Overcaution in Emergencies Risks Wide-ranging Costs

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When residents at long-term care (LTC) facilities report nonspecific symptoms that may signify any number of illnesses, caregivers must address a host of questions: Should the resident be sent to the emergency department (ED)? Is a trip to the hospital medically indicated? What are the legal consequences of failing to send an ill resident for emergency care? Are there risks in a transfer? What are the costs to the facility? What are the costs to the resident? To their families?

For example, a resident with a cough may need nothing more than over-the-counter medication and fluids. But another resident presenting with nearly identical symptoms could be experiencing signs of pneumonia. Similarly, an elderly resident complaining of indigestion might only need a light diet and an antacid. But another resident with the same complaints could be in the first stages of a heart attack.

Scenarios as diverse as these lead to questions that can only be answered by practitioners with medical training and the ability to determine when a headache is just a headache or when a fall results in only minor bruising. At some LTC facilities, those practitioners are not required to be present at all times, which raises even more questions about liability and the proper allocation of medical resources.

The facilities for whom these questions are particularly vexing are assisted living (AL) facilities, personal care homes, or residential care facilities. Despite disparate designations, these homes all offer the promise of support and supervision for older residents while allowing them to live in a relatively independent environment. However, with this independence comes the challenge of deciding the proper course of care when a resident becomes ill. In these cases, it is often the tendency of staff members, particularly those without medical training, to err on the side of caution and send a resident to the ED rather than attempt to provide onsite care.

This overabundance of caution is often the first instinct of an untrained care provider, and it may even save the life of a resident. What's more, by turning the local ED into a *de facto* attending physician, a facility can also shield itself from potential litigation that may be brought if in-house care proves unsuccessful. In fact, it is not hard to imagine scenarios in which residents-turned-plaintiffs claim that earlier intervention by trained personnel represents an essential, nonnegotiable first step of emergency care. To plaintiffs' attorneys, the logic of earlier intervention as a panacea can be repeated as a convenient mantra, which, in turn, can be understood by jurors all over the country to mean that the facility failed in its responsibility to provide care to those residents. For this reason, and because of the difficulties in establishing differential diagnoses, some caregivers may decide that their only option is to send any resident with any complaint, no matter how vague or nonspecific, to a hospital and hope for the best.

Is the mindset of sending residents with minor complaints to the ED good medicine?

However, this decision may do more harm than good. For example, a *Boston Globe* report described the experiences of a 92-year-old nursing home resident with a drop in blood pressure.[1] The resident's son informed the nursing staff that she was merely experiencing a recurrence of a long-standing condition, but the resident was sent to the ED by an overcautious nursing staff.[1] This occurred twice more and, according to her son, "[s]he sat around for 5 or 6 hours getting really frustrated and angry. They did all kinds of tests and realized there was nothing wrong…."[1] During a later hospitalization, she caught a hospital-acquired infection, causing high fever and vomiting.[1]

Is the mindset of sending residents with minor complaints to the ED good medicine? Such a strategy could lead to misused healthcare resources, overcrowded EDs, the potential for hospital-acquired infections, and unnecessary stress for residents and their families. Additionally, saturating EDs with residents who do not need emergency care can lead to substandard care for those suffering from true emergencies, possibly leading to further injury or death. However, in the case of residents with certain conditions, a failure to send the resident to an ED could cause an even worse injury. If that occurs, the facility could be suddenly faced with a lawsuit for failing to properly address an emergent situation.

Different States, Different Rules

Unlike skilled nursing facilities (SNFs), for which a standardized minimum level of care is defined by federal statute, a national standard for AL facilities does not exist. In fact, the standards and vocabulary used are so wide-ranging that the prospect of opening a national dialogue among AL directors may seem daunting, if not impossible. It is up to the states to define who may be admitted to such a facility. For example, in Alabama, state regulations provide that residents must be "ambulatory adults who do not require acute, continuous, or extensive medical or nursing care and are not in need of hospital or nursing home care."[2] By contrast, in Pennsylvania, these facilities are known as *personal care homes*, and accommodate nonambulatory residents, as long as they do not require nursing care. Further, "residents who are not relatives of the operator or owner and who require assistance or supervision in such matters as dressing, bathing, diet, or medication prescribed for self-administration" may be admitted.[3]

These contrasting requirements for admission reflect the sharp disparity in the laws regulating these facilities across the country. Of course, this disparity does not end once the resident has been admitted to the facility. Each state has its own rules governing staffing, the ratio of rooms-to-residents, the number of bathrooms, the care to be provided, and whether Medicaid assistance is available. For example, the Pennsylvania Department of Welfare makes it clear that "[p]ersonal care homes are not medical facilities and they do not have to hire medical staff. Personal care homes are required to hire staff who meet basic education requirements."[4] In California, where there are more than 5100 licensed residential care homes, 90% of them are licensed to have 6 or fewer residents housed in a private residential home setting.[5]

AL regulation by states is a hodgepodge.

Recently, several states have made strides to coordinate and improve the baseline care provided at these facilities. For example, the American Association of Retired Persons (AARP) waged an extensive grassroots campaign in New York to encourage lawmakers to strengthen that state's regulations, which led to the successful passage of a bill that took effect in February 2005.[6] According to Bill Ferris, a senior legislative representative for AARP New York, "[b]efore this legislation, anyone in New York could put out a sign and say they were running an assisted living facility."[6] To view the issue more broadly, while more than half of the states use the term *assisted living* in their laws, DaCosta Mason, AARP's national coordinator for state affairs on AL issues, acknowledges that "it's a hodgepodge, and many states are looking for ways to clarify what AL means, just what services these homes guarantee."[6] In Pennsylvania, some have claimed that there has been a failure to recognize AL as an increasingly popular option for those "who need a higher level of care whose option is not to live in a nursing home."[7] Along with other factors, this has led to what experts in elder care have referred to as "one of state government's worst failures."[7] Fortunately, the recognition of this problem has led to proposed legislation that would provide the state with more oversight of AL facilities.

EDs in Crisis

According to an investigation by the Institute of Medicine, which advises the government on healthcare issues, the nation's emergency care system is "at a breaking point" to the extent that 500,000 times each year, ambulances carrying sick patients are turned away from full EDs to seek care elsewhere.[8] To illustrate the problem, in 2003, the nation's EDs saw nearly 114 million patients.[9] Of this number, roughly half represented true medical emergencies.[9] A study funded by the National Institute of Aging and presented at a national meeting of the American Geriatrics Society found that 37% of all hospitalizations for long-term residents at urban nursing homes across the nation were potentially avoidable.[1]

Another national study concluded that more than one third of hospitalizations of nursing home residents could be prevented if nursing staff recognized symptoms of illness sooner and if more doctors were available at nursing homes.[1] To reduce these problems, some nursing homes are hiring on-call nurse practitioners. Some states, such as Massachusetts, are targeting conditions that frequently result in unnecessary or avoidable hospitalizations: dehydration, urinary tract infections, chronic pulmonary disease, and congestive heart failure.[1] The difficulties typically faced by SNFs are compounded in AL facilities, where many states do not require medical personnel to be in the facility at all times.

These issues reveal a problem that must be faced every day by administrators and directors of these facilities as they reconcile the need to provide quality care with the expectation of independence for the residents and the desire to avoid the perceived stigma of skilled nursing. As our population ages, facilities will encounter even more difficulties in determining what actions are in the best interest of their residents and what care represents the standard of care. As more states take the initiative to define these standards, the industry is trying to provide more

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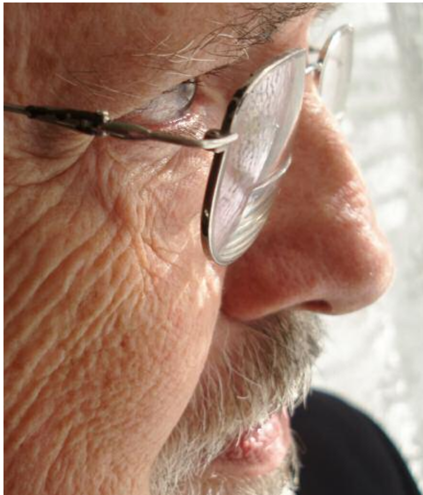

In fact his sage advice is, "It is best to sing out loud and loudly. Thinking about singing is like thinking about sex. It is much, much more satisfying if done with all of your body instead of just between your ears. It is much, much more satisfying if others can and do join in." Richard concludes his brief essay on singing with the resolve that "I am going to do more singing. I feel safe, sound, healthy, and alive when I sing!"

The more than 80 essays that are included in the book are punctuated with highlighted quotations from within the essays that, even at a glance, help provide new awareness of how to live with and care for people with AD. A short selection of these highlighted quotations follows.

On learning of his diagnosis:

"I called my wife, who was at work, and read her the conclusions; neither of us responded. I hung up the phone, poured myself a stiff glass of orange juice, and began to cry."

"I have learned to recognize the difference between sympathy and empathy, and I have learned how to accept both of them."

"The fact that I know I have Alzheimer's disease motivates my focus on actively making today better than yesterday, not hoping tomorrow will be better than today."

"I'm not talking about polysyllabic words. I'm looking for my granddaughter's name."

"I want psychiatrists to put down their prescription pads for a moment and listen to me."

On family:

"We spend more time really being together: We talk more, we hug more, we cry more, we laugh more and harder and longer together." ALC

Richard Taylor maintains a busy schedule of lecturing, writing, editing a newsletter, gardening, and playing with his 2 grandchildren. Richard and his wife live in Cypress, Texas. His son and family live across the street.

Richard Taylor has agreed to maintain frequent E-mail contact with *Assisted Living Consult*. In the coming months, Richard will provide a diary of his impressions, struggles, and conquests. Watch for updates in future issues.

Legal Corner

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answers. However, the disparity of AL legislation across the country often fosters more questions and creates more confusion among administrators and directors, especially in times of emergency. To combat this confusion, many industry experts believe that uniform federal regulations governing these facilities will be necessary, putting an end to the hodgepodge of state regulations. The first step in this process will be for state legislatures to recognize that the burgeoning AL industry is made up of facilities that vary in scope, size, and function, and that comprehensive and carefully tailored regulations are necessary. Once this hurdle has been overcome, these regulations can be debated and fashioned into legislation, which can provide the facilities with the tools they need to evaluate perceived emergency situations and determine when they represent true emergencies. ALC

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Our panel of experts also grapples with the issues raised by Mr. Corso and Mr. Littman. Please see *Ask the Experts* on page 37 of this issue for perspectives from those across the AL industry.