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The Discharge Dilemma: Technological Challenge

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Introduction

With changes in health care funding and regulation, in hospitals today, the issue of reducing length of stay is commonly heard. While health care managers revel in their reduced lengths of stay and cost savings, the cost to the patient may be unpreparedness to handle their health care needs at home. Care after discharge in the United States is fragmented and unequally accessible and unequally distributed based on numerous factors, including location, available health care resources, reimbursement inequities and clientele lack of knowledge to just name a few.

For those working in the hospital, the life beyond the door of the hospital for the patient is not major priority in light of the patient's high acuity. The acuity of the patient needs to become a reality of assessment and preparation for the needs of the patient and the family at discharge. One reality is that the push to reduce the length of stay of the patients reduces the time for teaching and preparation of services for the patient as an outpatient [1].

We are way ahead in our design of care for the acutely ill, with such treatments as highly technical stents, robotic surgery, hip replacements, bypass surgeries, etc. Patients are now living long days after the amazing medical surgical procedures or with resolution of their acute state of their chronic illnesses, and they return to families and community services for the health care supports they need. An unmet challenge is developing more efficient systems of after care in the community that provide the support for the patient and their family to complete the recuperation process and prevent further complications.

Where is technology in all of this? We are miles behind in the design and development of the technological communication that could coordinate and facilitate that care. Technology has streamlined health care delivery processes in the acute care inpatient setting from electronic health records, computerized physician order systems to computerized medication dispensing and administration, to name a few. Technology is embedded in the culture of hospitals and hospital systems. Where is technology to facilitate communication for the outpatient needing health care services that are widely dispersed and non-interactive with each other? We need to create a culture that values communication within the community health care services serving out patients [1].

For the patients and their families, complexity and fragmentation of community health care services are two major barriers to care provision that facilitates health self-management abilities and skills after discharge. A major concern is the complex availability and accessibility to health care providers for acquisition of necessary supplies and supportive health care. The fragmentation of health care services requires the ability to effectively communicate among care providers, health services and health reimbursement agencies to coordinate the complex care needed for the patient's condition. Many frail and often elderly patients do not have the ability to coordinate and self manage the resources that are available [2]. Telehealth communication systems that allow interaction among patients and providers are a frontier waiting for further development.

The Centers for Medicare and Medicaid Services (CMS) have a financial perspective and have focused on the need for reducing hospital readmissions, and thereby, reducing hospital costs. It revealed that 19.6% of Medicare beneficiaries were readmitted within 30 days of hospital discharge. Preventing such readmissions could potentially save 17.4 billion dollars [3]. Saving such money is noteworthy, but the it seems as if the underlying assumption of such action is that community and family care outside of the hospital is either not an issue of importance, or is adequate to meet the patient's need upon discharge. The consequences or sequelae of early discharge have not been taken into consideration. What technology would be appropriate to follow up on patients after discharge and solve problems, as they arise so that the patient can remain in the community and not relapse to the point that readmission is necessary? Investment in funds for effective outpatient technological communication systems have the potential for reducing the readmission rate and result in savings not only in readmission rates, but in the improved care and quality of life for the patients.

The CMS reports on readmission rates for acute myocardial infarction, congestive heart failure and pneumonia. Such illness events are those that require care much beyond the two or three days of hospitalization in the acute care setting. It seems as if it is assumed that care in the community is available and accessible to all without consideration of socioeconomic factors. Unfortunately, the issue of vulnerability of those in less than favorable socioeconomic states has not been taken into consideration. Not surprisingly, in a study it was found that among heart failure patients, socioeconomic state was significantly associated with higher one year readmission to the hospital rates and mortality [3]. Residing in lowest income communities has been associated with higher hospitalization rates for 12 adult medical conditions than for those living in highest income areas [4]. Other sociological factors such as education and racial and ethnic disparities have been related to health care outcomes disparities. One cannot assume that persons with these sociological disadvantages are suddenly going to be able to have available and access the care supports when they are discharged from the hospital, and at the mercy of community care resources. Where are the technological communication systems to reach these people?

The challenge for solving the discharge dilemma of care provision within a community base must be addressed from many perspectives, and with a multidisciplinary approach. In nursing and health care delivery, the imperative continues to be that of preparing the patient for discharge the first day of admission to the hospital by assessing the needs of the patient at the moment, along with anticipating the

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planning for the patients when they return home. For policy makers, the task must include consideration of the socioeconomic issues and community characteristics in setting policy to ensure that those the most vulnerable do not end up in a situation of double jeopardy, increased vulnerability from early discharge and decreased community care resources. Policies for reimbursement for effective and efficient follow up care that include funds for development of effective outpatient technological communication systems are desperately needed.

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