Repatriation of Patients – A Process to Ensure a Safe Patient Transfer

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Abstract

To ensure the safe care of patients repatriated to HDGH, we have implemented a process that identifies patient needs prior to their repatriation. The process provides us with critical information regarding a patient's condition well before repatriation so our staff can confirm that we can safely meet the patient's needs. The process is simple and easy for both the sending and receiving facilities to adopt.

Hotel-Dieu Grace Hospital (HDGH) is one of three hospitals serving approximately 350,000 residents in Windsor-Essex. HDGH is a community hospital with 278 acute care beds, and is the trauma centre for the community and the lead hospital for neurosciences, nephrology, cardiology, orthopedics and mental health. However, the hospital does not provide some patient services, including cardiovascular surgery. Adult and pediatric patients who require services not provided by HDGH are referred to other centres in the province of Ontario or in the United States (HDGH is minutes from two U.S. border crossings).

Background

Patients are repatriated to local hospitals for a variety of reasons. Some patients are Windsor-Essex residents who have become sick or injured while travelling out of the area. They ask to be repatriated to be closer to their families or because they do not have insurance to pay for out-of-province or out-of-country healthcare. A second group of patients who are repatriated to local hospitals are Windsor-Essex residents who have been sent from a local hospital to the U.S. or other area of the province for care that could not be provided in Windsor-Essex. A third group are Canadian citizens who have become ill or injured in the United States whom the U.S. hospital wants to send back to the closest Canadian hospital, whether or not the patient is from this area.

Hospitals that have the ability to provide a service are not always aware of the limits of the receiving hospitals in smaller communities.

The need to develop a process for safely repatriating patients to HDGH became clear following a couple of situations in which the hospitalists (physicians who care for unattached patients) found themselves accepting patients back from other

hospitals without having an appreciation for the complexity of the patients' needs. Complex patients can require not only a variety of physician services, which may or may not be available at local hospitals, but also technical support and medications that may or may not be available.

One U.S. facility recently requested that we repatriate a patient who had an intra-aortic balloon pump (IABP); however, we do not have staff trained to use an IABP. Hospitals that have the ability to provide a service are not always aware of the limits of the receiving hospitals in smaller communities.

Another facility transferred a patient without advising the receiving physician that the patient was intubated. The physician who accepted the patient claimed that the verbal report he was given over the phone did not identify the patient as an intubated patient who would require critical care. This was a problem because the patient required a specialized bed, and specialized or critical care beds are not always readily staffed and available.

Another Canadian patient who was to be repatriated was on a medication that was only available in the United States. The medication was made available to the patient on compassionate grounds; and the U.S. Food and Drug Administration (FDA) permitted the administration of the research medication as a treatment of last resort. The patient was repatriated, but only after all the doses of the research medication had been administered. The research medication approved for use by the FDA could not have been ordered by a physician in Canada or dispensed by a nurse in Canada.

The physician or hospital that is considering repatriating a patient must have an opportunity to review the patient records and ask questions of the sending facility to ensure that they can meet the patient's needs.

Intervention

The request for repatriation of a patient usually comes in the form of a phone call from the sending hospital or from a family member of the patient. An intervention was established by HDGH to access information about the patient to be repatriated in a format that is easy for both the sending and receiving hospitals to use. A one-page checklist of information to be requested from the sending facility was developed with input from physicians and staff of the Admitting Department and Resource Utilization. The checklist requests pertinent information about the situation that brought the patient to hospital, the current condition of the patient, consultations over the past several days or weeks, laboratory work and other tests performed, and the type of bed that the patient requires. Critical care, telemetry, medical, surgical and rehabilitation beds all have different care and staffing implications. Knowing the type of bed needed helps HDGH staff ensure that the appropriate bed is available to meet the patient's needs.

After receiving a phone call from the sending hospital or the family about the need to repatriate a patient, some verbal information about the patient's condition is secured. Subsequently, the checklist is reviewed by HDGH staff to ensure that the requested information will provide a complete synopsis of the patient's condition. The checklist identifies several areas of the patient's chart that must be faxed by the sending hospital. The checklist is faxed to the unit at the sending hospital where the patient is residing.

Information from the sending hospital is faxed prior to the patient's arrival at HDGH. Hospitals wanting to repatriate patients to HDGH are told that a patient will not be accepted until HDGH staff or physicians review the patient's information. A 24-hour turnaround time to review the information is set as the benchmark for responding to the sending hospital's repatriation request.

The process has been revised to include trauma transfers, which are reviewed by the trauma director. Other requests to repatriate patients are reviewed by the most appropriate physician. This is determined by asking the sending hospital who the referring physicians are, what their specialty is, and the immediate needs of the patient.

The process was put in place to prevent or minimize the number of patients being repatriated to HDGH who were simply transferred to the HDGH emergency room (ER). Given our proximity to two international border entry points, prior to the development of this process, we experienced instances where insurance companies, at the request of patients and families, would have Canadian patients in need of a Canadian hospital sent back to our ER. We found that the ER is not the best place for a repatriated patient to be cared for along with other incoming, often unstable patients.

Prior to the development of this process, insurance companies, at the request of patients and families, sometimes just had Canadian patients in need of a Canadian hospital sent back to our ER.

Change Process

Prior to the implementation of the current strategy, physicians who were asked to assume care for repatriated patients were uncomfortable with the practice. They felt that if they had information about the patient to review prior to talking with the physician who wanted to repatriate the patient, they could ask better questions about the care the patient requires.

Now, the requested information is usually faxed by the unit clerk at the sending hospital. The sending hospital's chart copies are kept with the repatriated patient's new HDGH chart. These

copies help all members of the HDGH team understand what happened to the patient prior to arrival at HDGH.

From the perspective of resource utilization, HDGH was interested in repatriating patients to one of three local hospitals with the right service for the patient or where the patient's family physician or specialist had active hospital privileges. The rationale was that if the patient was repatriated to the hospital where the patient's family physician or specialist had active privileges, this would ensure continuity of care. The patient would be seen by a physician who knows the patient and family. Continuity of care can result in better patient care, fewer tests and investigations ordered, and possibly a shorter length of stay and increased patient satisfaction.

The resource utilization team has identified benefits from the process. Prior to a patient transfer, reviewing the patient's information is helpful to determine whether it is appropriate to repatriate the patient to an acute care facility. Reviewing the patient's chart allows the hospital to determine whether the patient has provincial insurance and is from the Windsor area, and whether one of the three local hospitals is the appropriate hospital to accept the patient. Patients without provincial insurance are sometimes refused repatriation. Every effort is made to avoid taking on obligations that cost the healthcare system money or create barriers to discharge. The repatriation of a patient without provincial insurance is scrutinized closely; however, if the patient is a Canadian citizen and a former resident of Windsor-Essex, plans to repatriate the patient can be made.

The resource utilization staff and the Admitting Department review the patient's information prior to asking a physician(s) to review the chart. The two departments work closely together to identify the physician that would likely be responsible for providing care to the patient and to consider the right bed and the "right time" to admit a patient. Admissions are generally accepted Monday through Thursday during the day. If a transfer is to take place on a weekend, the transfer is negotiated with the physician on call to ensure that they can provide care for the patient and hopefully be the physician most responsible for the remainder of the patient's stay. The hospital works with the sending hospital to have the patient arrive during the day shift, when most of the hospital's resources are available to accommodate the patient.

The ability to assess a patient's needs prior to accepting them is important because, once accepted, the patient cannot be sent back. The accepting physician assumes the responsibility for the repatriated patient's care. Admission avoidance is a positive result of receiving patient information prior to their arrival. On several occasions, U.S. hospitals simply wanted to transfer back Canadian patients to the closest Canadian hospital – which meant HDGH was the hospital of choice. Upon reviewing a patient's information and specifically the patient's address, the resource utilization staff determined that the patients were from another area of the province or country. Utilization staff then assisted the U.S. hospital in repatriating the patient to the hospital closest to their home.

Assessing a patient's level of care by reviewing the patient's chart prior to the patient's arrival has also proven to be an advantage. On several occasions, Windsor-Essex residents asked to come back to a hospital, but the level of care required was that of a rehabilitation facility, rest/retirement home or nursing home. Admissions were avoided by talking with each patient and their family and making them aware of the need to protect acute care beds and to have the patient admitted to another facility that could provide the right care for the patient at that time.

One family simply wanted their relative admitted to hospital from another hospital rather than moving in with them while the patient recuperated. By identifying the diagnosis for the patient and speaking with the staff from the sending hospital, HDGH was able to determine that the family did not want to take the patient home. HDGH did not accept the repatriated patient to an acute care bed and avoided the admission. When staff and physicians have an opportunity to review the patient's chart from a sending facility, they can ask questions about the care provided, discharge plans, etc., thereby avoiding inappropriate admissions.

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Results

Insurance companies and U.S. hospitals that repatriate the majority of the HDGH patients are now familiar with the process, which has minimized the risk to the patients, staff and physicians. In 2002–2003, 147 patients were repatriated to HDGH. In 2005–2006, 97 patients were repatriated to the hospital. In total, since the program's inception in 2002, 543 patients have been repatriated to HDGH, without incident when the process was followed. Staff and physicians are better prepared for the arrival of patients or they can refuse patients when the transfer cannot be accommodated safely.

Patients have been safely repatriated from as far away as Europe, even when the patient's records were written in a foreign language. Patient charts sent in foreign languages are translated by physicians or hospital staff who speak the language.

The process has reduced the number of repatriated patients that arrive in the ER. With hospital occupancy at close to 100% daily, the hospital cannot have patients from across the province and from out of country arriving in the ER. Patients and families assume that they can just send patients to the hospital; however,

with today's limited resources, including physician manpower, hospitals are not always available to provide safe care.

Patients repatriating from a U.S. hospital must be isolated by admission to a private room. HDGH staff must prepare a room in advance for these patients, and a private room is not always available. Unplanned repatriations that result in a patient being received in the ER can impact negatively on the patient's care. Because of the unexpected demands and pressure that ER's face, they are not appropriate receivers of repatriated patients. When one of our ER doctors agreed to accept a patient from a Florida hospital, his colleagues, other physicians, were not prepared to admit the patient or to be the physician most responsible to care for the patient.

Planned admissions are much better than those unplanned. Receiving copies of a patient's chart prior to repatriation permits the physician and nurses to identify any barriers or problems prior to the arrival of the patient, thereby minimizing the risk to the patient.

In addition, inappropriate admissions can be avoided. The process ensures that acute care patients are repatriated to the appropriate hospital. By determining who the repatriated patient's family practitioner is, we can explore the appropriateness of sending the patient to the hospital where the family doctor has active privileges.

Conclusion

The new process is helping us ensure that repatriated patients are safely cared for by HDGH or that they are sent to the centre that can provide the most appropriate care. Admissions to acute care have been avoided, thereby saving acute care beds for patients who require acute care. Having patient information in advance helps the hospital, physicians and staff prepare for the safe arrival of the patient. The process minimizes surprises for staff and physicians and risk to the patient. Insurers and sending hospitals are also satisfied with the process because it ensures a safe transfer. Patients and families have thanked the hospital for assisting with the repatriation of their loved one. HQ

Acknowledgements

Thanks to Shelley Cole, Coordinator of Patient Registration, Brenda LeBlanc, Health Records Technician, Dr. R. Chow, Hospitalist, Dr. J. Cohen, Hospitalist, Dr. S. Doyle, Hospitalist, Lori Newton, Public Affairs, and Dr. O. Evoy, Hospitalist, all of whom work at Hotel-Dieu Grace Hospital.

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Online Case Study

Ensuring Continuity of Care for Patients with Complex Needs

Lynda A. Monik

Introduction

Hotel-Dieu Grace Hospital (HDGH) is one of three hospitals serving approximately 350,000 residents in Windsor-Essex. HDGH is a community hospital with 278 acute care beds. The average length of stay (LOS) for patients at the hospital is 7 days. Patients can be discharged home or to other facilities in order for patients to receive the appropriate care they need.

Background

While the average LOS for most patients admitted to hospital is 7 days, some patients with complex needs can end up staying in hospital much longer. Patients with complex needs and their families become accustomed to the hospital's environment and the supportive care offered by registered nursing staff, physicians and other professional ancillary staff. When a complex patient is ready for discharge it is often difficult to convince the patient/family that there is a more appropriate facility that can now meet the patient's needs.

Patients are often discharged and transported by staff not employed by the hospital, who meet the patient for the first time at the time of transfer. This can be a frightening experience for some patients, especially those who have complex needs – vented patients or patients who can become frightened by new people and environments, such as patients with dementia or Alzheimer's.

Even those patients without complex needs have indicated that they feel uncomfortable going to another facility for care where they will be exposed to new staff that they do not know. Patients and families often express concern about the ability of the new facility to provide the same care and support as the hospital. Patients with complex needs and their families often fear that every bit of progress made over the course of the patient's stay in hospital may be lost by a transfer to another facility.

Patients/families also voice concern over the need to answer "the same" questions asked at the hospital about patient care by the staff and physicians in the new facility.

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