Discharge Planning 101

By Linda Ziac
September 24, 2018
The Caregiver Resource Center
www.CaregiverResourceCenter.com

Welcome to the Case Manager's Corner – Sept 2018

"Discharge Planning Aids Recovery & Reduces Readmission"

Every day, The Caregiver Resource Center receives calls from individuals who feel overwhelmed by the challenges of life; whether it's dealing with parenting, a healthcare issue, an aging parent, or the struggles of living with a disability. Often times these individuals aren't sure what questions to ask, what rights they have, or where to turn for help.

The goal of The Case Manager's Corner is to provide a venue where Linda Ziac can share tips and skills that Linda has acquired over more than 40 years as a licensed psychotherapist; board certified case manager and board certified dementia practitioner; while helping readers become better educated consumers for themselves and their families.

Each month Linda will present a case that she's worked on and the steps she's taken with clients and their families, to positively impact their lives and overcome challenges. Please note that this information is provided in a way that helps protect the client's privacy and confidentiality.

The purpose of this article is to encourage everyone to become an educated consumer, and to learn your rights when it comes to advocating for yourself and your loved ones in health situations.

TODAY'S CASE PRESENTATION - SUE

Keep in mind that every situation is different, as is every hospital.

All too often Linda speaks with a distraught family member, following a patient returning home after a hospitalization.

A while ago Linda received a call from Sue, who lives outside of the New Haven area, seeking guidance for her family.

Sue is the power of attorney for her grandmother Bessie, who had been discharged from the hospital 6 days prior to calling The Caregiver Resource Center.

When Sue called The Caregiver Resource Center Sue shared, “My Grandma was discharged from the hospital on Friday, she isn’t doing well, and we don’t know what to do.”

THE SITUATION

Linda asked a several questions, and Linda learned the following:

1. Did Sue and Bessie have the opportunity to meet with Bessie’s care team for a discharge planning meeting, before Bessie left the hospital?

Sue said that a planning meeting was never offered, although she did meet with a hospital social worker on the day her grandmother was leaving the hospital.

2. Did Sue and Bessie receive a written discharge plan?

Sue said that the social worker handed her a piece of paper with the name of a homecare agency, and the social worker instructed Sue to call the agency on Monday.

3. When Sue met with the social worker, did the social worker review Bessie’s diagnosis upon admission, treatment while in the hospital, test results, medication changes while in the hospital, or Bessie’s current needs, prognosis, treatment recommendations, etc.?

Sue said that she wasn’t told anything like that, except to call the home care agency, and that the agency would help set up a plan for Bessie.

OUR PLAN

Linda suggested that Sue and Linda arrange a conference call with the case manager and social worker, who had worked with Bessie while in the hospital, in order to gather valuable information.

Together we reviewed the following:

- Bessie’s status upon admission to the hospital

- All tests and test results, that were conducted while Bessie was in-patient

- Treatment provided during Bessie’s hospitalization

- Bessie’s medications that were discontinued while in the hospital, as well as any new medications with dosages that were prescribed by hospital physicians

- Bessie’s diagnosis, prognosis, progress to date at time of discharge, challenges, areas of concern, treatment recommendations, referrals to medical personnel that were made for Bessie to see after discharge including the doctor’s name, address specialty, and phone number (e.g. Dr. Smith -neurologist) along with the reason for the referral.

Following this phone call, Linda and Sue discussed the new information, and together developed an action plan and time line.

THE IMPORTANCE OF A DISCHARGE PLANNING MEETING

Just the facts:

- 20% of Medicare patients discharged from the hospital are readmitted within 30 days
- 33% of Medicare patients are readmitted to the hospital within 90 days

Research shows that:

- 20% to 30% of adverse events following discharge that lead to readmission, are preventable
- another 30% of these events, could at least be minimized

Source: Medicare

SOME EVENTS THAT ARE ATTRIBUTED TO PATIENT READMISSION

- Fragmented system of care
- Lack of patient understanding about their diagnosis, care plan, or follow up instructions
- Failure to fill new prescriptions
- Confusion about medications that were prescribed while in the hospital
- Lack of understanding whether to continue medications prescribed before the hospital visit
- Absence of a discharge plan that addresses patient issues and provides needed services
- Poor coordination of care between hospital staff and primary care physician
- Uncertainty about which doctor to see for follow up (e.g. primary care physician or specialist)
- Inability of the patient to fill prescriptions, schedule appointments or arrange for transportation to doctors

Source: The Revolving Door, Feb 2013

WHAT IS DISCHARGE PLANNING?

According to Medicare, discharge planning is “A process used to decide what a patient needs for a smooth move from one level of care to another.”

The goal of discharge planning is to work with the patient and their family to create a plan that will identify the best level of care and services for a person after the patient leaves the hospital, while reducing adverse events and preventable readmissions.

Keep in mind that a patient may have arrived at the hospital from home, an assisted living facility, short term rehabilitation, or a nursing home.

A discharge plan is unique and needs to be individually customized for each individual patient, with the hospital providing the patient with a written discharge plan.

A DISCHARGE PLANNING MEETING

The discharge planning process starts the first day the patient is in the hospital or rehab facility, and continues until the patient is officially discharged.

In my work as a certified case manager with clients who are hospitalized or in a rehab facility, I work closely with the hospital staff (e.g. doctor, nurse, social worker), and I request a discharge planning meeting well in advance of the discharge date.

The purpose of the discharge planning meeting is to have key people in the room at the same time, in order to:

- Have an open discussion
- Make sure that there is a clear understanding of the patient's abilities and needs
- Understand benefit coverage
- Discuss all viable options
- Develop an appropriate plan of action (care plan)
- Ensure that the patient and family have a clear understanding of the plan moving forward
- Put as many pieces of the plan in place, before the patient leaves the hospital.

Participants in the meeting usually include the patient, family members, and members of the patient's care team (e.g. physician, nurse, physical therapist, social worker).

Depending on where the patient resided prior to admission, participants in this meeting may also include the primary care physician, a representative from an assisted living facility, short term rehabilitation facility, or a nursing home; as well as any other persons deemed appropriate.

As Per Medicare Regulations:

Discharge planning should result in a written document - a discharge plan.

The discharge plan should be a comprehensive tool and should be based on:

- Where and how a patient will get care after discharge
- What the patient and his or her support groups (e.g. family, friends, hired help) can do to facilitate recovery
- Particular healthcare problems that might occur in the new care setting
- Clarity about medications going into the new care setting
- Arranging for necessary equipment or supplies in preparation for activities of daily living
- Resources available to cope with and manage one's illness
- Resources that are available to help with costs attendant to care

SAMPLE QUESTIONS TO ASK DURING A DISCHARGE PLANNING MEETING

This is a list of some questions that the patient and their family may find helpful to ask, when designing a plan for the next step after the patient leaves the hospital or rehab facility.

• What is the most appropriate post-hospital/rehab discharge destination for the patient based on their abilities and needs?

(e.g. home with no assistance, home with assistance, a family member's home, short term rehabilitation, assisted living facility, or nursing home)

- Is the patient at their pre-hospital/rehab level of functioning?
- Does the patient qualify for rehabilitation services in a facility or at home?
- Does the patient and/or family need to explore assisted living facilities or nursing homes?
- What does the patient prefer to do? Is this realistic?
- Does the patient have family who will help with care?
- Is the patient's residence compatible with their current issues and needs?
- Is home modification necessary? (e.g. ramp, railings, grab bars, raised toilet seat)
- What services can the patient afford?
- Is there a need for additional patient education? (e.g. diabetes, colostomy, IV antibiotics, etc.)
- Is there any indication of abuse or neglect?
- What equipment and services are needed? (e.g. wheelchair, caregiver, transportation)
- What options best meets the patient's needs and wishes?

This may all seem very overwhelming at first, but if taken step by step, this process will help improve the patient's health, safety and quality of life.

If you feel that this is too much to handle on your own, you can seek help from a professional such as a certified case manager, physician, or nurse.

Linda Ziac is a Board Certified Case Manager with over 40 years of experience working with patients, families and medical professionals; in developing solid discharge plans and care plans for patient leaving the hospital or short term rehab facility.

THE VALUE OF WORKING WITH A BOARD CERTIFIED CASE MANAGER

Now that the discharge plan has been decided, the next step is to ensure that everything is in place before the patient actually leaves the hospital, and that the discharge plan is followed.

Keep in mind that some patients do not have family in the area that can help.

As I shared at the beginning of this article, a patient can have a very comprehensive discharge plan, but if the patient is unable to follow the plan for any reason, their health and well-being may be compromised potentially leading to a re-admission to the hospital.

The value of a having a certified case manager such as Linda in place serves two key roles:

1. **Help with the patient's transition out of the hospital or rehab facility**

Now that the patient has a clear discharge plan, the certified case manager can help ensure that all the initial items are in place before the patient actually leaves the hospital or rehab facility.

The following are examples of how a certified case manager can help if a patient plans to return home.

- Oversee that all equipment and supplies are ready for the patient's arrival home (e.g. wheelchair, grab bars, ramp, etc.)
- Arrange transportation home from the hospital or rehab
- Ensure all prescription medications have been picked up
- Schedule follow up doctor and provider appointments
- Accompany the patient to follow up appointments ensuring that good understanding and follow up on doctor orders and recommendations
- Ensure that there is food in the house
- Arrange for caregivers if needed (in addition to any Medicare homecare services provided)
- Serve as an advocate for the patient ensuring that whatever the patient needs during their transition phase is taken care of

2. **Additional Case Management Services as Needed**

Care for seniors and people with special needs often requires a multi-disciplinary approach that encompasses many aspects of life such as:

- Health and Mental Health
- Activities of Daily Living (ADLs)
- Transportation
- Finances
- Social Opportunities
- Emotional Well Being

This process needs to focus on a person's:

- Hopes and Desires
- Short and Long Term Goals
- Abilities and Needs
- Spectrum of Resources to address current and evolving needs

Case management is a collaborative process that consists of four (4) steps:

1. Needs Assessments
2. Development of a customized Care Plan (road map)
3. Implementation & Monitoring of the Plan
4. Ongoing Review and Modification of Care Plans as a client's needs change

Our future articles will focus on a variety of health and mental topics, in an effort to help readers become more knowledgeable and comfortable in their role as advocates, for themselves and their loved ones.

Photo from Microsoft

The information in this article is provided as an information resource only, and is not to be used or relied on for any diagnostic or treatment purposes. This information is not intended to be patient education, does not create any patient provider relationship, and should not be used as a substitute for professional diagnosis and treatment.

Please consult your health care provider for an appointment, before making any healthcare decisions or for guidance about a specific medical condition.

Linda Ziac is the owner and founder of The Caregiver Resource Center. The Caregiver Resource Center is a division of Employee Assistance Professionals, Inc. which Linda founded in October 1990. The Caregiver Resource Center provides a spectrum of concierge case management and advocacy services for seniors, people with special needs and families.

Linda's professional career spans more than 40 years in the health and mental health field as a CT Licensed Professional Counselor, CT Licensed Alcohol and Drug Counselor, Board Certified Employee Assistance Professional, Board Certified Case Manager, and Board Certified Dementia Practitioner. In addition, Ms. Ziac has 15 years of experience coordinating care for her own parents.

Linda assists seniors, people with special needs and their families; in planning for and implementing ways to allow for the greatest degree of health, safety, independence, and quality of life. Linda meets with individuals and family members to assess their needs, and develop a Care Team, while working with members of the Team to formulate a comprehensive Care Plan (a road map). Once a plan is in place, Linda is available to serve as the point person to monitor and coordinate services, and revise the plan as needed. This role is similar to the conductor of an orchestra; ensuring that there is good communication, teamwork, and that everyone remains focused on the desired goal.

http://www.CaregiverResourceCenter.com