Case Management: Discharge Planning

What We Know

› Discharge planning begins on the first day of the inpatient admission at the time the patient initially enters the hospital system or before if the admission is planned\(^{(10,13)}\)
  • Well-planned discharges begin within 24 hours of admission and include involvement of the patient and family, clear and honest communication, early teaching, and a backup plan in the event of changes\(^{(10,13)}\)

› Case managers develop a discharge plan using 4 steps — screening, assessment, planning, and implementation — which are designed to assist the patient in transition of care as well as support the hospital financially\(^{(1)}\)
  • Hospitals can be penalized by Centers for Medicare and Medicaid Services (CMS) if patients with a specific diagnosis (e.g., heart failure) are readmitted within 30 days of discharge\(^{(15)}\)

› Case managers should practice objectivity in creating a discharge plan and providing information to the patient and family members; if the patient/family are not involved in planning, the discharge plan is set up to fail. Case managers should recognize patient choice as a right and empower the patient and family by listening to their concerns and acknowledging their specific and individualized needs\(^{(1,13)}\)

› Discharge planning includes incorporating patient choice of available and suitable options; hospitals are required to give patients a choice of skilled nursing facilities or home care agencies, but patients can choose anyone that they want\(^{(15)}\)

› Same-day surgery or early discharge from the hospital after planned surgery often requires planning to be started at the time of admission or days before the surgery\(^{(4)}\)

› Challenges related to discharge planning in case management include assisting the patient and their family/other support systems to identify individualized discharge needs while also verifying the accessibility of services and the affordability of the discharge plan. A financial assessment should be part of the initial patient assessment\(^{(8,14)}\)

› Standardized discharge databases for accumulation and organization of discharge information are not available in every hospital. Poor communication of discharge instructions can lead to adverse patient events (e.g., medication errors, improper or missed clinician follow-up) as a result of
  • charting inaccuracies (e.g., partial patient history) and omissions (e.g., missing discharge or other clinician instructions)\(^{(2)}\)
  • illegibility of patient-related information
  • undelivered patient information
  • delays in completion and/or appropriate review of paperwork

› The discharge process and the patient’s transition to home or a skilled nursing facility can be confusing and seem complicated to patients and their families. Poor documentation creates misunderstandings by nurses from home health agencies who are assigned to provide patient care in the home after discharge from the inpatient setting\(^{(2)}\)
  • The goal of transition to home or another facility is patient safety, complete patient recovery, and avoidance of adverse events and the need for inpatient readmission\(^{(2)}\)
Discharge nurses should be identified and have a designated role in the hospital. Lack of formal identification, consultation with family members/primary caregivers, and lack of time leads to ambiguity in discharge instructions. Investigators of a rehabilitation-in-the-home (RITH) program recommend enhancing the transition from hospital to home by the following:

- Promoting effective communication among members of the healthcare team who are involved in the patient’s care
- Establishing effective communication with the patient, family members, and other caregivers
- Involving the patient and family members/caregivers in the entire process of discharge planning
- Providing a written agreement to support reviewing and explaining the expectations of RITH to the patient, family members, and other caregivers

The RITH program utilizes a written agreement that documents the expectations of the healthcare staff and provides the patient, family members, and other caregivers with written information about community support services that are needed for providing in-home care.

- Reviewing program protocols with the patient, family, and other caregivers to formally incorporate them into the case management/discharge planning processes

Case managers assist in the discharge plan process and develop the written discharge plan. Understanding of the patient’s financial circumstances and knowledge of their specific health insurance coverage is essential; poor insurance coverage and/or lack of financial resources can lead to the need for seeking emergency care and unscheduled readmission. The case manager should know the patient’s health plan coverage and noncoverage parameters, and their out-of-pocket costs (e.g., deductibles, copayments). When financial issues are a concern, case managers collaborate with the health insurance company, various community agencies, and pharmaceutical companies to maximize benefits and identify alternatives to meet patient needs.

Hospitals and case managers can create partnerships with discharge advocates and case management assistants to delegate clerical duties. Discharge advocates schedule post-discharge follow-up appointments with primary care clinicians, specialists, diagnostic facilities, and laboratory facilities before patients leave the hospital. Case management assistants (CMAs) are responsible for copying medical records and processing paperwork for the next level of care (e.g., transportation, transfer to rehabilitation). Overall, the goal is to decrease the case manager’s workload and decrease patient readmission rates.

Case manager directors must be cognizant that if multiple case managers were to rely on the efforts of a single CMA or a small group of CMAs, then the CMA(s) caseload could become difficult to manage.

Discharge checklists can help to enhance effective liaison between the patient, the caregiver and family, medical providers, multiagency services and community providers. They can be used throughout the hospital stay to communicate what actions have been taken and what remains to be done. Written information should be prepared in advance and transportation, treatment, medication, dressings and equipment should be prepared ready for transfer with the patient. Following transfer, the documentation should be filed in the patient notes as a record of the discharge planning process. Sending a copy with the patient should also be considered.

Case managers in rural hospitals face unique challenges. Lack of transportation and specialty services for patients in need of post-acute care can hinder the discharge process. Case managers should ask the patient and family for assistance in identifying friends, church-based services, neighbors, or family members who can provide transportation from the hospital to home. Collaborating with others in the healthcare facility to develop a relationship with community agencies and appropriate vendors can improve the logistics of patient transition. Transfer of a patient from the hospital to a post-acute facility (e.g., rehabilitation or skilled nursing facility) that is not local can be met with patient and/or family resistance. It is important to develop a discharge plan and communicate the its details with the patient and family on the first day of admission and throughout the inpatient stay to provide the family with opportunities to identify one or more preferred post-acute facilities.

Experts contend that having case managers in the ED is essential for optimal hospital services, reimbursement, and patient care. Case managers should be adept at providing the following services:

- Assist ED clinicians with evaluation of proper admission status and medical necessity criteria to avoid losing reimbursement
- Verify that discharged patients’ care needs (e.g., wound care from a home health agency) are arranged for to appropriately manage their conditions at home
- Manage a smooth transition of discharged patients from the hospital to the community, including organizing post-discharge services (e.g., clinician follow-up, durable medical equipment)
Housing assistance could be part of the care coordination interventions for homeless patients with chronic medical diagnoses.

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires emergency service access for all persons, regardless of their ability to pay. Under EMTALA, patients must be appropriately assessed, treated, and stabilized before discharge or transfer to another facility.

Post-acute healthcare facilities are not required by law to accept patient transfers from a hospital who are undocumented immigrants or are unable to pay for care. In some cases, undocumented immigrant patients have supportive family members, but others have few or no relatives and friends in the United States. Case managers should be resourceful when planning for discharge of undocumented immigrant patients who have little or no local support; knowledge of and connections with community charity services can be beneficial.

A case manager director’s duties include evaluating staffing and budgeting issues of a department, which will directly impact the facility as a whole. Unplanned and planned case manager staff absences, the need for cross training, and the use of part-time employees are a challenge for many directors; developing a planned rotation for staff is one approach to overcome this barrier. Involving the staff in planning and allowing for some flexibility can be helpful.

Collaboration with clinicians (often referred to as home care liaisons) who will be involved in the provision of in-home care is an important responsibility of case managers during patient discharge. Pitfalls in communication, role ambiguity, poor delineation of responsibilities, and varying styles of practice lead to negative consequences for discharged patients and their families. Suggestions for collaboration and care coordination include the following:

- Familiarization with the practices and backgrounds of the home care liaison and case manager
- Clear definition of roles, responsibilities, and expectations
- Designating time and appropriate forums for continuous communication and follow-up between home care liaisons and case managers
- Educating home care liaisons regarding responsibilities in the discharge planning process that are shared with the case manager, but emphasizing that the case manager has primary accountability for the effectiveness of the discharge plan

What We Can Do

- Become knowledgeable about case management pertaining to discharge planning so you can accurately assess your patients’ personal characteristics and health education needs; share this information with your colleagues
- Promote effective communication among healthcare clinicians, home care liaisons, patients, and family members/caregivers for optimal discharge planning
- Enhance the discharge process by tracking measurable data and verify the patient is stable for discharge
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