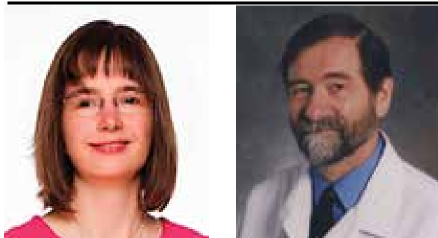
An Approach to 'The Social Admission'

Melissa K. Andrew, MD, PhD, Colin Powell, MB, FRCP (Lond, Edin et Glas)



About the Authors

Melissa K. Andrew is an Associate Professor in the Department of Medicine, Division of Geriatric Medicine, at Dalhousie University in Halifax. Her research focuses on frailty in relation to social vulnerability and dementia, and she leads a research team on these topics within the Canadian Consortium on Neurodegeneration in Aging (CCNA). Correspondence may be directed to mandrew@dal.ca. Colin Powell is Professor of Medicine (retired) at the University of Calgary, and Adjunct Professor of Geriatric Medicine at Dalhousie University. He served as Associate Editor for Ageing of the Canadian Journal of General Internal Medicine.

Although the 'social admission' is no doubt a familiar occurrence for most general internists and physicians who work in hospital-based practice, it is difficult to say exactly how common such admissions to hospital are, or what percentage of older people admitted to hospital are seen in this light. Nevertheless, this is frequent enough to merit attention to underlying causes and contributing factors; this is the aim of the current article.

What is a social admission?

There is no single accepted definition of a social admission, and it is likely that many different situations may end up with this label or one of its numerous synonyms (some, such as 'acopia' and 'bed-blocker,' which are less appropriate than others).[1] For the purposes of this article, a social admission is defined as a hospital admission for which no acute medical issues are felt to be contributing; rather the patient's social circumstances are felt to be the sole cause, be it the breakdown of home supports or the inability of the patient and/or family to cope with the demands of living at home. As we shall see, social admissions are heterogeneous, with many potential contributing factors. Therefore, an organized approach to the patient admitted for social reasons will be helpful for busy clinicians providing hospital care for older patients.

Causes and contributing factors

Similar to other geriatric syndromes like delirium and falls, the social admission should be considered to be an indication for a thorough investigation of underlying and contributing causes, in order to address any reversible ones and to identify a management plan that may improve or alleviate the patient's situation. The approach to anaemia provides a useful analogy. We would not accept a diagnosis of 'anaemia' as final, as doing so would miss the precise identification of contributing causes and consequent treatments. A key difference lies in the scope of required investigations; while investigation into most medical conditions, as with anaemia, can generally be limited to patient-level factors (bowel lesions, bleeding, hematological disorders etc,), unravelling the factors contributing to a social admission necessitates a broader approach. Recognizing that the patient is embedded in a nested social structure of families and caregivers, peer groups, institutions, and society more generally can provide a useful framework for organizing clinical thinking and investigation. (Figure 1)[2] Considering the factors that may contribute at each level will likely be a fruitful exercise, since in most cases, the social admission is multifactorial in aetiology.

Patient Factors

Progression in previously diagnosed (or indeed new and undiagnosed) illnesses, disabilities, poorly managed pain, psychiatric conditions, cognitive decline, behavioural and psychological symptoms of dementia (BPSD), polypharmacy and medication adverse effects can all contribute to a nominally social admission. Taken together, multiple interacting physical, mental and social problems lead to a state of frailty where there is insufficient reserve to compensate for any additional (even seemingly minor) perturbations in health, functional status or social conditions.[3] Social admissions are thus clearly an important marker of frailty, and more generally, of vulnerability.

Family and Informal Caregiver Fctors

Family members and other informal caregivers often play vital roles in supporting older patients. Informal caregivers (friends and family) are distinguished from formal caregivers (health care workers in various roles) by their long term relationships with care recipients, and the fact that they are unpaid and often have no formal training. Informal caregivers often face many competing demands for their time and

resources, and escalating care requirements may be a source of caregiver stress and burnout. Caregiver stress is experienced by a family or friend caregiver related to assisting their loved one, and it has important implications not only for the relationship but also for the physical and mental health of the caregiver.[4] Caregivers may also worry about physical demands (e.g. helping their loved one transfer and mobilize), and about safety (their own or the patient's).

Caregiving can also have financial ramifications, both in the short term (e.g. reducing hours of work or taking a leave of absence as care needs escalate), and the long term (e.g. time away from the workforce may have retirement income implications in the future). Socioeconomic considerations are thus very important.

Lack of a viable 'back-up plan' in case the caregiver becomes ill or engages in travel is another factor that may contribute to a social admission. Also important are features of the home environment including safety, accessibility, and suitability for meeting the patient's care needs. To complicate matters, patients and families may decline assistance or supports that are offered by health care providers; living at risk in this way is the prerogative of older adults who have the capacity to make personal care decisions.

Peer group factors

Engagement in social activities is known to be protective for health and cognition.[5] For example, does the patient have contact with friends and attend social gatherings or activities on a regular enough basis to prevent becoming isolated? A tangible example of the benefit of such engagement would be a person noted to be missing from a regular social gathering, leading to a search of their home and the discovery that they have become incapacitated and unable to seek help due to some illness or calamity. In less fortunate cases, isolated older people have been discovered too late, deceased in their homes or apartments, with no one having noticed their absence or distress. Another problem is that peers may stop socializing with an older person who has dementia or other serious illness due to discomfort surrounding a stigmatizing diagnosis or awkward social interactions.

Institutional factors

Formal supports, in the form of home care services, respite care or other assistance, may be available, but barriers to access often exist. Families may have limited awareness of available supports and how to initiate access. Provincial Home Care services may have lengthy wait times and limitations in the amount of time and types of services they can provide. Families may face economic or geographic barriers to hiring needed help at home. In the bigger picture of our health care system, frail individuals may not be well served by the current 'one thing wrong at one time' approach to medical care, which is not generally receptive of taking the 'big picture' of a patient's health and functional needs into account all at once.[6]

Societal and policy factors

The social and policy environments in which people live can greatly influence their opportunities to feel valued and seek access to needed supports. For example, government policies to support caregivers in caring for their loved ones at home can be instrumental; the lack of such support at a policy level can have the opposite effect. Likewise, the presence of a generally supportive community, which demonstrably values its senior citizens, may play a vital role in supporting vulnerable older people. Ideas such as social capital and social cohesion are important at this level – that is to say the overall connectedness and caring for others that exists in a community.[7] The built environment, or the design of buildings and communities in which people live, is another important factor. Accessible and age-friendly communities are key to enabling social participation.[8]

With careful attention to the above factors, in the majority of cases, the social admission will be found to be multifactorial with contribution from most if not all levels. In the end, varied causes require varied responses.

Outcomes

When combined with high levels of frailty that are commonly present in such cases, social factors precipitating admission to hospital place patients at a higher risk for poor outcomes. Even among the healthiest older adults who are community dwelling, high social vulnerability more than doubles the risk of mortality over 5 years, with an absolute mortality increase of 20%.[9] While there is a paucity of data on outcomes for hospitalized social admissions, it is clear that these outcomes are even worse. Mortality rates worse than those of cardiac failure have been reported; one study in the UK found that a diagnosis of 'acopia' was associated with high levels of frailty and an in-hospital mortality rate of 22%, and that only a small minority (6 percent) of patients so labeled actually had no acute medical issues identified after a proper workup.[10] In a Swiss study of 253 patients (mean age 81) triaged in the Emergency Department (ED) as 'home care impossible', acute medical problems were eventually identified in 51%, and 26% were found to have been undertriaged due to neurological symptoms or atypical presentations having been missed and vital signs not being taken.[11] This highlights the broader problem of frail older adults often being undertriaged in ED

settings particularly when frailty is not formally assessed.[12] A Swedish study of 380 patients presenting to the ED diagnosed with 'lack of community supports' identified physical medical causes in 85%. The vulnerability of these patients is highlighted by their finding of 34% one-year mortality.[13]

Suggested management

Given that complex medical issues are often present and that outcomes are so poor, it is important to avoid falling into the bias-laden trap of discounting a patient as 'only a social admission.' To address patient-related factors, a workup for underlying medical illness, cognitive impairment and mood disorders is indicated. Given the prevalence of polypharmacy in this patient population, careful attention to medication review is also warranted. Ideally, a comprehensive geriatric assessment and involvement of the multidisciplinary team should be sought. The issues around a social admission are broad, and involving a social worker is essential. Nevertheless, key roles remain for physicians and other team members. Medical expertise can contribute in important ways to both the diagnostic investigation and the ensuing problem-solving. The attending physician should therefore not simply defer care to others without thinking of the situation in a critical light.

One can expect that working through the framework presented here to identify potential contributing factors at each level from the patient through the family and caregiver, peer groups, institutions and society at large will lead to the identification of some modifiable contributing factors – for example treatable medical issues or areas in which increased supports could be sought. At the very least, embracing the complexity that underlies the (non-)diagnosis of the social admission will help to improve care for this vulnerable group of patients.

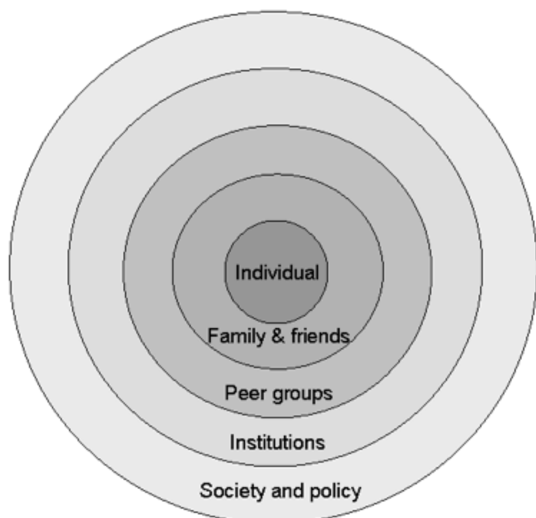


Figure 1. The patient is embedded in a nested social structure.[2]

- **'Social admissions' are of complex aetiology**
- **Patients admitted ostensibly for social reasons often have underlying unrecognized medical problems**
- **A structured approach is helpful for considering the patient's social circumstances at each level from the patient through the family and caregiver, peer groups, institutions and society at large**
- **Social admissions and social vulnerability are associated with adverse outcomes including high mortality**

References

1. Oliver D, 'Acopia' and 'social admission' are not diagnoses: why older people deserve better. J R Soc Med, 2008. 101(4): p. 168-74.
2. Andrew M and Keefe J, Social vulnerability among older adults: a social ecology perspective from the National Population Health Survey of Canada. BMC Geriatrics, 2014(14): p. 90.
3. Hogan DB, MacKnight C, and Bergman H, Models, definitions, and criteria of frailty. Aging Clinical and Experimental Research, 2003. 15(3 Suppl): p. 1-29.
4. Grunfeld E, Glossop R, McDowell I, et al., Caring for elderly people at home: the consequences to caregivers. CMAJ, 1997. 157(8): p. 1101-5.
5. Fratiglioni L, Paillard-Borg S, and Winblad B, An active and socially integrated lifestyle in late life might protect against dementia. Lancet Neurology, 2004. 3(6): p. 343-53.
6. Rockwood K, What would make a definition of frailty successful? Age Ageing, 2005. 34(5): p. 432-4.
7. Baum FE and Ziersch AM, Social capital. J Epidemiol Community Health, 2003. 57(5): p. 320-3.
8. WHO. Age-friendly cities. [cited 2013 July 14]; Available from: http://www.who.int/ageing/age_friendly_cities/en/.
9. Andrew M, Mitnitski A, Kirkland SA, et al., The impact of social vulnerability on the survival of the fittest older adults. Age and Ageing, 2012. 41(2): p. 161-5.
10. Kee YY and Rippingale C, The prevalence and characteristic of patients with 'acopia'. Age Ageing, 2009. 38(1): p. 103-5.
11. Rutschmann OT, Chevalley T, Zumwald C, et al., Pitfalls in the emergency department triage of frail elderly patients without specific complaints. Swiss Med Wkly, 2005. 135(9-10): p. 145-50.
12. Goldstein JP, Andrew MK, and Travers A, Frailty in Older Adults Using Pre-hospital Care and the Emergency Department: A Narrative Review. Can Geriatr J, 2012. 15(1): p. 16-22.
13. Elmstahl S and Wahlfrid C, Increased medical attention needed for frail elderly initially admitted to the emergency department for lack of community support. Aging (Milano), 1999. 11(1): p. 56-60.