pushing for the hospitalization – even when there is a DNR or advance directive outlining a more restrained plan. A Director of Nursing in St. Louis said, “What happens a lot of times is that [care] is driven by the families because they are not yet ready to deal with it... ‘Mom or Dad, they might die this time and we have to do everything to save them.’”

**“ I need families to understand this can be done there [at the facility], they are not hurting their mother or father by not sending them to the hospital all the time.”**

Medical Director, St. Louis

## 9. Behavioral Health Challenges

Social workers and nurses say that residents with dementia and other mental health needs are often hospitalized when they “act out” or their behavior becomes disruptive to the other residents. “When it’s to the point where these patients are getting where they have to be restrained, and they cannot be restrained in a nursing home, they’ll send them out,” explained a social worker in Miami.

**“ She becomes very agitated, very angry. She kicks the staff, bites the staff, screams and yells, cursing, yelling. They put up with it pretty much until it gets to the physical part, and that’s when they call us and they say, ‘We can’t control her. We’re going to have to take her by ambulance to the hospital and put her in a facility.’”**

Family Member, St. Louis

Some interview participants explained that these hospitalizations can be particularly harmful to the residents since their medications are likely to be changed in an ER, often with negative consequences. Social workers in this study, in particular, assert that patients sent to the hospital for behavioral or mental health issues often return to the facility more disoriented and heavily medicated, sometimes with their cognitive capacities permanently decreased. A physician from St. Louis said, “They never do as well. They have dementia and when they are at home or a nursing home and you transfer them out... families call [and say], ‘Mom is ten times worse, she is screaming, she is pulling her IVs

out.’ What I tend to tell them is that she is out of her environment, that is very common.” A social worker from Phoenix explained, “With behavioral health, when you send someone to an inpatient psych [unit at a hospital]... if they are kept there longer than a couple of days you can see a regression in their behaviors. What happens is they go there, they get stabilized and then all of the sudden, they are looking around at all of the other people around them... and they pick up on those behaviors.”

## 10. Reluctance of Family Members to Intervene and Second-Guess Decisions to Hospitalize

Hospitalizing their loved one taps a complex set of emotions and feelings among family members in this study. These feelings can make family members passive in the decision making process and more likely to defer to the nurse or physician. “If someone’s suggesting she needs to go, you trust that,” explained a family member in Miami.

Many are supportive of hospitalizations, viewing this as a sign that the facility cares for their loved one and is watching over them. “No, I don’t question their decision to send her because I want her to get the best care,” said a family member from St. Louis. Comments made by family members suggest that guilt about placing their loved one in a nursing home can make them more likely to support hospitalizations when there are medical questions – they do not want to be neglectful and delay care that could save the life of their loved one. But others see the toll these hospitalizations take on their loved one and question if so many trips to the ER are needed.

**“ The impression is that they are doing the loving thing for their family member by sending them to the hospital.”**

Medical Director, Philadelphia



## Transitions To and From the Hospital Need to Improve

Even when hospitalizations are appropriate, interview participants suggest that there is no overall management of the process of transitioning the patient to and from the hospital, which they say is very fragmented. There is minimal information following the resident as they move between the long-term care facility and the hospital; between the hospital and the skilled nursing facility; and between the skilled nursing facility and the long-term care facility. A physician from Phoenix said, “All those transitions of care are where care gets broken down.” This is also a problem when long-term care facility residents go to different hospitals to receive care. A medical director from Miami commented, “The problem that we’re having is that a patient goes to X hospital and the next time is taken to Y hospital and then Z hospital the next time and then to W hospital the next time. There is no way that X hospital knows what Y hospital did.”

The biggest complaint is that medications are changed or dosages increased in ERs and during hospitalization without the providers knowing the resident’s medical history or without communicating about the medication change when the resident returns to the long-term care facility. Physicians, nurses, and social workers also say that the residents’ medical records do not follow the resident as they move between care settings. They say there is rarely a care summary or discharge report after a hospital stay. That means physicians and nurses that care for the residents in long-term care facilities lack information about the care provided to the resident when off of their premises. A physician from Phoenix said, “I would say less than half of my patients that come to skilled nursing facilities have a discharge summary with them.”

They refer to ERs as “black holes” where no information goes in or comes out relating to the residents’ care. “I had a lady go out a couple of weeks ago. Her sister was concerned about her dementia. She took her for a psychological evaluation. They admitted her. I still do not know what they did and she has been back for about 10 days,” said a Director of Nursing in St. Louis. A physician from the same city commented, “I go to nursing homes. They have no connection whatsoever with the hospital, so I couldn’t get any information if it was not photocopied and sent with the patient.”

**“  
More often than not  
medications are changed  
[in the ER] and the  
emergency room doctor is  
not the one who is going  
to continue to follow the  
patient.”**

Physician, Miami

Complicating these transitions is that residents often return to the long-term care facility in poorer health, more confused, on different medications, and with infections from the hospital. “What I’ve observed personally is confusion. They’ve adjusted to a certain environment and then when they go to the hospital... maybe because they’re being tested and their blood is being drawn and maybe their medications are being changed and they’re being given other medications depending on the condition they have... for some reason, I’ve noticed that their memory gets worse, kind of like amnesia,” explained a social worker from Miami. A social worker in Phoenix said, “A lot of our members [residents] get MRSA [a bacterial infection resistant to commonly used antibiotics]. They will be in the hospital for a couple of days, the next thing you know they are diagnosed with MRSA... It is an infection in your blood and it is due to being in the hospital. It is very contagious, it can be airborne and it can be blood-borne.”

Two participants in this study said their facility or company is trying to improve transitions of care for long-term care facility residents. A nurse in Philadelphia said she has started a tracking system for her residents, while a social worker in Phoenix explained that her private geriatric care management company has created a role for a discharge nurse to monitor transitions. She explained, “We just created a role at our company and it is called a discharge planner. What that RN does is she goes out and she meets with the person after they get out of the hospital, she will meet with them for a month. She will visit them in their homes or in the facility one time a week and make sure that it was a proper discharge.”

### **Strategies for Reducing Avoidable Hospitalizations of Long-Term Care Facility Residents**

The following ideas for reducing emergency room visits and avoidable hospitalizations among long-term care facility residents emerged directly from interview participants:

- **Additional support and training for long-term care facility staff.** Physicians, nurses, and family members said more training, additional support, increased hiring (to improve the staff-resident ratio), and less staff turnover would improve the ability of facility staff to handle a variety of medical situations without hospitalizations, if medically appropriate. The training should also address the special challenges presented by residents with mental and behavioral health issues since many of the hospitalizations occur with these residents.
- **More medical support for facility staff during late nights and weekends.** Facility staff members need greater medical support – particularly during nights and weekends – to minimize hospitalizations that result when staff members “panic” without sufficient access to physicians.
- **Philosophy shift in the appropriateness of hospitalizations.** According to some physicians, nurses, and social workers in this study, hospitalizations are often viewed as the “path of least resistance.” Policymakers should start conversations about what care can and should be provided in facilities, rather than in a hospital setting, as well as discussions about the cost implications of frequent hospitalizations.
- **Better management of transitions to and from the hospital.** Physicians, nurses, and social workers say better management of transitions to and from the hospital would minimize complications that result from a lack of communication, which sometimes results in preventable readmissions. Transitions could be better managed by a medically trained patient advocate, a discharge nurse following the patient between transitions, physicians talking more to one another, or another way (i.e., electronic, paper, or person-to-person) in which the information in the medical record follows the resident to and from the hospital. Interview participants noted the importance of transferring medical information, including changes in drug regimens, to and from the long-term care facility in real time, noting that ERs and hospitals are too often a “black hole” of information.
- **More ongoing advanced care planning and discussions among residents, families, physicians, and staff of long-term care facilities.** Physicians in the interviews say these discussions and planning typically occur only once, if at all; they also suggest this information needs to be updated as the residents’ health conditions change. Physicians indicated that they were unclear whether it was their responsibility or the responsibility of the facility staff to talk with the resident and family about updating their wishes, as their medical situation evolves.

- **Improve capacity of assisted living facilities to deal with the medical needs of residents.** The predominant model for assisted living communities is a social model, not a medical model, but as the aging baby-boom generation gravitates more to this setting for long-term care rather than nursing homes, physicians and facility staff recommend more attention to the medical care and support provided to residents in assisted living facilities.
- **Review the financial incentives for physicians and facility staff.** Although interview participants did not have specific suggestions for changing the financial incentives for physicians and staff, physicians agreed that they could financially gain by sending residents to the hospital and there were no financial disincentives to discourage hospitalizations. Changing the financial incentives or creating disincentives may help to discourage inappropriate hospital admissions.

## Conclusions

The 2010 health reform law is expected to move forward with a number of delivery system reforms, including care for patients transitioning out of hospitals to the community, and care coordination for geriatric patients in the community. These interviews with long-term care physicians, nurses, social workers, and family members indicate that greater attention to the management of medical care for seniors living in long-term care facilities could also prove fruitful. Relatively high numbers of potentially avoidable hospitalizations, coupled with inadequate attention to transitions to and from the hospital, take a toll on residents and result in disproportionately high Medicare spending for long-term care facility residents. This issue will grow in importance as the population ages, and the number of Medicare beneficiaries living in long-term care facilities increases.

Individuals interviewed for this study recognize the vulnerability and medical fragility of residents living in long-term care settings. Many residents have multiple chronic conditions or cognitive impairments, and are at risk for falls and other events that require intensive care that may be most appropriately provided in an inpatient hospital setting. Yet, facility staff and physicians generally agree that hospitalizations of long-term care facility residents are routine - perhaps *too* routine - and often preventable. Study participants generally agree on the need to strike a better balance between providing appropriate medical care to long-term care facility residents and avoiding unnecessary trips to the hospital. As policymakers consider strategies to improve the delivery of care for high-cost Medicare beneficiaries, greater attention to those living in long-term care facilities could improve the quality of care and potentially reduce unnecessary and costly medical care.



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