Why some patients who do not need hospitalization cannot leave: A case study of reviews in 6 Canadian hospitals

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Abstract
In an optimal healthcare system, patients receive care in the most appropriate, least expensive setting. In Canada, too many patients remain in hospital well after they no longer require hospital-based care. This study examines the observations on this problem by a team with a home and community lens in six cases. The underlying issues across the six are the insufficiency of home and community supports before hospitalization, the routine underestimation of these patients’ potential for independence, the deconditioning of patients while in hospital, and hospital staff’s lack of understanding of home care. Addressing these issues would help many of these patients transition from hospital to less costly, more fitting settings.

Introduction
In an optimal healthcare system, patients receive care in the most appropriate, least expensive setting. In Canada, however, a significant number of hospital patients remain in hospital, even after recovering to a level for which care could most appropriately be provided outside the hospital. These patients require an “Alternate Level of Care” (ALC) in another setting, such as a Long-Term Care (LTC) home. Estimates suggest that up to 14% of inpatient beds in Ontario are occupied by patients who could benefit from an ALC, for example. When people are in hospital unnecessarily, they are at an increased risk of mortality, functional decline, and contracting an infectious disease, and they are more socially isolated. Patients needing an ALC and their families can also experience anxiety and depression. Hospital staff are under intense pressure to discharge patients who need an ALC, creating a stressful, frustrating situation. Most of the patients needing an ALC are waiting for LTC placements, even though most lived at home prior to hospitalization.

Over time, a range of recommendations have been made to address ALC issues at the healthcare system and organizational levels. These have included improving the flow from hospital to LTC, increasing the capacity of LTC and Complex Continuing Care (CCC) settings to meet the needs of patients requiring ALC, and increasing community supports so people can remain at home or wait there for a LTC placement. However, progress has been inadequate and inconsistent to date: the rates of patients needing an ALC have remained relatively stable over several years.

Between 2011 and 2017, six hospitals invited a team from Saint Elizabeth Health Care, a large Canadian home and community care provider, to conduct in-depth reviews of their patients who needed an ALC but for whom this was the most difficult to achieve. The reviewers were invited to bring a new perspective—a home and community, rather than hospital, lens—to recommend ways to decrease the number and length of stay of patients who remained unnecessarily and inappropriately in hospital. To understand the affected patients and context of each organization, the reviewers used a multi-faceted approach, including assessing patients using the RAI-HC tool, participating in rounds, conducting focus groups with hospital direct care and management staff, interviewing patients and families, and scanning available community support resources.

Methods
An instrumental, collective case study approach was used. Six cases were examined, each representing an acute care organization in which a review took place. This enabled a focus primarily on the ALC issues and the generalizable aspects across the cases rather than the specific cases or situations.

The case study had three phases:

1. Document review: All six final review reports were analyzed to identify the reviewers’ approach, the context, and the issues in each case. These data were used to refine the interview questions for phase 2 and to validate, corroborate, and contextualize the data from the interviews.

2. Key informant interviews: Interviews were conducted with four experts involved in the six reviews to elicit their perspectives and insights. The interviews were recorded and transcribed verbatim, and analysis and interpretation was undertaken throughout the study, using the constant comparison method.

3. Triangulation of data: Data from phases 1 and 2 were analyzed to identify commonalities and differences across the cases and generate general strategies for reducing the incidence of patients requiring an ALC.

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The Southlake Regional Health Centre Research Ethics Board reviewed and approved the study.

**Results and discussion**

Across the six cases, 393 patients needing an ALC were assessed, most of whom were over age 70. The document review and interviews with the reviewers led to four general observations about the underlying causes for the ALC issues, which are summarized in the “current state” of Figure 1.

**Home and community supports are insufficient before hospitalization**

Consistent with findings from a previous study, the majority of patients needing an ALC first arrived at the hospital through the Emergency Department (ED). The reviewers found that the trigger for the ED visit was both the patient’s acute healthcare need and the patients and their caregivers not managing well at home. Often these patients were older adults with pre-existing indicators of frailty.

“Patients who often progress to an ALC present themselves to the emergency department in some sort of a crisis . . . but there’s often predecessor circumstances that led to that crisis . . . They come with informal caregivers who are . . . stressed, anxious, concerned, exhausted with having to either provide care [or] worry about their loved ones . . . Those situations don’t just happen, they happen over time.”

Therefore, one key observation across all sites was that additional formal supports and resources at home were lacking for many patients who eventually needed an ALC when in hospital. Proactive efforts to support people in their homes as they age could prevent many of the incidents that prompt people to go to EDs, get admitted, and then, because of the unresolved lack of support at home, have unnecessarily extended stays in hospital.

Across all six cases, the reviewers observed that simply providing these patients with more hours of the most commonly available home care services would not suffice. Often, a thorough assessment of clinical and non-clinical needs could have opened up opportunities for creative thinking about different supports to meet those needs. For example, the reviewers identified that other kinds of supports might be appropriate, such as more flexible interprofessional community teams, including physicians, supported by tele-homecare, home visits, remote patient monitoring, and ongoing reassessments to allow for anticipatory planning and care adjustments to meet evolving needs at home. As one reviewer
commented, “...even if people did truly want to live in their home, there’s not enough upstream support, monitoring, watching...Why don’t we actually think through modifying someone’s home earlier?” Providing respite has also been shown to be effective in preventing ED visits and hospital admissions. 20-22

Like Walker (2014) and Lavergne (2016), the reviewers suggested that primary care providers might have screened patients to identify support needs that would allow them to prevent crises that led to ED visits. The reviewers also saw opportunities for hospitals to play a role in assessing people who present in an ED for additional supports they need to live safely in their homes. The reviewers characterized a more formal approach to screening as an admission avoidance program, in which a hospital representative situated in the ED could facilitate immediate access to primary and community care services, including case management, for 1 or 2 days, for example, rather than admitting the patient. This would enable the patient to return home with a home and community support plan suitable to their home environment.

Routine underestimation of patients’ potential for independence

The reviewers found the majority of patients assessed in the various reviews had planned discharge destinations of LTC. This acute care → LTC trajectory typically encounters lengthy waits for LTC placements so that the time a person is waiting in hospital for an ALC is extended significantly. The reviewers found that about half the patients with this acute care → LTC trajectory could have been cared for at home, either as an alternative to LTC or as an interim measure. This is consistent with a recent report, which found that up to 30% of those entering LTC could have been cared for at home with supports. 15 The report also found that those assessed for placement while in hospital were 6.4 times more likely to give up intentions in which a “sequential single systems approach or narrow differential diagnosis” resulted in patients’ needs being ignored and being held in hospital longer than necessary. Here, the reviewers observed a focus on the issue that gave rise to admission rather than also addressing patient’s potential functional and mental decline.

The reviewers noticed that hospital staff tend to be highly risk averse on behalf of their patients. This manifested in hospital staff responding to patient needs with institutionalized care, first while they are in the hospital, and then by discharging them to LTC. These were considered to be “safe” options without an assessment of the risks associated with hospital stays. 11 If, instead, the first consideration was what patients need to allow them to return home, there would be a greater focus on rehabilitation and restorative care in hospitals, as there is in programs such as Acute Care for Elders (ACE). 28

General deconditioning of patients while in hospital

The reviewers found that patients routinely deconditioned during their hospital stays and this affected the possible options for leaving the hospital. Deconditioning is a consequence of inactivity and bed rest, and it affects mental status, continence, activities of daily living, and mobility. 25,26 In all six cases, the reviewers observed many people not able to return home because of their diminished capacity, even though the issue that precipitated their hospital stay had been resolved.

“As soon as [they’re] designated as [needing] ALC, they’re institutionalized...They don’t do any dishes, they don’t do any laundry...Nothing normal happens in their time at the ALC beds...The hospitals inadvertently institutionalize people very quickly, and so that’s where people lose a lot of function and ability...and all that’s preventable.”

“If you’re a little bit weak, then you’re not allowed to get out of bed...If you really have to go to the washroom and you’re pressing a call bell and you have to wait for somebody to come and you don’t have great bladder control, you could then lose control...and then you’re also incontinent and you’re put into...[incontinence products]. As time goes on, you just become that sick person...So then there’s a decision that they can’t go back home anymore...They go into this thing called ALC where the amount of resources that are allocated to them starts to drop...You have less physio, sometimes no OT [Occupational Therapy], and so it’s even more difficult to regain anything that you had before.”

Rashidi et al., 27 in a recent review of an Ontario hospital, observed instances in which a “sequential single systems approach or narrow differential diagnosis” resulted in patients’ needs being ignored and being held in hospital longer than necessary. Here, the reviewers observed a focus on the issue that gave rise to admission rather than also addressing patient’s potential functional and mental decline.

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Restorative care, which might include increasing physical activity, promoting independence for activities of daily living, and addressing motivational issues, 29 has been found to be a safe and effective way to improve patients’ functioning across care settings. 29-32 The reviewers felt it should be a responsibility of hospitals, given the significant decline that can occur in a brief time span. 29 One noted that a focus on restorative care could also reduce unnecessarily long stays in hospital for those who are typically harder to transition to LTC homes.
“... If you [need] a two-[person] transfer or you need a lift chair, you sit on that waiting list [for LTC] a lot longer. If you can improve their nutrition and improve their cognitive state a bit, get rid of the delirium and help them move a little bit easier, [LTC] homes are more open to taking them. Who knows? Maybe they can even go to retirement homes.”

Restorative care requires an interprofessional team approach with geriatric training, including physio-, occupational, and recreation therapists; dietitians; social workers; personal support workers; nurses; and physicians. The reviewers observed that across all sites, reassessments of patients in need of an ALC were infrequent; however, they suggested reassessments would allow status changes and new support needs to be identified. At times, an early patient assessment might have concluded the most appropriate post-hospital setting as LTC, but a reassessment during efforts to restore and maintain function might conclude that a return to the patient’s pre-hospital setting—usually home—would be possible. This observation aligns with an “assess and restore” philosophy.

Home care is not widely understood in hospitals
Across the six cases, the reviewers observed that hospital staff thought patients were safer in the hospital because the staff did not know about home and community care resources, or they believed that more home supports were needed than could be made available under current rules. Further, they rarely know whether the recommendations they make to patients upon discharge are actually implemented as part of their home care plan. These factors contributed to a reluctance to discharge patients to their homes. The reviewers noted from their experience that many patients with several comorbidities and complex needs are safely cared for in the community with the currently available services.

Summary
These four observations are linked by overlapping beliefs, attitudes, processes, and structures that often militate against patients being in the most appropriate and least costly care setting. This overlapping opens the possibility that the observations might best be addressed simultaneously to realize more appropriate, less costly care for patients. To move from the “current” to “ideal” state, as outlined in Figure 1, the case study results lead to the following recommendations:

1. Reinforce the need for primary care, home and community care, and EDs proactively to identify and provide supports for people, including frail older adults, to enable them to remain in their homes and avoid hospital admissions.
2. Reorient hospital staff to focus on helping patients maintain and restore function while in hospital so that they are not prevented from returning home as a result of hospital-acquired deconditioning.
3. Bring together hospital and community providers to collaborate on clearer, more integrated admission criteria for post-acute programs that can help transitions to home, such as rehabilitation, transitional beds, and CCC, so that more patients would benefit.
4. Increase hospital staff knowledge and experience of the potential of home and community care to accommodate a wide variety of care needs, and make reassessments of patients’ status part of the care process so that changes and resulting support needs are identified as early as possible. This might include hospital and home care providers transcending the boundaries between their settings, and feedback to hospital-based providers on how their patients have managed at home.

Conclusion
These case study findings echo those from earlier reports, indicating inconsistent progress has been made by the healthcare system to ensure patients are able to be cared for in the most appropriate, less expensive settings. This and previous studies have revealed that a large number of patients destined for LTC could have been cared for at home with appropriate supports, potentially freeing up thousands of days of occupancy of acute and LTC beds and of funds that could be re-directed to other sectors. It has been estimated that, in Ontario, each 10% shift of patients (300) in acute care waiting for an ALC (ie, LTC) to home care, would result in a $35 million saving. In 2015/2016, there were about 4000 beds per day occupied by patients in need of an ALC in Ontario. If 50% of those could have been cared for at home with appropriate supports, as we found, this could equate over $230 million in savings, which could be re-allocated to improve care and meet the reasonable expectations of patients and caregivers about receiving care in the most appropriate place. Although some elements of the recommendations emerging from this case study have been implemented in specific settings (eg, ACE), further evaluation of the impact of a more comprehensive, cross-sector approach is needed to continue to build the evidence base to address the needs of patients and the healthcare system.

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