

“Waiting for placement?”

Waiting for solutions

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The most humbling aspect of inpatient medicine is often not the severity of the illness treated, the ability to effect diagnosis and treatment where we were previously left to guesswork and acquiescence, or the complex array of psychosocial issues that accompany explaining a loved one's condition to family. Rather, patient placement is the overriding issue in so many cases for inpatient neurology. Neurologists are often confronted with more than half of the neurology ward census, where we have done the good work of making the diagnosis, exhausted the treatment opportunities, and now are waiting for the patient to be accepted and transported to a rehabilitation hospital, a skilled nursing facility (SNF), or to home with home health care. Pressures to move the patient can be immense from the facility administration, but also from the emergency department and intensive care unit, where the bulk of future neurology inpatients is waiting to come to the ward.

In this issue of *Neurology: Clinical Practice*, Roberts et al.¹ take a first step in defining this problem. The authors looked at 100 consecutive patients in 2 months on an academic inpatient neurology ward, defining cut points where patients were ready for discharge, then tallied hospitalization days after acute care diagnosis and treatment endpoints were achieved. They found a mean of 4.8 inpatient days as medically unnecessary, including 80 days for 1 patient. Extrapolated annually, this would be more than 7,000 inpatient days where no meaningful investigations or therapies were applied. At costs of greater than \$1,000/day, excess expenditures could be in the millions of dollars for a single institution. Nationally, the expenditures for medically unnecessary hospitalization for neurologic inpatients may total in the billions.

The consequences for protracted inpatient stays are more than just financial. Longer hospitalization exposes patients to hospital-acquired (often antibiotic-resistant) pathogens.² Medical errors including receiving wrong or inappropriately dosed medications are more likely,³ and medical inertia with unnecessary daily blood draws is increased.⁴ Patients waiting for placement may receive less scrutiny, so new medical issues can be overlooked. Turnover in ward physicians and poor handoffs in care⁵ risk reduplication of costly and invasive testing and treatments. Patients and their families become discouraged and frustrated, as do the providers caring for them. Hospital quality metrics that incorporate patient satisfaction can suffer as a result.⁶

The efficient transition from acute inpatient care to postacute care is elusive for many hospitalized patients.⁷ Roberts et al. cite obstacles ranging from financial (insurance approval, arranging for vital medications outside the inpatient facility), to administrative (application to and evaluation by the postacute care facility), to legal (establishing family and guardianship claims). Each of these hurdles must be overcome to reduce the number of medically unnecessary inpatient days.

Placing neurologic patients in a safe, caring postacute environment poses unique challenges. Neurologic conditions can cause severe disabilities that discourage acceptance to postacute care. Falls, pressure ulcers, and use of antipsychotics for behavioral modification are all cited by the Centers for Medicare and Medicaid Services (CMS) as indications of poor quality care at SNFs,⁸ but patients with neurologic disorders are at inherently greater risk for these problems

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owing to mobility issues and impaired cognition. Long-term care facilities can exclude patients who affect their quality and safety ratings, leaving neurology inpatients with fewer options for postdischarge care.

Methodologically, the study has limitations. “Medically ready for discharge” is subjectively defined by the “neurology inpatient team” at a single institution. Their criteria, however, are commonsense and have commonalities with utilization management around the country. The study is at a tertiary care academic institution, where the severity of illness may be higher than in nonacademic community hospitals. The results here are not further risk-adjusted to account for illness severity or comorbidities. The authors admit that the reason for delay in discharge cannot be ascertained for most of the sample, leading to speculation on cause. That medical readiness for discharge is addressed at a multidisciplinary conference daily suggests an acute awareness of the problem, and in institutions where less attention is focused on postdischarge care, the extent of medically unnecessary inpatient days may be even greater. Therefore, the findings of Roberts et al. may represent a conservative estimate when compared to other hospitals around the nation.

Having described the problem of delays in discharge, the next step is development, testing, and implementation of interventions designed to address it. Greater planning and coordination of care from day 0 of hospitalization is imperative to preventing medically unnecessary days. Timely engagement of social workers, care managers, therapists, psychiatrists, and rehabilitation therapists are crucial to patient flow. Integrating acute and postacute care through preferred referral networks is another important step, although the authors note that this study occurred in the context of a preferred postacute care referral network. Interoperability of electronic health records between hospitals and SNFs may also help reduce delays in evaluation and placement.⁹ Ultimately, policy changes from regulatory agencies or Congress may be needed. The greater disability and needs that neurologic patients have should be acknowledged and care must be adequately compensated by Medicare and other payers to encourage access to SNF and home health care. Quality and safety metrics and rating programs of postacute care facilities must not discourage the acceptance of patients with complex needs.

Roberts et al. highlight a thorny problem in hospital medicine, exacerbated among our patient population by the nature of the disorders neurologists treat. The effects on cost, patient safety, and quality of care and patient and provider morale are enormous. This is an issue with myriad causes and no simple

solution, but increased awareness and the discussions that it will hopefully generate may bring us closer to resolution.

Author contributions

Dr. Ney: manuscript writing, initial concept and design, critical revision of the manuscript for important intellectual content. Dr. Weathers: writing, initial concept and design, critical revision of the manuscript for important intellectual content, study supervision.

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