There have been drastic changes in the political and health care paradigms in the past 14 years. Politics’ entry into health care and easier access to large datasets have created a new era of accountability for health care providers (Nunes, Brandão, & Rego, 2010). This accountability increasingly demands quality care in return for tax dollars provided to hospitals. This trend is especially apparent in geriatrics, where Medicare is the primary source of health care reimbursement for a growing group of Baby Boomers.

Forcing hospital accountability, the Centers for Medicare & Medicaid Services (CMS; 2012) developed an evolving list of hospital-acquired conditions (HACs) after a mandate from Congress—the Deficit Reduction Act of 2005. CMS (2012) notes that the list identifies the following:

- Conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG [diagnosis-related group] that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. (para. 1)

According to Birnbaum (2009, p. 242), “CMS will start denying payment for service in cases where various adverse outcomes occur unless they were present on admission.” With already dwindling CMS reimbursements to hospitals for patient care, a denial of payment for treating HACs can create significant financial risk for patient stays. It is possible that making delirium an HAC would discourage health care professionals from identifying and managing delirium. This is important to consider as delirium is already under-recognized and under-documented (Fick, Hodo, Lawrence, & Inouye, 2007; Kales, Kamholz, Visnic, & Blow, 2003; Saczynski et al., 2014). Delirium is a quality of care, high cost, and high burden of care issue that needs to be addressed with investments in both practice and research (Inouye, Westendorp, & Saczynski, 2014).

Falls, increased lengths of stay, and higher mortality and overall costs are associated with delirium (Babine, Farrington, & Wieman, 2013; Fick, Steis, Waller, & Inouye, 2013; Inouye et al., 2014). Delirium rates for postoperative hip fracture repair can reach 65% (Franco, Litaker, Locala, & Bronson, 2001; Marcantonio, Flacker, Wright, & Resnick, 2003), and when patients have pre-existing dementia, rates can reach 80% (Fick, Agostini, & Inouye, 2002). According to Franco et al. (2001), the mean technical cost (i.e., cost burden by hospital without professional fees) per hospital stay for patients with delirium (versus no delirium) was 20% higher ($11,762.51 versus $9,415.95) in 2001. Bearing the cost of delirium can weigh on a hospital’s bottom line and be as costly as heart failure and diabetes (Leslie & Inouye, 2011).

Many prevention, identification, and mitigation interventions lie within the nursing domain. Nurses spend the most clinical time with at-risk patients. Early detection can reduce delirium’s severity and duration (Fick et al., 2013). Mattison et al. (2014) showed that interventions based on prevention and recognition by bedside...
staff, combined with computer support, facilitates safer prescribing of high-risk medications and possibly results in less need for extended care. Although nurses may lead bedside delirium care, an interdisciplinary approach to delirium is most effective. For example, nurses can implement cost-effective programs, such as the Hospital Elder Life Program (Leslie & Inouye, 2011).

Hospitals funding delirium research enjoy special benefits. Their research teams may work with the unique demographics they serve and thus are able to make research translatable on a local level. With the information gathered, researchers can reduce delirium rates while enhancing health care quality and value and offer interventions tailored to the local context. Implementation of outside research advancements often occurs many years after discovery. An in-house research team should shorten that process. Several resources exist for hospitals to plan agendas for enhancing delirium care and research (Table).

Increasing demands for efficient, uncomplicated care place the burden of higher costs and less reimbursement on hospitals. This trend is true with delirium, in that associated patient costs can increase to 20% or more per stay. Hospitals funding in-house research on delirium and investing in improved delirium care should reap the benefits of increased quality of care and cost containment. Geriatric nurses can play an important role in advocating for delirium research at their facility and participate in research at the bedside. Ideally, nurses should take part in research planning and evaluation. The potential gains in quality care and cost savings provide positive reinforcement for investing in delirium research locally.

REFERENCES


TABLE
DELIRIUM PRACTICE AND RESEARCH RESOURCES FOR HOSPITALS

<table>
<thead>
<tr>
<th>Resource</th>
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<td>American Delirium Society</td>
<td><a href="http://www.americanedeliriumsociety.org">www.americanedeliriumsociety.org</a></td>
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<tr>
<td>Hospital Elder Life Program</td>
<td><a href="http://www.hospitalelderlifeprogram.org">www.hospitalelderlifeprogram.org</a></td>
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<td>European Delirium Association</td>
<td><a href="http://www.europeandeliriumassociation.com">www.europeandeliriumassociation.com</a></td>
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<tr>
<td>Nurses Improving Care for Healthsystem Elders</td>
<td><a href="http://www.nicheprogram.org">www.nicheprogram.org</a></td>
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