

The Right Care, At the Right Time, In the Right Setting: Understanding the Healthcare System's Continuum of Care

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Background

It's both the *mission* and the *mandate* of hospitals to provide care to all patients who arrive at their doors. That care is provided to patients regardless of their nationality. Arizona and U.S. hospitals are prepared to care, 24-hours-a-day, 7-days-a-week. This is their *mission*.

Additionally, the federal government *mandates* that hospital emergency departments (EDs) medically screen and stabilize all patients arriving at their facilities. Such screenings are designed to determine if the individual has an emergency condition and provide stabilizing treatment as needed. This federal mandate is called the Emergency Medical Treatment and Active Labor Act (EMTALA). Hospitals must comply with EMTALA in order to receive payment from the federal government for medical services provided to Medicare and Medicaid patients.

This document provides information on hospital discharge planning and how patients may access other providers that are part of the continuum of care in the healthcare delivery system.

Who decides how long a patient stays in an acute care hospital?

This is first and foremost a medical decision made by the patient's physician and dictated by the patient's need for acute medical services. Once a patient is medically ready for discharge from an acute care hospital, the physician recommends an appropriate discharge location. Hospital "discharge planners" work with the family to arrange services that are in the patient's best interest. Based on their medical needs, patients may be discharged to:

- home;
- home with a physician recommendation for home health services;
- a long term care facility;
- a rehabilitation center; or
- other healthcare facilities that meet the patient's medical needs.

Are patients and their families involved in the decision as to where a patient receives follow-up healthcare services?

Yes. Hospital healthcare professionals—discharge planners, nurses, physicians and others—work with patients and their families to find a facility or program that can address the patient's healthcare needs and is safe as well as affordable for the patient. The discharge planner also considers the patient's network of providers as designated by his or her health plan coverage, whether the patient participates in a private insurance plan or a governmental program.

Why can't patients stay in the acute care hospital to receive their follow-up care?

Acute care hospitals are one component of a continuum of care within the healthcare system. Their role in that system is to stabilize and treat patients with complex medical conditions. Patients who require follow-up services are transferred or discharged to facilities or services that specialize in the delivery of such care, including skilled nursing facilities and home health agencies. Discharge plans are developed by the physician and hospital staff in partnership with the patient and his or her family.

Advocate > Collaborate > Achieve

Also, Arizona has a significant shortage of inpatient hospital beds due to its rapidly growing population. This makes it even more important for patients to receive the right care in the right facility. When people who no longer require acute care services remain in an acute care setting, others who need that intensive medical attention may be placed in a precarious medical situation.

How does a patient’s healthcare coverage affect discharge planning from an acute care hospital?

If a patient is covered by a particular health plan, the hospital’s discharge planner will coordinate with his or her plan to ensure there is coverage as the patient moves to the next phase of care. This also is true for patients who receive services as part of the Arizona Health Care Cost Containment System (AHCCCS)—Arizona’s Medicaid program—or the federal government’s Medicare program.

The discharge planner considers many factors when assisting patients and families, including the:

- physician’s recommendations for follow-up care;
- needs of the patient and family;
- capabilities of the facility/service; and
- network of providers available to the patient through his or her coverage (private or state-sponsored).

Is this true for a patient from another state or country?

Yes. The hospital’s discharge planning team works with the patient and family to create a plan that fulfills the physician’s recommendations for follow-up care. This plan should also meet the service and health plan coverage needs of the patient and family, and may include transferring the patient to the state or country where coverage is provided.

What if the patient is from another state or country and does not have a health insurance plan or cannot afford to pay for follow-up care?

Patients and their families may not have the resources to cover the cost of long-term or rehabilitation services on their own. If it is not safe for a patient to be discharged to their home, the hospital staff works to locate an appropriate physician and facility in the patient’s home state or country. People from states outside of Arizona may be eligible for their state’s respective Medicaid program. Citizens of Canada or Mexico are eligible to receive care through their national health insurance program. In these cases, the discharge plan involves physicians from their respective country’s network of providers.

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