The Caregiver Resource Center

Concierge Case Management & Advocacy

What You Need to Know Before Leaving the Hospital

"Discharge Planning Aids Recovery and Reduces Readmission"

The goal of this newsletter 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.

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

AN ALL TOO COMMON SCENARIO

All too often The Caregiver Resource Center receives a call from a distraught family member, following a senior returning home, following a hospitalization.

Several weeks ago Linda a certified case manager received a call from Sue, who lives outside of New Haven, seeking guidance for her family.

Sue is the power of attorney for her grandmother Bessie who had been discharged from the hospital 6 days earlier on a Friday.

When Sue called The Caregiver Resource Center she

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Don't Become a Statistic

Are you one of the 78% of Americans who are unprepared should a medical emergency strike?

According to the File of Life.org

- 116 million Americans are involved in an accident each year
- 50% of people suffer with chronic illnesses such as high blood pressure, diabetes or asthma
- 58% of all 911 calls involve a senior

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shared, “Grandma isn’t doing well and we don’t know what to do.”

Linda asked a few questions, and she 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.

THE IMPORTANCE OF A DISCHARGE PLANNING MEETING

Just the facts:

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Concierge Case Management & Advocacy Brochure

Successful Aging Brochure

Benefits of Our Services

- Well respected company serving the community since 1990
- All services are individually designed to meet your unique needs
- We are available 7 days a week by appointment and 24/7 for emergencies
- Professional support & guidance
- Our services are provided on-site in the home, ER, hospital, short term rehab, assisted living, and nursing home

Menu of Our Services *

- Advocacy
- Home Safety Audit
- Emergency Medical Advocacy while in the ER and hospital
- Screening, arranging for and monitoring Care Services

- 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

- Lack of patient understanding about their diagnosis, care plan, or follow up instructions
- 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)

Source: The Revolving Door, Feb 2013

- Crisis Management
- Family Support & Counseling
- Insurance Claims Research & Assistance
- Research of Community Resources
- Referrals to Specialists (e.g. medical, legal, or financial professionals)
- Family Discussions and Issue Mediation
- Transitioning to an alternative living option (e.g. home to assisted living)

* Fee for service

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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.

As a certified case manager Linda has clients who are hospitalized or in a rehab facility, and she works closely with the staff (e.g. doctor, nurse, social worker), and arranges for 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 facility.

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).

Linda Ziac is a Board Certified Case Manager and CT Licensed Professional Counselor; 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 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 hospital or rehab admission.

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, a 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 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 addressed

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

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.

Photos from Microsoft

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