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Aftercare Tips for Patients Checking Out of the Hospital

By LESLEY ALDERMAN

IN mid-March my 85-year-old father checked into a prominent New York City hospital for a scheduled operation. The procedure, to remove a cancerous tumor from his thigh, went well, and soon he was sent home.

But three days later, unable to cope with a complicated wound care regimen, he landed back in the hospital.

My father had become part of a notorious trend. Discharge from the hospital is a critical point in a patient's recovery, particularly for older people with chronic conditions. The process is supposed to be carefully planned, but instead it often is rushed and poorly coordinated, resulting in complications that send patients back to the emergency room.

According to a study published last year in The New England Journal of Medicine, one in five Medicare patients returns to the hospital within 30 days of being discharged. The problem is an expensive one: in 2004, these readmissions cost Medicare $17.4 billion dollars, the researchers also found.

Hospital stays certainly are shorter now: the average stay was 4.6 days in 2007, down from about 5.7 days in 1993. But the readmissions problem is not simply the result of compressed care, experts say.

"Hospitals tend to focus their efforts on the admissions process, because that's when the patient is most sick," said Dr. Mark V. Williams, one of the authors of the study. "The discharge process can be just as important but rarely gets the same level of attention."

At discharge, the assumption is that the patient is better and all will be fine, said Dr. Eric A. Coleman, a geriatrician and professor of medicine at the University of Colorado Denver. But many patients, especially older ones, leave the hospital with a host of issues to manage. They may have additional medications to take, new symptoms to monitor and follow-up appointments to keep, all of which require focused attention at a time when patients may not be at their sharpest.

What's more, while insurers will pay for limited hospital stays, there's no financial incentive for hospitals to insure that patients get out and stay out. "A hospital may actually be financially rewarded for a mishandled discharge," said Dr. Williams, chief of hospital medicine at Northwestern University. "If the patient is readmitted, they get paid again."

Discharge planning winds up being an overlooked issue because it "falls into the space between billable events," said Dr. Coleman.

But there is a movement to improve care after discharge and to reduce readmissions. Dr. Coleman has developed a hospital-based program called Care Transitions Intervention, with the support of the John A. Hartford Foundation, which helps reduce the number of re-hospitalizations for older adults by coaching them to take a more active role in their care.

The federal Centers for Medicare and Medicaid Services has a program at 14 locations to improve hospital hand-offs for high-risk patients. Officials also are developing a program to reward hospitals for lowering readmission rates.

Project Boost, a program developed by the Society of Hospital Medicine, provides hospitals with a tool kit of forms and procedures that standardize and enhance the discharge process. Piedmont Hospital in Atlanta, one of the first hospitals to use the Boost program, has reduced 30-day readmissions for patients under 70 years old to 3.97 percent, from 13.05 percent. Readmissions of older patients have fallen to 11.17 percent, from 15.9 percent.

"The program has been a thing of great beauty," said Dr. Matthew J. Schreiber, chief medical officer of the hospital.

If you or a relative is hospitalized in an institution that has not recently revamped its discharge process, you may need to take an active role in managing the discharge. Here's what you need to know to smooth the transition.

TAKE CHARGE "The biggest problem in the discharge process is that no one person takes ownership of the patient," Dr. Schreiber said. In the hospital, multiple people may have been involved in supervising a patient's care: a surgeon, a nurse, an attending fellow and a discharge planner.

That means it's up to patients and their advocates to make sure discharge plans are sound and to challenge any information that doesn't add up.

If you believe the hospital is sending a patient home too soon, talk with the doctor. If that fails, talk to the hospital's patient advocate. Medicare patients can call their local Quality Improvement Organization, which handles quality-of-care issues for Medicare beneficiaries.

"Sometimes you have to be a jerk," Dr. Schreiber said.

When my father was readmitted to the hospital, I went over the discharge planner's head and dealt only with her supervisor. Guess what? The second discharge went much better than the first.

CHECK THE DRUG LIST Medication errors are a frequent cause of readmissions, Dr. Schreiber said. Ask for an up-to-date medication list and then double-check the information with the hospital pharmacist. Make sure the patient knows when and how to take new pills.

You can print out a medication form from NextStepInCare.org, a Web site created by the nonprofit United Hospital Fund that offers free guides to help patients learn how to make the transition to a different care setting.

MAKE A DISCHARGE PLAN Most hospitals provide a discharge plan in writing, but it may be incomplete and difficult to decipher. Compile your own plan that can be a guide for the patient, the caregiver and other doctors.

The document should include a precise diagnosis, future appointments, a contact list and whom to call if new symptoms arise.

You can download the Boost program's one-page Patient Pass form from the Project Boost Web site at hospitalmedicine.org. A similar form tailored to your situation — for example, for discharge from hospital to a home or to a nursing home — is available at NextStepInCare.org.

A patient ready to leave the hospital may not be ready to go home. Physical therapy, occupational therapy or wound care that would best be administered at a rehab facility or a nursing home may be needed first.

Talk to the doctor and the discharge planner about what location would be best for the patient. “A good transfer requires that care needs match the care setting,” Dr. Coleman said.

CONTACT THE PRIMARY DOCTOR Urge the discharge planner or the hospital doctor to contact the patient’s primary care physician and set up required future appointments. Ideally, the primary care doctor will take over where the surgeons and specialists left off.

“Research shows that the sooner patients see their P.C.P., the less likely they are to be readmitted,” said Dr. Barry M. Straube, chief medical officer of the federal Centers for Medicare and Medicaid Services.

If the hospital staff is not making that connection, then pick up the telephone and make the call yourself.