Thinking Ahead for Emergency Care

"Plans are useless, but planning is indispensable."
-– Dwight D. Eisenhower

We plan dinner parties and trips and we plan for earthquakes and fires. But it is unlikely that you have planned for a hospitalization unless you've had an elective surgery. Such planning is the smart move because the risk of being hospitalized after an Emergency Department visit increases as we age and failure to plan can make a stressful situation far worse.

This guide to hospitalization came about because several members of the Corte Madera Women's Improvement Club became inpatients over a short period of time. While their stories were individual, they all felt unprepared for the many decisions they had to make. The guide builds on their lessons learned and on internet searches. Its focus is short-term care. It is not intended to replace medical or other professional advice, and any use of this information is at the reader's discretion.

Chance of Hospitalization after Emergency Department Visit by Age

40% for persons age 65-74
57% for persons age 75-84
83% for persons age 85 and older

"I have to ask you one question. Feeling lucky?"
— Dirty Harry Callahan

Planning is an ongoing process, not a one-time task. It may feel overwhelming. If you take the first step, that is, just reading this guide, you will get the lay of the land and feel better knowing what options and decisions you may face.

A second small step is to identify a care partner who can act as a second pair of eyes and ears for you. They take notes and record conversations with medical personnel. They can make sure that you understand your options and that medical staff take your preferences, values and goals into consideration. As you make your own decisions, your care partner can help you feel less alone in the process. This person may or may not be the same person identified as your surrogate decision maker in your advance directive. Make sure the person you identify understands their role and will be comfortable in it.

Advance directives are a topic unto itself but it is not one to neglect. In nearly half of major medical decisions for hospitalized older adults someone other than the patient and physician is involved.

To get an overview of this broader topic:

- Watch “Comprehensive Planning for Health and Illness” with Dr. Eric Widera, UCSF Geriatric Medicine, and lawyer Sarah Hopper at: https://youtu.be/0gVtNUFYn1A, and

- Read about advance directives and portable physician orders (POLST) at https://www.caregiver.org/advance-health-care-directives-and-polst

Only when you are formally admitted by a doctor’s order do you become a hospital inpatient. Each day you stay, ask the person responsible for discharge planning what your classification is. Your inpatient or outpatient status impacts Medicare reimbursement and subsequent coverage in a skilled nursing facility. See https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf for further information.

Your primary care physician may or may not have privileges at your hospital. Upon admission, coordination of your care is passed over to a “hospitalist,” a physician who specializes in hospital care. Hospitalists often earn a residency in internal medicine but they confine their practice to a hospital setting. It is the hospitalist with whom other doctors and nurses communicate, and it is the hospitalist who serves as your medical gatekeeper. The discharge summary you receive upon leaving the hospital is an important tool for communicating with your primary care physician.

You may be unpleasantly surprised by hospital bills if you assume you are an inpatient just because you have been in the hospital overnight. Until a doctor has written an admission order, you are an outpatient getting emergency or observation services (lab tests, x-rays, drugs, etc).

Hospital care is for people who need a high level of medical attention. When you leave the hospital, it is likely you will still need some type of care. If you are not ready to go directly home, you may go to a skilled nursing facility (SNF or “sniff”). If you need physical rehabilitation, you will go to a rehab facility.

Increasingly short hospital stays make arranging post-hospital care challenging and stressful. Although you cannot know your discharge condition ahead of time, the tip sheets included in this guide will outline the options. Websites listed under Resources provide specific information for SNFs.

Your discharge options will be constrained by requirements for your care and safety plus your insurance coverage. Care that is “medically necessary,” ie, prescribed by a doctor, may be paid for by Medicare, Medicaid, or other insurance.

Personal care such as walking, feeding, dressing, toileting, bathing, and transferring from bed to chair are called Activities of Daily Living (ADL's). They are not covered by Medicare although they may be covered by long-term care insurance. Such assistance may be provided by family and friends, by a home health agency, or by hiring a private aide directly.

A qualifying hospital stay (three inpatient days) is just one of several conditions that must be met for Medicare to pay for care in a SNF or rehab facility. See https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care for additional details.

Only a doctor can authorize release from the hospital but you will also work with a nurse, or a social worker or case manager to complete discharge planning. Excellent planning and good follow-up can prevent medication errors and reduce re-admissions as well as hasten your recovery and decrease healthcare costs. You may be surprised how much there is to plan for. Make sure you have answers to your questions before you leave. When you fail to get an answer, ask who can address the question. Knowing who has responsibility is key to getting correct information and resolution.

At or near admission and again near discharge, the hospital must give you the "Important Message from Medicare." This Medicare notice explains your rights. If you are not ready for discharge, tell your doctor and the hospital staff immediately about your concerns. Ask your doctor to advocate for your interests. If your concerns are not resolved, request an appeal.

Your discharge summary is an important tool to ensure continuity of care. With a hard copy in hand, you can ensure that your primary care physician and other providers are informed about the reason for your hospitalization, significant findings and diagnoses, procedures and treatment provided, your condition at discharge, and instructions for follow-up care.

Finally, things seldom go completely as planned. For every major decision, consider a backup.

"I had my transportation to the hospital arranged but then X had her own medical emergency. Luckily I found someone else at the last minute."

A list of additional resources (internet access December 2020) follows.
The accompanying guide consists of a checklist :

Prepare Before and During Your Hospital Stay

plus three tip sheets:

Medication Management
Pain Management
Getting Care at Home

Additional Resources

Below is a selective list of resources that are potentially helpful but easily overlooked. For a comprehensive guide to senior services and programs in Marin and Sonoma counties, see https://borntoage.com/.

https://medicareadvocacy.org/self-help-packet-for-hospital-discharge/
The Center for Medicare Advocacy produced this packet to explain Medicare coverage for hospitalization and how to file an appeal if appropriate.

https://docplayer.net/10801468-Be-prepared-to-go-home-booklet.html
This booklet from the federal Agency for Healthcare Research and Quality is a handly checklist with space to make notes during one's hospitalization.

https://www.medicare.gov/nursinghomecompare/search.html
At this website, you can enter your zip code and get a listing of nursing homes within 25 miles. A comparision feature allows you to see Medicare ratings for four separate categories: Health Inspections, Staffing, Quality Measures, and Overall.

https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg
Go here to see COVID-19 data for specific nursing homes. Scroll down to the map, then click on a dot to see the data for that nursing home location (last accessed November 2020).

https://marinmer.org/
Marin Medical Equipment Recyclers accepts donations of clean, useable medical equipment and supplies and gives them to individuals in our community. This volunteer non-profit suspended operations during the COVID-19 pandemic but invites you to recheck its status (last accessed November 2020).

http://www.canhr.org/factsheets/index.html
If you need long-term care, go to this site for fact sheets about nursing homes and residential care facilities published by California Advocates for Nursing Home Reform.

https://marintransit.org/marin-access
This site summarizes Marin Transit's access services. The Program Finder tool helps determine which transportation programs in Marin are available to suit your needs. You can get individualized help from a Travel Navigator at 415-454-0902 or travelnavigator@marintransit.org.

https://www.marinhhs.org/content/marin-county-meals-wheels-program-faq
Marin County offers home-delivered meals for persons 60 years old or greater who are unable to drive and need substantial support in at least two areas of function.

https://www.aarp.org/home-family/personal-technology/info-2019/top-caregiving-apps.html
In this article, AARP reviews apps that help organize caregivers and caregiving tasks. The apps can be especially handy to coordinate care if you have a team of friends and neighbors helping you.

https://www.consumerreports.org/medical-alert-systems/how-to-choose-a-medical-alert-system/
Consumer Reports reviews the steps in choosing a medical alert system and reviews nine devices.