Next Step in Care
Family Caregivers & Health Care Professionals Working Together

For Providers: Hospital Discharge Planning – First Steps with Family Caregivers

Misunderstandings about discharge options may lead to delayed discharges and unnecessary stress on patient and family caregiver, as well as on staff. Guiding patient and family caregivers through the discharge process is an important part of **integrating family caregivers into the care plan**. Unless family caregivers have had a lot of experience, they may have unrealistic expectations about their family member's recovery, the level of care needed at this point, and what home care and rehab are likely to provide.

Several conversations may be needed. During the first conversation about discharge, which should happen as soon as possible after admission, it is important to find out what the caregiver thinks is likely to happen. This, as well as information obtained from the Next Step in Care caregiver needs assessment ("What Do I Need as a Family Caregiver?"), will help guide the conversation. Offering the family caregiver the guide "Leaving the Hospital and Going Where?" ahead of the discussion will provide some basic facts to orient him or her.

It is important to remember that regulations issued by Medicare and most state departments of health give patients **and families** rights:

- To be involved in choosing the next site of care
- To know the expected date of discharge
- To have an explanation of staff recommendations for after-discharge care
- To be given a list of providers for after-discharge care
- To appeal what they feel is an unsafe discharge or an inadequate discharge plan. To find the phone number of the Quality Improvement Organization in your state, go to www.qualitynet.org and search for MedQIC.

Patients and caregivers also have responsibilities:

- To discuss the choices with the discharge planner or case manager
- To decide which setting is best for them, given the patient's care needs and other factors
- To select providers whose services they will accept so that they are ready when the discharge occurs.

Many people start discharge planning with unrealistic expectations because they have inaccurate information about what insurance will pay for and for how long. Detailed information is available for the family caregiver on the *Next Step in Care* website. You may want to keep copies of the relevant guides easily available to discuss and give to families. To get the conversation going on the right track, here are some quick talking points:

Reminder list for hospital discharge planning discussion with family caregivers

- Identify family caregiver(s) and acknowledge their roles in the family and in caregiving
- Explain the patient's diagnoses and condition, as well as the tasks that the patient will need help with
- Discuss caregiver needs, as identified by the caregiver, including availability/ability to take on certain tasks, and education needs
- Identify preferences for discharge location, based on the caregiver's self-assessment and patient care needs. These are the most likely options:
    - Home with no services
    - Home with home care services
    - Rehab program in a skilled nursing facility
    - Long-stay placement in nursing home
- Based on your understanding of the patient's medical condition and likely recovery, is this preference realistic?
    - Discuss the pros and cons – present options based on patient and caregiver needs
    - Discuss financial implications of discharge options

Rehabilitation Program in a Skilled Nursing Facility

Many caregivers don't want to consider inpatient rehab because they think of it as placing their relative in a nursing home. **It is not the same.** In recent years many nursing home have expanded their services to include short-term rehabilitation. Medicare (and other insurers) will pay for a limited amount of time in a rehabilitation facility **only** if:

- A doctor orders these services.
- The patient can benefit from physical, occupational, or speech therapy following an illness, accident, or surgery.
- A rehab unit is willing to accept the patient.

If rehab is an agreed-upon choice:

- Offer a list of nursing homes with rehab units
- Recommend that the caregiver or another family member visit or call the most likely choices and ask about services, visiting hours, types of rooms, meals, and other concerns
- Remind the patient and caregiver that discharge decisions are often made quickly
- Discuss the transition to rehab

Home Care

If inpatient rehab is not an option, explain that Medicare (and other insurers) will pay for home care services provided by a certified home health agency **only** if:

- A doctor orders home care services. As of April 1, 2011, Medicare requires that the doctor (or nurse practitioner, clinical nurse specialist in collaboration with the doctor, physician assistant in collaboration with the doctor, or certified nurse midwife as authorized by state law) certifying a need for home care services must have a face-to-face encounter with the patient within a certain time period and must document current information about the patient's condition and need for home care services.
- The patient has a skilled nursing need (such as wound care, medication follow-up, evaluation, and other services provided by a trained professional). Physical, occupational, or speech/language therapies may count as a skilled need.
- This need is part-time and intermittent (not all day and not every day) and
- The patient is homebound (can leave home only with assistance).
- The home care agency accepts the patient.

If the patient qualifies for skilled nursing services and needs personal care in addition, a home health aide **may** be assigned to provide this care. Generally the aide will come to the home for a few hours a day and probably not every day. Home care services will probably last a few weeks, not months.

If home care is an agreed-upon choice:

- Offer a list of home care agencies
- Advise the caregiver that the first nurse visit, which may not happen for a few days, will be an evaluation, **not** the start of services
- Advise the caregiver that home care services will be short-term
- Suggest ways that the caregiver can fill the gaps

- Discuss the transition to home care
- Discuss Medicaid eligibility and other Medicaid program alternatives

Following Up

If there was a decision after this discussion, communicate with staff at the next setting about patient care needs and stated needs of the family caregiver

If there was no decision:

- Arrange a follow-up discussion
- Ask if there are any further questions
- Offer support for a difficult decision

Helping patients and family caregivers make realistic and appropriate choices will make the day of discharge and the transition process much smoother for them and for you.