Essential Elements for Successful Discharge

Discharge Brief 5
2010

Designed For Nursing Facility Staff to Help Discharge Medicaid Residents with Mental Health Diagnoses from Nursing Facilities

Early Discharge Planning

Starting discharge planning at admission for *all* residents is important. Discharge can be a time consuming process, and starting it at admission allows time for aligning schedules, setting up services and supports, addressing concerns, modifying the home, and educating residents and family members.

Early discharge planning makes it clear to residents and family members that discharge is possible and provides them with workable goals while living in the nursing facility. Having discharge goals from the beginning can also help avoid situations in which the resident may consider leaving the nursing facility before services and other supports are in place.

Although discharge planning sometimes varies for "short-term" versus "long-term" residents, it is important to remember that long-term residents can and do discharge. Treating each resident's needs and goals individually helps in making discharge possible for all residents.

"It takes a long time to set up a discharge plan, but if we know from the get-go that that's their plan, that gives us a lot more time to explore what's going to be available for them. So I think having that conversation initially is really important"

– Social Services Director/Social Worker

About This Brief

- This brief is designed to help discharge older persons who use Medicaid and have mental health diagnoses from the nursing facility.
- Staff members of nursing facilities who have helped persons with diagnoses of anxiety, bipolar disorder, or schizophrenia successfully discharge to the community suggested and use these helpful discharge strategies.

"I think the critical piece here in our building is that it really is a team approach … it's about involving the whole team. And the more people who have a vested interest in this person returning home, the more successful it's going to be."

– Social Service Director

Team Approach

Approaching discharge planning as a team is important for successful discharge, including the resident, family members and other support persons, and qualified personnel. Qualified personnel typically include social workers, physical and/or occupational therapists, speech therapists, physicians, nurses, dietary aides, mental health professionals, and community-based professionals.

Team work helps ensure that the progress needed for discharge is made and that supports and arrangements will be available once in the community, all with the goal of a safe discharge.

Team Evaluations of the Home Environment

Complete team home evaluations prior to discharge. Ensuring the individual and informal support persons are part of the home evaluation is essential. Home evaluations ensure those helping to discharge the individual have a good understanding of what the resident can do as well as the extent of help they may need once they are in the community environment. Importantly, an evaluation also helps guarantee the safety of the environment for the individual living there.

A thorough home assessment with a physical and occupational therapist and a social worker, in addition to the individual and informal support persons, can prevent falls and other negative events.

The roles of physical and occupational therapists in the home evaluations are to ensure safety and accessibility and to make recommendations for needed home modifications and medical equipment. Some home modifications may be as simple as removing rugs and rearranging furniture. Other modifications, such as building ramps, installing hand rails, and securing durable medical equipment, require more advance planning.

Social workers should attend the home evaluations in order to make psychosocial recommendations. This includes assessing family situations and interactions and ensuring that planned support is feasible.

Home evaluations can also help in identifying potential safety concerns related to the home environment, such as hoarding or bug infestations.

"Seeing a resident in their own environment can really give you a different perspective on that resident. People act kind of differently sometimes when they're in a facility, versus when they're in their own environment … [The team] can spend an hour or two at somebody's home making recommendations. And I think we've been really successful with that."
– Social Service Director/Social Worker

"This (discharge summary form) is something that I developed… I think that a big part of discharge planning is education. Families and residents don't know what services are available to them. They don't know how to get them … So I try to be as concise as possible on this form with the typical things that might be set up when they discharge."
– Social Service Director/Social Worker

Comprehensive Discharge Form

Having a comprehensive discharge form to give to individuals and families can help ensure a successful discharge for Medicaid residents with mental health diagnoses. Suggestions for discharge forms include:

- **Tailor discharge forms for use by individuals and family, have them sign off on the discharge plans, and send copies home with them.**
- **Include the individual's preferences and ensure self-determination when identifying specific tasks and supports for community living.**
- **Include easy-to-use instructions that avoid medical jargon for physical and mental health care and safety recommendations.**
- **Include contact information for health providers, mental health providers, home care providers, and other recommended community supports. Also include emergency contact information.**
- **Include information on meeting the diversity of health, safety, and psychosocial needs, which could include home health care, home care, medical equipment, home modifications, medications, nutritional and dietary needs, transportation supports, therapy services, and recreational and leisure pursuits.**
- **Have an interdisciplinary team review and make recommendations for changes to the discharge form.**

Agencies to Contact with Policy Questions

Suggested resources include:

- Your Area's "Explore Your Options" book
- Area Agency on Aging (AAA)
  Toll-Free (866) 457-2364 www.k4a.org
- Kansas Aging and Disability Resource Connection
  www.ksadrc.org
- Social and Rehabilitation Services
  www.srs.ks.gov
- Medicaid/Medicare
  - Kansas Medicaid/Kansas Medical Assistance Program (KMAP)
    (800) 933-6593
  - State Medicaid Assistance Office
    (800) 766-9012
  - Kansas Foundation for Medical Care, Inc.
    (800) 432-0407
  - Medicare (General) Hotline
    (800) 633-4227 www.medicare.gov
  - Kansas Health Solutions
    www.kansashealthsolutions.org
  - BestSeniorCareOnline.com
- Senior Health Insurance Counseling for Kansas (SHICK)
  (800) 860-5260
- Association of Community Mental Health Centers of Kansas, Inc.
  www.acmhck.org
- Kansas Advocates for Better Care (KABC)
  www.kabc.org

Follow-Up After Discharge

Conduct follow-up phone calls to the individual and family members. Also, encourage persons who discharge and their family members to call the nursing facility with any questions; you could even leave the number by the phone. This can help to ensure individuals can receive the supports they need for success while living in the community.

Individual and Family Goals

Individuals and their families sometimes have different ideas and expectations about what is needed to discharge from the nursing facility to the community. Therefore, it is a good idea to take extra time to listen to what both the individual and their family members are saying. If needed, be the mediator if you have the time and training, or call an ombudsman to assist them. Furthermore, make sure both the individual and family understand the discharge process. Helping match discharge goals contributes to working toward a safe, successful discharge.

"You'd be surprised how many times the [resident] and the family member aren't wanting the same thing … So I like to try and get everything out in the open in the beginning." -Social Worker

Options for Those Without Informal Support

For individuals without access to a caregiver or other informal support, it is important to find an AAA or community mental health center (CMHC) case manager, particularly a social worker with training in aging and mental health. This assistance will help to make sure the person's needs are being met. Additionally, nursing facility staff found that assisted living facilities and supportive housing may be good options for those without informal assistance, due to the ability to provide wrap-around services and regular monitoring.

KANSAS DEPARTMENT ON AGING

Kansas Department on Aging
www.agingkansas.gov
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KU SCHOOL OF SOCIAL WELFARE
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Office of Aging & Long Term Care
www.oaltc.ku.edu