

# Successful Discharge Scenarios

**Designed for Nursing Facility Staff  
to Help Facilitate Discharge for Medicaid Residents  
with Mental Health Diagnoses**

## Discharge Scenario A

Mr. J., a 66-year-old man with diagnoses of diabetes and schizophrenia, discharged from the nursing facility to the community after living in the nursing facility for a year. He lives alone in a private home in a rural town and has a son in the area who stops by daily. The social worker at the nursing facility met with Mr. J. and his son to develop a plan for paying bills and monitoring medication usage and physical & mental health status. Mr. J.'s son also takes him to church every week.

The nursing facility social worker helped Mr. J. purchase a \$30 pill reminder box from the internet that beeps to remind him to take his medicine for both diabetes and schizophrenia. His son refills the pillbox each week and monitors medication usage by checking the box each day. A team from the nursing facility also completed a home evaluation with Mr. J. prior to discharge. Mr. J. receives assistance with activities of daily living (ADLs), such as cleaning the house and assisting with bathing through the HCBS-FE waiver. The nursing facility social worker contacted an Area Agency on Aging (AAA) caseworker, who met with Mr. J. prior to discharge to set up home health services to help with ADLs for the first 100 days. A dietician from the nursing facility provided Mr. J. with an outline of suggested food, and he gets Meals on Wheels to help meet his nutritional needs.

Prior to discharge, Mr. J. attended individual therapy at the community mental health center (CMHC) to help him develop coping skills for his schizophrenia; he continues the therapy now that he lives in the community. Finally, Mr. J. was given diabetic training prior to discharge, specifically on how to administer his own insulin shots, and he has check-ups with his primary care doctor to make sure he is comfortable with and able to follow the routine.

### About This Brief

- This brief is designed to help discharge older persons who use Medicaid and have mental health diagnoses from the nursing facility to the community.
- These examples are based on actual discharges. The information was provided by nursing facility staff who have successfully discharged Medicaid residents to the community; however, the names and details of the cases have been changed to protect confidentiality.

### Key Strategies to Success

- Social worker met with person and a family member to develop a plan for helping person pay bills, monitor medication, and provide transportation.
- Social worker helped person purchase a pillbox that beeps as a medication reminder.
- Staff members completed a home evaluation with person:
  - Physical therapist determined person's physical limitations and assistance needed.
  - Occupational therapist ensured safety and mobility throughout the house.
  - Social worker and person completed a psychosocial assessment.
- AAA case manager met with person to set up a combination of home health through Medicare and HCBS-FE waiver services that began upon return home.
- Dietician and person outlined recommended food & Meals on Wheels provides meals regularly.
- Person continues to attend individual therapy at the CMHC to help cope with schizophrenia; therapy sessions started before discharge.
- Person provided information on how to give self insulin shots and learned about side effects and symptoms.

## Discharge Scenario B

Mrs. R., an 84-year-old woman with diagnoses of chronic obstructive pulmonary disease (COPD) and anxiety discharged to an apartment where she lives with her daughter. Prior to discharge, the nursing facility social worker and nurses worked together with Mrs. R. and her daughter to learn about treatment regimens and diagnosis-related behaviors, specifically geared towards mental health concerns. The social worker connected them with a durable medical equipment agency that provides oxygen services and other needed items (e.g. bath chair, walker). An Area Agency on Aging (AAA) case manager also met with Mrs. R. and her daughter prior to discharge and helped get the daughter enrolled as a self-directed service provider through HCBS-FE waiver services.

Physical and occupational therapists completed an evaluation of the home prior to discharge, where they gave recommendations to the daughter about helping Mrs. R. transfer in and out of bed as well as to the toilet. The daughter helps Mrs. R. with her activities of daily living throughout the day and night.

Now that Mrs. R. is living in the community, the case manager regularly comes to their home for monitoring visits. In addition, Mrs. R. attends adult day care three days a week. The daughter also attends a caregiver support group. The social worker suggested and assisted to arrange for services after the daughter expressed concerns about taking on the caregiver role again during the discharge planning meetings.

For Mrs. R.'s mental health needs, she had a check-up from a psychologist at the community mental health center (CMHC) within a week after discharge. The psychologist assessed anxiety symptoms and discussed treatment plans & psychoeducation with Mrs. R. She also made recommendations for crisis management (e.g. phone numbers to call, what daughter should do if Mrs. R. experiences an anxiety attack). Finally, Mrs. R. had an appointment with her primary care physician within two weeks of discharge.



## Key Strategies to Success

- Social worker spent time getting to know family member, which helped in identifying concerns and setting up services.
- Social worker and nurses worked with person and family member to inform them about treatment regimens and diagnosis-related behaviors.
- Durable medical equipment agency provides oxygen services and other needed items.
- AAA case manager met with person and family member prior to discharge to help enroll the family member as a self-directed service provider through HCBS-FE waiver services, and the case manager continues to visit routinely.
- Physical and occupational therapists evaluated home and helped family member with providing transfers in and out of bed and to the toilet.
- Family member is the primary help with activities of daily living.
- Person attends adult day care three days/week.
- Family member attends a caregiver support group.
- Psychologist from the CMHC assessed anxiety symptoms within a week of discharge and discussed treatment plans, psychoeducation, and crisis prevention with person, including phone numbers to call for different emergencies.

## Discharge Scenario C

Mrs. S., a 79-year-old woman with diagnoses of osteoporosis bipolar disorder, and anxiety discharged from the nursing facility after four years. She moved to a subsidized, low-income apartment where she receives HCBS-FE waiver services, including: house cleaning, shopping, bath support, and a Lifeline for emergencies.

Prior to discharge, the nursing facility social services staff, with Mrs. S.'s permission, spoke with the apartment complex director to inform him of Mrs. S.'s condition and needs. The director agreed to call Mrs. S.'s case manager or adult protective services if he ever noticed problems. He also installed bath support bars and found an apartment with lower carpet so that Mrs. S. could maneuver her wheelchair safely. A physical therapist, during a home evaluation, had recommended these modifications during an assessment. An evaluation of the apartment was also completed by an occupational therapist and a social worker with Mrs. S. This helped determine the placement of rugs and ensured Mrs. S. could easily access the bathroom and kitchen.

To manage symptoms of bipolar disorder, Mrs. S. takes medications. She also visits with a mental health case manager each week, who is extremely supportive and has developed a solid relationship with Mrs. S. To help Mrs. S. take her medications, a nurse at the nursing facility assisted her in making a chart to serve as a reminder. The nurse informed Mrs. S.'s case manager of the chart, so the case manager reviews the chart with Mrs. S. weekly. The nursing facility social worker also worked with Mrs. S. to secure a primary care physician that accepts Medicaid prior to discharge. The social worker helped Mrs. S. set up an appointment with the doctor within two weeks of discharge from the nursing facility. Finally, Mrs. S. has a niece who lives in the area who takes Mrs. S. to appointments as well as social activities and support groups at the senior center. Mrs. S. also requested that her niece assist with managing her finances, which alleviates much anxiety.

## Key Strategies to Success

- HCBS-FE services set up prior to discharge.
- Person agreed to inform the housing director about condition/needs in order to help monitor person's status.
- Staff members (PT, OT, & Social Work) completed a home evaluation with person.
- Housing director installed bath support bars and found an apartment with short carpet.
- Person attends support groups at the senior center, which aids in controlling bipolar disorder.
- Nursing facility nurse made a medication chart prior to discharge to serve as a reminder for person to take medicine and keep track of usage.
- Supportive mental health case manager meets with person weekly and reviews medication chart.
- Social worker worked with person to secure a primary care physician that accepts Medicaid prior to discharge and set-up appointment within two weeks of discharge.
- Family member manages finances and provides transportation to appointments and social activities at the senior center, at the person's request.



## Discharge Scenario D

Mr. L., a 78-year-old man with mild cognitive impairment, hypertension, and bipolar disorder discharged from the nursing facility and moved into an assisted living facility (ALF). Mr. L. does not have an informal support person available, and he was very determined to discharge from the nursing facility. Therefore, the nursing facility social worker worked to identify an ALF that would accept Medicaid (HCBS waiver). Building off the social worker's routine contact with the admissions coordinator at the ALF and with case managers from the Area Agency on Aging (AAA) and the community mental health center (CMHC) and through various provider luncheons and committees, the social worker helped transition Mr. L. into the ALF. The admission coordinator from the ALF met with the nursing facility social worker and Mr. L. prior to discharge, which helped ensure continuity of needed services.

Before discharge, Mr. L. also visited a neurologist to assess his cognitive function. The neurologist, with a consultation from a psychiatrist, helped to identify additional depressive symptoms related to his cognitive impairment as well as medications he can take for all of his diagnoses (bipolar disorder, mild cognitive impairment, and hypertension) that interact well together. Following this appointment, Mr. L. now utilizes Senior Outreach Services provided by the CMHC to address his current depressive symptoms.

The ALF staff helps him with the few activities of daily living with which he needs assistance, and he has regular appointments with his primary care physician to monitor his physical and mental health status. He eats his meals with other ALF residents, which ensures proper nutrition to help control hypertension and provides an avenue for social engagement. Finally, Mr. L. goes on daily walks and partakes in various exercise activities at the ALF.



## Key Strategies to Success

- Older adult without informal support person moved to an assisted living facility (ALF) that accepts Medicaid (HCBS waiver) payments.
- Social service staff person from ALF met with older adult and nursing facility social worker to ensure continuity of needed services.
- Older adult visited a neurologist prior to discharge to assess cognitive functioning and consider mental health concerns prior to discharge.
- Neurologist, with consultation from a psychiatrist, prescribed medications that limited the possibility of negative drug-related interactions.
- Older adult utilizes Senior Outreach Services through the CMHC to address depressive symptoms.
- ALF staff helps older adult with activities of daily living.
- Older adult has regular appointments with his primary care physician.
- Older adult eats meals with other ALF residents.
- Older adult goes on daily walks and partakes in exercise activities at the ALF.



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