

The New York Times

In the Trenches: The Discharge Planner

Bridging Gaps Between Hospital and Home



Richard Perry/The New York Times

"I try to give patients a sense of control, a concrete sense of something that can be done: 'O.K., I'm going to help you with XYZ, just to get you through the day.'" Alicia Tennenbaum

By JAN HOFFMAN
Published: June 19, 2007

Almost as soon as patients are admitted to 9 Silver, a general medicine floor at [Beth Israel Medical Center](#) in downtown Manhattan, Alicia Tennenbaum starts planning how to get them to leave.

As a hospital discharge planner, Ms. Tennenbaum is a health care traffic cop, patrolling a wildly busy intersection of medical, economic and social challenges. On 9 Silver, she visits patients who are elderly, impoverished or just reeling from a diagnosis, asking: Do

you need a ride home? Do you have a home? Do you need help with shopping, meals? Grab bars in the shower? Physical therapy? Do you have someone who can get you to check-ups?

“Sometimes, a successful day just means I was able to get someone transportation home from the hospital,” Ms. Tennenbaum says as she clips and unclips her long brown hair in frustration.

She begins her day by ferreting out a dozen patients’ charts and speed-reading them, debriefing doctors in a staccato dense with acronyms. It’s the responsibility of Ms. Tennenbaum, a 30-year-old social worker, to translate diagnoses and prescriptions into the practical impact on patients’ lives, setting up plans for care after discharge. With clipped intensity, she wrangles slots in rehabilitation centers, the delivery of medical equipment or extra hours of an aide’s help.

Several times a week, administrators scrutinize the cases of Ms. Tennenbaum and 14 other social workers on medical-surgical floors: when patients stay in the hospital longer than allowed by their insurance plan, the hospital may have to eat the cost.

Although Ms. Tennenbaum works for the hospital, she must also advocate for patients. Sometimes those interests conflict. On a recent Monday morning, reviewing the patients who had been discharged over the weekend, she spotted a name and her jaw tightened: a doctor had signed out a patient before Ms. Tennenbaum had finalized plans for a home health aide. “I need to re-educate that doctor!” she said tersely.

“Discharge planners are put in impossible situations,” said Dr. Eric Coleman, a Denver geriatrician who studies health care transition problems. “But there is expanding evidence to show that hospitals are not preparing people properly for aftercare.” When patients are poorly prepared for discharge, Dr. Coleman has written, they become vulnerable to medication errors, improper care and other complications that can put them right back in the hospital.

Hospitals must ensure that a patient’s transition is “safe and adequate” to comply with accreditation standards and state health department regulations and to remain eligible for Medicaid and Medicare reimbursements. But increasingly, discharge responsibilities are being assigned to clerical staff members rather than nurses or social workers.

Despite six years in a job with low status and a high burnout rate, Ms. Tennenbaum seems to thrive as a troubleshooter. During her childhood in northern New Jersey, she watched a relative struggle with [mental illness](#) and alcoholism. She can still taste the residue of helplessness from those sieges.

“Now I try to give patients a sense of control, a concrete sense of something that can be done,” she says while typing up action plans in her oversized shoebox of an office behind the nurses’ station. ““O.K., I’m going to help you with XYZ, just to get you through the day.’ ”

It's time to meet the patient in 14A, an elderly woman contorted in bed. Ms. Tennenbaum introduces herself to Ms. 14A's adult daughters, who are helping pay for their mother's care. To them, Ms. Tennenbaum is the personification of the Incompetent Institution. They seethingly detail problems that led to three hospitalizations in two weeks.

Ms. Tennenbaum lets them vent, interjecting with quick questions of clarification. She knows they are frantic. "Your mother is bed-bound, but she has so many doctors," she says. "She needs one doctor as her gatekeeper." The daughters nod. "I know there are some doctors who will make home visits. Do you think this will be helpful?"

Next, she heads down the hall to 16B. The patient is in his late 30s, with a bandaged, drained abscess in his armpit. He is supposed to be discharged today. He still needs a strong course of [antibiotics](#), but he has no insurance.

Ms. Tennenbaum suggests applying for Medicaid. "Do you work?" she asks.

Yes, he says, as a security guard.

"You probably earn too much to qualify," she says. Looking worried, Mr. 16B says his benefits cover only outpatient visits to his union's clinic. The battle over his hospital bills will continue for months; prescriptions require payment up front. "We'll approve two weeks for you," Ms. Tennenbaum says.

Mr. 16B looks anxious: "How much will that cost?"

"We'll pay," she replies.

Ms. Tennenbaum's hands are tied and untied by the vagaries of insurance coverage: a young woman who needs [radiation](#) treatment but is otherwise fully functional will be discharged with round-the-clock aides because she receives Medicaid. But Ms. 14B, 81, who has a fractured pelvis and a managed Medicare plan, may only be approved for an aide four hours a day, five days a week, for a few weeks. Her middle-class family smiles politely as Ms. Tennenbaum describes obstacles and solutions, not yet comprehending their looming financial burden.

"But you have [Parkinson's](#)," Ms. Tennenbaum continues. "That's a good diagnosis. We may be able to get you a little more therapy."

Housing is another roadblock. Patients without permanent addresses need a safe place to live before she can authorize their discharge.

"We often have to refer them back to the same place where they weren't getting help before," she says. Recently, a shelter patient with a diagnosis of early-stage lung [cancer](#) remained at Beth Israel for nearly two months before the shelter cleared him to come back.

Under her desk, Ms. Tennenbaum keeps bags of donated clothes, and she often dips into petty cash and makes a Payless run to buy shoes for indigent patients. “That’s part of a ‘safe and adequate’ discharge plan, too,” she says.

“So you’re going home today!” she says to Ms. 12A, a 77-year-old British patient who lives alone. Ms. Tennenbaum enumerates Ms. 12A’s new services.

“Good show!” replies the patient, who maintains that friends will fetch her. Chatting, Ms. 12A manages to hold Ms. Tennenbaum captive for a few more moments.

In the hallway, Ms. Tennenbaum explains that although many people can’t wait to get out of the hospital, others are afraid to leave, especially the elderly. Loneliness and the inability to make meals or even get to the bathroom frightens them. Many do not want an ambulette to take them home, wary that their frailty will be exposed to predators.

Ms. Tennenbaum understands. But there are sick people stalled in the E.R., needing those hospital beds.

By 4 p.m, Ms. 12A has not been able to find a friend to take her home. Ms. Tennenbaum starts working the phones.

It is 6:20 p.m. Ms. Tennenbaum, a newlywed, would like to be leaving for the night. Today she has met with and made calls for 10 sick people, including a repeat patient who now needs arrangements for thrice-weekly dialysis, and a bellowing man who refuses to go until he gets Dilaudid, a narcotic painkiller.

She checks on Ms. 12A, whose ambulette, paid by the hospital, should be arriving soon. She is eating supper, still in her hospital gown.

Ms. Tennenbaum frets. “You should be changed into your clothes,” she says. “Do you need help getting dressed? If you’re not ready, the ambulette will leave and you’ll have to pay for a taxi!”

Ms. 12A regards Ms. Tennenbaum with a gracious smile of forbearance. “Oh, I’m not ready to leave yet, dear,” she says. “I think I will stay here and finish this lovely salmon.”