Medicare patients at risk of long-term institutionalization after hospital stay

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Confirming many elderly patients' worst fears, a national study has shown that being hospitalized for an acute event, such as a stroke or hip fracture, can lead to long-term institutionalization in a nursing home. Equally alarming, researchers found that direct discharge to a skilled nursing facility -- a common practice designed to reduce hospital stays -- put patients at "extremely high risk" of needing long-term nursing home care.

According to researchers at the University of Texas Medical Branch in Galveston, these findings suggest that programs aimed at helping older patients recuperate successfully at home instead of in an institutional setting could greatly improve their health outcomes and reduce healthcare costs. The study is published online today in the *Journal of Gerontology*.

"Hospitalization is a tipping point for older patients, often reducing their ability to live as independently as before," said lead author James S. Goodwin, MD, Director, Sealy Center on Aging at UTMB and the George & Cynthia Mitchell Distinguished Chair in Geriatric Medicine.

Goodwin also noted that certain factors common among the elderly -- cognition problems, frailty, lack of social support -- increase the risk of nursing home institutionalization.

"Add the enormous systemic pressure to reduce hospital stays and a dearth of viable programs to help patients fully recover their health and

independence after hospitalization, and there simply isn't a clear path to get the patient back home," he said.

Medicare pays 100 percent for 20 days at a skilled nursing facility for patients who have just been released from the hospital but still need extra care.

"There is a very narrowly defined view of what Medicare will provide post-hospital," said Goodwin. "If Medicare payment guidelines were broadened to cover in-home care -- bathing and food preparation for example -- there is a tremendous potential for savings and patients could adjust gradually back to their familiar home environment. Medicare will not pay for the in-home care."

Goodwin and his colleagues measured a five percent sample of Medicare enrollees (approximately 762,000) aged 66 or older between 1996 and 2008 who were admitted to nursing homes. Of that population, 75 percent were admitted to a nursing home for long-term care within six months of a hospital stay.

According to Goodwin, the period studied paralleled a time of growth in the use of skilled nursing facilities, which may have been due to Medicare's adoption of a prospective payment system that encouraged hospitals to reduce the length of stays.

Institutionalization after hospitalization increased with older age, in women and in patients without a primary care physician. The odds of institutionalization were also more than six-fold higher in patients with a dementia diagnosis and increased in patients with other co-morbidities, including delirium and incontinence.

Being transferred to a skilled nursing facility on discharge was the primary risk factor leading to substantial long-term care. The percent of

hospitalized Medicare patients transferred on discharge increased from 10.8 percent in 1996 to 16.5 percent in 2008. Additionally, the study found that nearly 65 percent of patients in a nursing home six month after hospitalization had first been transferred to a skilled nursing facility. This was up from 50 percent in 1996.

Risk-reducing factors

Researchers also found several factors that reduced the risk of long-term institutionalization. Patients cared for in larger hospitals and major teaching hospitals were less likely to be in a nursing home six months after discharge, as were patients treated by their primary care physicians. In general, rates of nursing home institutionalization were lower in Midwest and Western states, where regulations, cultural and social factors may reduce nursing home use.

Goodwin recommends that hospitals consider alternatives to skilled nursing facilities post-hospitalization, such as community-based facilities, assisted living facilities and at-home care. Developing preventive programs that target the population at-risk for long-term nursing home care -- hospitalized Medicare patients -- may serve as another avenue to avert long-term institutionalization. He also suggests exploring ways to reduce the economic incentives of keeping patients in long-term care and divert savings to such alternatives and prevention programs.

"There is no perfect solution for caring for patients who may not be able to function completely independently and who lack a social network of able caregivers," said Goodwin. "We do know that most people fervently wish to remain at home and it is our responsibility to help avoid preventable nursing home admissions."