In Washington, D.C., an elderly woman spent nearly four months, 116 days to be exact, in a bed at Howard University Hospital for multiple health issues. She had no insurance and no place to go. Each day, the hospital bore the cost of her treatment at $2,000 a day. As a last resort, the hospital went to court to win legal guardianship and eventually placed her in a suburban nursing home. Another uninsured patient stayed in the hospital from March 2008 to October 2010 to the tune of $3.1 million.

In Chicago, Northwestern Memorial decided to pay $500 a month in rent so a terminally ill patient with heart disease and no insurance could have a place to stay and hospice care. That was on top of the thousands of dollars for his hospital bill. The man, who was in his 40s and didn’t want to go to a nursing home, died two months later.

In Cleveland, an illegal immigrant with no insurance had been in MetroHealth Medical Center for more than a month after a motorcycle accident. The patient had severe brain trauma and extensive limb injuries. Hospital officials didn’t know when he might be leaving. And for each day, they covered a cost of at least $3,150.

These stories are being replicated in hospitals across America. In addition to the toll on patients, the cost to the nation’s health-care system is about $50 billion for the uninsured alone. Those costs are ultimately passed on to everyone who pays taxes and anyone who has a medical bill. The problem, health-care officials say, is that more people need long-term care and that fewer people have insurance because of downsizing and the recession. Consequently, these patients experience discharge delays in moving on to the next step in their care. They are stuck in hospitals, because it’s hard to place patients with high medical needs and low benefits.

“The person is caught in the middle, because some facilities don’t want to take them,” says Carol Levine, director of the Families and Health Care Project at the United Hospital Fund in New York.

“It is a big, big problem,” acknowledges Donald M. Berwick, M.D., administrator for the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services (DHHS).

In California, for example, patients in the state’s Medicaid program (known as Medi-Cal), those on Medicare and the indigent averaged 26 hospital days in 2009 before being transferred to skilled-nursing and intermediate-care facilities. That’s a 30.8 percent increase from the average length of stay of 18 days in 2005, ac-
cording to an analysis of hospital data from the Office of Statewide Health Planning and Development.

So, what should happen?

Although many people complain about being released from the hospital too soon, they might not like the new normal of staying in the hospital for a few days as possible with as few procedures as necessary. Over the last two decades, U.S. hospitals have reduced the average length of stay from 7.2 days in 1980 to 4.4 days, according to the American Hospital Association. However, hospitals stay for hard-to-place patients are going up, not down.

“Hospitals are no longer a place where you stay until you get better and then go home,” says Barbara Ozman, director of patient care coordination at Piedmont Hospital in Atlanta. “The general public at large doesn’t fully appreciate that we get you well enough to transition your care.”

Ideally, the transition should be seamless. The team of doctors, nurses, social workers and others should start discharge planning upon admission, and a patient could be transferred to long-term care within 24 hours.

It’s a different story for hard-to-place patients who must wait in hospitals a few extra days, weeks or even months before they can be discharged to rehabilitation centers, nursing homes, hospice or their homes. This problem has traditionally centered around sicker, older and poorer patients. However, in today’s evolving economy, it can affect almost anyone who needs long-term care and has complicated medical needs or finances.

Patients could become underinsured or uninsured. They could be badly injured in a car accident or fall. They could end up in a hospital because of a choice that patients take on dialysis, ventilators or intravenous medication. They could end up waiting for a bed, period.

“It cuts across all ages and backgrounds,” says Elana Patz, executive director of the Family Voices Project, a national association of health care journalists and the caregivers they support. “It’s a real challenge.”

The average hospital charge for an uninsured person went up 88 percent from $11,400 in 1998 to $21,400 in 2007, according to a report by the Agency for Healthcare Research and Quality (AHRQ). Hospital stays also grew by a third for the uninsured as well as for Medicaid patients. These costs contributed to the $2.2 trillion the United States spent on health care in 2007—16 percent of the nation’s Gross Domestic Product. “This is a growing national problem,” Ozman says. “It’s huge, and it’s going to get bigger.”

Many Americans are in worse shape at earlier ages for a host of reasons, including health care disparities, genetics, inadequate exercise, poor nutrition, obesity, or drug abuse. Doctors say they see patients in their 20s or 30s who are already candidates for hip replacements and other medical procedures more common to their grandparents.

Add to this the aging of America, the increase in the level of care required as people age and the fragmentation of families that might have been on hand to support long-term care patients years ago. Unable or unwilling to provide care, some family members abandon relatives—even resorting to drive-by drop-offs at emergency rooms.

The percentage of people 65 and older is rise to 15 percent by the middle of the century, according to a census report, “The Next Four Decades: The Older Population in the United States: 2010 to 2050.” Of this group, those 65 and older are expected to increase from 14 percent to 21 percent. In addition, the pool of candidates for long-term care includes 50 million people who have disabili- ties—and their ranks are expected to grow, according to “The Future of Disability,” a 2007 report from the Institute of Medicine. The pool is overflowing with people who have multiple chronic conditions and account for a disproportionate share of health expenditures—much of it covered by federal dollars. From 1997 to 2008, the number of discharges to nursing homes and other long-term care facilities grew by 35 percent, according to the AHRQ’s Healthcare Cost and Utilization Project. Discharges to home health care grew 69 percent over the same period.

“Typical patients are the ones who come here with emphysema, diabetes out of control, heart failure and a whole host of other issues,” says Jim Pile, M.D., the hospitalist at MetroHealth. “Many of our patients are on 10 to 15 medications.”

With such a strong demand for long-term care, institutions can afford to be selective. Some avoid Medicaid pa- tients, complaining about the reimbursements and lengthy review for new patients. “Most of them try to decide what they’re going to make of you,” says Alfred Chipin Jr., managing attorney at the Center for Medicare Advocacy in Washington, D.C. “Everything is being driven by reim- bursements. It’s a real challenge.”

In Prince George’s County, Maryland, for example, a nursing home might make $600 a day from a patient who has private insurance, but be reimbursed only $200 for a Medi- care patient, according to Tracey Boseman, a representative of Capital Caring, which provides hospice and palliative care at area nursing homes, residences and other sites in the Washington area. The gap makes it tempting for long-term facilities to bypass patients who come with fewer dollars.

Chiplin says Medicare and Medicaid advise providers to accept a mix of cases across the income spectrum. “The norm is that it should even itself out,” he says. “That’s theoretical, and I know the nursing homes and home-health agen- cies play games with that. Most of these facilities are way understaffed. They find ways to limit their exposure to the patients that are the most complicated.”

Facilities that lack certified respiratory therapists may turn down patients who need ventilators to breathe. Patients who require long-term feeding tubes or dialysis to treat kid- ney failure also end up waiting in hospital beds while dis-
charge planners and sometimes their families hunt for places that will accept them. “Ventilator care is generally more expensive, and a lot of nursing homes won’t—or say they can’t—provide it,” Chipman says. “It often causes delays, and it often requires patients to be placed at facilities at considerable distance from where they reside and where their families live.”

“It gets to be problematic; it sometimes has a racial compo-

nent,” Chipman adds. “At one time, minorities, particularly African Americans far too often felt too far from their homes in general, particularly when they had complicated care issues. That was particularly a problem in the South.”

Health-care access and quality issues persist along racial and ethnic lines. “For Blacks, Asians, Hispanics and poor popu-

lations, at least half of the core measures used to track access are not improving,” the DHHS indicated in its 2008 National Healthcare Disparities Report. “The problem of persistent uninsurance is a major barrier to reducing disparities.”

Uninsured people tend to be in worse health and are less likely to receive preventive or ongoing care, especially for chronic conditions. Some are in such bad shape that they are considered “train wrecks.” Fifty million children and adults are uninsured in the United States, an increase of 5 million from 2007 to 2009, the height of the recession. Their ranks have swelled over the years, largely because of the drop in coverage by employers and a rise in the unemployment rate.

In some regions, the uninsured and underinsured overburden public and nonprofit hospitals that have a mission or mandate to admit them. For those who live in the nation’s capital or deep into neighboring Virginia and Maryland, all roads lead to Howard University Hospital, says Vivien A. Fonjong, direc-
tor of Utilization Review, Case Management and Social Work. “If you don’t have insurance, this is where you come.”

Sherry Aронson, vice president of Inpatient Operations at MetroHealth in Cleveland, says that’s also the case in Cuyahoga County. “It’s extremely high, because there are not sufficient resources delivered by the county for care,” she says. At MetroHealth, charity care rose from $100 mil-

lion in 2009 to $110 million in 2010. “Are the other health-care systems as committed as we are to taking care of these patients?” Aronson asks. “I came from some of these places, and the answer is no. … In fact, we should double-down care the other systems to step up and play their part.”

The National Association of Public Hospitals (NAPH) reports the number of uninsured patients at member hospi-
tals rose by 23 percent from the beginning of the recession through 2009. During this same period, uncompensated care went up 10 percent. This also includes thousands of dollars that some institutions pay to send a growing number of uninsured, undocumented workers to their home countries for long-term treatment at much less than the cost of continuing care at their hospitals.

Uninsured care drives down profit margins for public hospitals, which averaged 2.5 percent in 2009 compared to 5 percent for hospitals overall. The overflow of poor patients at safety-net hospitals also increased after neighboring hos-

pitals shut their doors or closed costly trauma centers in De-

troit, Los Angeles, New Orleans, New York and Washing-
ton. The tragedy, Aronson adds, is that sick and injured residents sometimes die if their trip to a hospital is even a mile or two longer than it was previously.

The DISCHARGE DILEMMA

For hospitals, hard-to-place patients remain a small sig-

ificant problem. The number of patients who occupied beds that could be turned over more rapidly amid regulatory and business pressures to control costs, reduce lengths of stay and avoid readmissions. “We’ve had a 3 percent change in our payer mix from privately insured to government cover-

age,” says Matthew J. Schreiber, M.D., chief medical officer at Atlanta’s Piedmont. And hard-to-place patients have added at least a day to his hospital’s length of stay.

“They require a huge amount of time and human re-

sources to deal with them,” Dr. Williams says, especially when there’s a pile-up of complications. “It’s frustrating for staff, frustrating for patients and their families.”

And when ambulances drop off patients who are uncon-

scious, social workers must double as detectives trying to as-
certain not only their identities, but also the whereabouts of their families, says Justine Buildt, a social worker at the MetroHealth in Cleveland. Buildt says she often has to be creative since she works with a lot of trauma patients who are sedated with breathing and feeding tubes. But Buildt loves “the drama of the trauma” and the challenge of finding a family. “I get to do a lot of ‘CSI’ work,” she says, referring to the crime scene investigation series on television.

Social workers search wallets for identification cards, credit cards, business cards and scraps of papers with phone numbers scrawled on them. They surf the Internet. They check missing persons reports. Buildt gets excited when she finds a yellow and blue Blockbuster videocard. She used one to find a patient’s sister, who had renting privileges on her brother’s card. The economy can make hot leads grow cold when a phone has been disconnected or when a house goes in foreclosure and neighbors can point in the right direction.

If a patient remains incapacitated and no relatives can be found, hospitals may seek guardianship. “Once you are in the land of true guardianship, then you are into months because that process,” J.L. Greenwald, M.D., a hospitalist at Massachusetts General Hospital.

Families can contribute to delays by blocking patient trans-

fers to rehabilitation centers and nursing homes, or when the patients themselves are reluctant to move on. “A lot of patients are in complete denial that they need this kind of care,” Ozmar says.

The committee has taken this route and the lack of options can be daunting, Dr. Greenwald says. “Families want to explore multiple options—look for the nicest, closest, most friendly, environment for mom, dad, brother, sister. There is a lot of pressure to accept the offers, however, because the hospital needs to move that patient to an appropriate level of care.”

WHAT HOSPITALS ARE DOING

Many hospitals are taking steps to address discharge issues overall, with some assembling senior-level strategic teams to expedite decisions on the most complicated cases. The Difficult Discharge Response Team at Northwestern Mem-

orial came up with the idea to pay rent for the terminally ill man so that he’d have a place to receive Dobutamine inf-

usions for heart failure, says Jessica Sooo Pulowski, senior social worker and case manager. The hospital also arranged long-term care for a young man whose insurance covered only his hospital stay. The man had fallen and injured his spinal cord.

Denver Health has a Complex Discharge Committee that meets every Friday to discuss patients who have been med-

ically ready for discharge at least 10 days. The committee’s work along with the hospital’s waste-cutting initiative, LEAN, have helped cut average hospital stays from six to four days, says Philip Mehler, M.D., chief medical officer. But two patients have been there for about a year.

During any given week, the hospital has about 20 com-

plex discharges at a combined cost of roughly $3 million. Sometimes a solution comes at the suggestion of the ad-

ministrators on the committee. A patient suffering from head trauma and respiratory problems had been in the hos-

pital for 100 days, but couldn’t be transferred to a skilled nursing facility because he needed to be seen three times a day. At Dr. Mehler’s request, a physician was able to get the patient down to one a day, an acceptable limit for placement. In one case, the committee recommended the hospital install a video conferencing system so patients could “attend” guardianship hearings from a hospital bed rather than be taken to probate court.

Broader initiatives that show promise, medical profes-
sionals say, include:
Partnerships and expanded facilities help, but they still aren’t enough in economically depressed areas such as Detroit or Northeastern Ohio, says Aronson, the vice president at MetroHealth in Cleveland, which has a 150-bed long-term nursing and rehabilitation center as well as community clinics. “It’s a really challenging situation.”

OUTLOOK FOR THE FUTURE

Dr. Berwick, the nation’s Medicare and Medicaid administrator, has heard all of the complaints about inadequate and slow reimbursements to hospitals and nursing homes. He scoffs at the idea of throwing more money at the problem and says institutions have to learn to do more with less. “It’s a tough time for everybody,” he says. “The challenge is to use what we have to do, with the very, very best advantage. Orienting hospitals and nursing homes and communities to continual improvement of their processes of care so they can afford to give great care under stringent circumstances, that’s the job now.”

“Hospitals have created a handle on them. There are still some people that don’t even realize they are in outpatient care—especially if they have received a hospital wristband, regular meals and a comfortable environment for as long as two weeks.”

**ARE YOU REALLY IN THE HOSPITAL?**

The growing reliance by hospitals on outpatient care is not a reality. Medicare patients who need more treatment. Medicare recipients are often ineligible for transfer to long-term care if they were outpatients and failed to meet the requirements of three days of inpatient hospitalization. Outpatient care lasting at least two days has increased by 70.3 percent. Some people don’t even realize they are in outpatient care—especially if they have received a hospital wristband, regular meals and a comfortable environment for as long as two weeks.


**• Project Boost:** Boost is aimed at improving the overall discharge process for all patients, says Dr. Williams, co-chair. Started by the Society of Hospital Medicine, the program is being used in more than 60 hospitals, including Northwestern Memorial and Piedmont. It has shown early drops in readmissions by targeting high-risk patients and improving coordination and communication in all aspects of their care.

**• Project RED (Re-Engineered Discharge):** Brian Jack, M.D., created RED in 2006 to create what he calls a “perfect storm” in discharge. Like TCM, it also designates a point person, in the case of Nursing. Studies have shown improvements in all quality measures and lower costs.

**• Transitional Care Model:** This program, a nurse coordinator that follows a patient—in the hospital, at a skilled-nursing facility, at home and on follow-up doctor’s appointments. “The goals of transitional care is to create a seamless transition,” says Mary D. Naylor, Ph.D., TC/M, founder and director of the New Courtland Center for Transitions and Health at the University of Pennsylvania School of Nursing. Studies have shown improvements in all quality measures and lower costs.

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