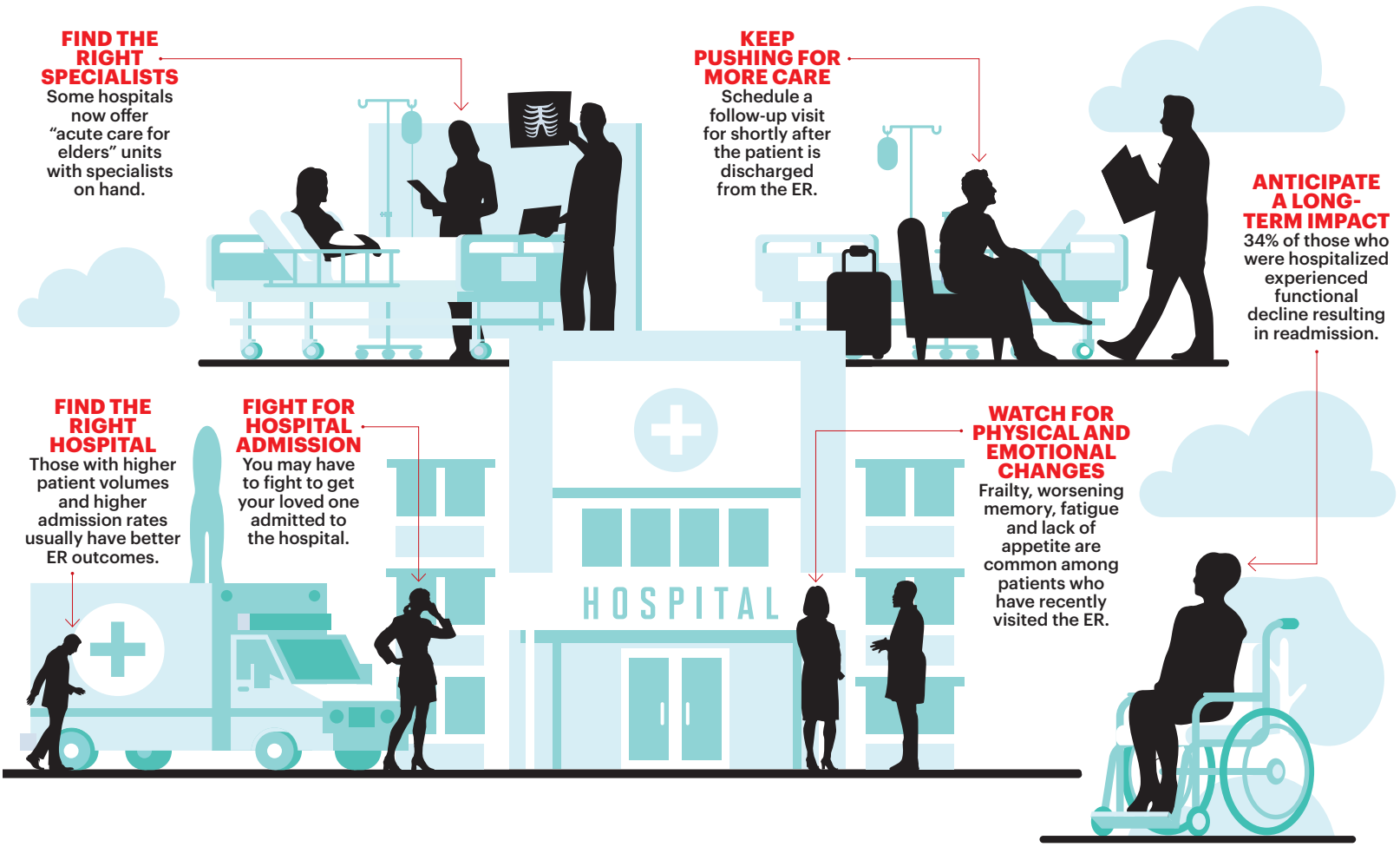
HOW TO SURVIVE THE EMERGENCY ROOM

For older people, a visit to the ER can unleash a spiral of hospitalizations and decline. Some ways to prevent the downturn



BY **KENNETH FRUMKIN, M.D.**

Walking into the emergency treatment room, I noticed two things: First, there were several family members circling defensively around a small figure on the bed. And second, they looked hostile.

Then I recognized the patient, a tiny older woman I had admitted to the hospital several weeks earlier for a badly broken wrist she'd sustained after she fell on her icy porch.

I had fondly thought of her as "Ma," as her family referred to her. Her liveliness and her kindly manner reminded me of my own mother, who, until a fall in her 90s, had also been sharp, active and living a full and independent life in her own home.

Ma smiled, recognizing me and remembering my name. Her greeting defrosted the family a little, but their doubts about her well-being soon became obvious:

"Ma was fine before the fall and admission, and now she's back."

Unspoken, but loud and clear, was: "Did someone do something wrong?"

The wrist was healing, but her chart said "Fever, Weak," and she looked the part. I quickly diagnosed her with a significant urinary tract infection and dehydration. She would need to be admitted to the hospital again.

And regrettably, I needed to have a serious conversation with her family about *post-hospital syndrome* and the genuine possibility that Ma might never be the same.

ILLUSTRATIONS BY NICOLAS RAPP

EXPLAINING POST-HOSPITAL SYNDROME

After 36 years of emergency practice, this scenario had become all too familiar to me: A self-sufficient older patient visits the ER, often for a minor issue or injury. But what at first seems like a small setback begins a rapid functional decline and a loss of self-sufficiency that results in that patient returning to the hospital again and again. Often, those hospitalizations unleash a torrent of health woes that severely impact the patient's long-term well-being and that can even lead to death.

Successful aging requires us to optimize every bodily system in order to preserve an ever-more-fragile status quo. The ability of your body to compensate for even a minor health problem often becomes more limited with age. Think of a pyramid of oranges in a supermarket: It's stable, but if you remove just one of them, the whole structure collapses. It can be like that with an older person's health as well. Something like a fall or an illness happens and, all of a sudden, a once healthy person becomes frail.

Approximately 1 out of every 5 ER visits by people 65 and older result in readmission, even when the initial visit is for something minor, like Ma's broken wrist. One in 3 of those patients will return to the ER within 30 days; 1 in 10 will die within 90 days of their first visit. In a study, 34 percent of Medicare patients who were hospitalized experienced functional decline resulting in readmission.

This is the phenomenon known as post-hospital syndrome. Researchers attribute it to the stress of hospitalization itself rather than to the nature of the original illness or its treatment; in fact, only 17 to 30 percent of return hospital visits are for the same condition as the initial admission. Instead, patients wind up returning to the hospital for any number of reasons—from opportunistic infections and unrelated injuries to entirely unexpected diseases.

Each subsequent return to the hospital increases the likelihood of permanent functional loss and makes it more likely that the patient will need to be discharged into a long-term care facility.

GETTING A HANDLE ON ER TRAUMA

No older adult's discharge paperwork ever states the reality of "a 15 to 35 percent short-term chance of functional decline, return to the hospital, or failing to regain one's prehospitalization state." But if you need to visit the ER, or if you need to bring a loved one, it's important to understand that even a brief hospital visit may have long-term implications. That doesn't mean "don't go to the ER." It means to "go prepared."

ONE IN 5 OLDER PATIENTS WHO VISIT THE ER WILL BE BACK IN THE HOSPITAL WITHIN 30 DAYS.

1. Find the right hospital. Sometimes you don't have a choice which hospital you go to, but sometimes you do. ERs with lower return rates tend to have a greater volume of patients, assigned social workers and higher hospital-admission rates (meaning more of the people who go to the ER are admitted rather than treated and released). To find the best option, your physician should almost always be the first source of information. Doctors and their families get sick, too. Where would they go?

Multiple organizations compile statistics and create ratings on various hospital quality indicators, including:

- ▶Medicare (medicare.gov/hospitalcompare)
- ▶The Joint Commission (qualitycheck.org)
- ▶The Leapfrog Group (leapfroggroup.org)

2. Even better, find specialists who know how to treat aging patients. Many hospitals have specialized "acute care for elders" inpatient units, and there is a growing number of certified geriatric emergency departments across the country; to find one near you, visit acep.org/geda. The Institute for Healthcare Improvement recognizes 450 "age-friendly health systems" on its website.

3. Don't just think *over and out*. It may feel like a win if your loved one is discharged from the ER on the same day, but often it's

not—especially if this is a return trip. Instead of declaring the case closed, make a follow-up doctor visit shortly after the ER episode. If things don't check out well, push hard for a hospital admission or for an aggressive, rapidly initiated outpatient care plan.

This is an important step in shielding your loved one from further complications. One study found that half of Medicare patients needing rehospitalization within 30 days had not seen a physician in the interim. But you may have to push: Medicare targets and fines hospitals for readmissions within 30 days, which means providers are often resistant to readmitting patients. Question your doctor thoroughly before letting your loved one return home.

4. Anticipate a long-term impact. Someone who fell once is likely to fall again. Aids as simple as a cane or walker, along with home-based training for balance, mobility and muscle strength, can reduce future falls and the associated decline. And the home should be assessed for hazards, from challenging stairs and slippery rugs to icy front porches.

But don't leave it at that; a watchful eye can make a big difference in detecting signs of creeping frailty. Keep an eye out for decreased mobility or an increased need for assistance with the activities of daily living: getting out of bed, using a toilet, bathing, dressing, grooming and eating. If you're not there, ask care providers or friends to keep an eye out, too. And check with insurers to see what services or gear they will cover.

5. Watch for physical and emotional changes. In addition to frailty, other findings associated with hospital returns are depression, worsening memory, fatigue, dizziness, decreased appetite, incontinence, trouble communicating or thinking, or increasing numbers of prescribed or over-the-counter medications. Any of these clues can indicate an acute, reversible illness such as pneumonia or urinary infection. Recognizing and then treating them early can help avoid a return trip to the hospital.

As for Ma, the last I heard, she was again well and living independently, thanks to a mobilized and vigilant family working with her doctors to avert post-hospital syndrome. A concerned, informed and proactive patient and support system are the best defense against the real possibility of functional decline in older adults following illness or injury. ■

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