Discharge Planning

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WHO ARE SOCIAL WORKERS?

- Licensed professionals who help individuals, families, and communities understand the causes of their personal and social problems
- Assist and empower individuals, families, and communities to work to modify and change attitudes and behavior
- Work with people from all economic, educational, and cultural backgrounds

MEDICAL SOCIAL WORKERS AT LUMC

- Work in the inpatient, outpatient, outpatient dialysis unit, and the home settings
- Help patients and their families cope with chronic, acute, and terminal illness
- Handle problems that may stand in the way of recovery or rehabilitation
- Assist the medical team in understanding emotional, social, environmental, and economic factors affecting the patient
- In addition to the medical factors, patient's behaviors and interpersonal relationships can also affect the treatment plans

LUMC SOCIAL WORKERS ROLE

- **Psychosocial Assessments** –complete patient assessments to identify patient's current levels of functioning, and medical, emotional, social, and environmental needs that must to be addressed during hospital admission to facilitate d/c
- **Crisis Intervention** –work with victims of traumas, violence, including children who are abused or neglected, rape victims, victims of domestic violence, and elders who are abused or neglected
- **Counseling** –provide supportive counseling for patients and their families to reduce anxieties, and assist in adjustments to life changes resulting from illness and traumatic events

LUMC SOCIAL WORKERS ROLE

- **Behavioral Intervention** –assist in design and implementation of behavioral interventions to address maladaptive behaviors of patients and families
- **Advocacy** –intervene on behalf of patients particularly when they are incapable of representing themselves or give consent
- **Discharge Planning** –work with patients, families, and the medical team to anticipate and plan for medical and resource needs at discharge from the hospital
- **Referrals** –provide referrals to community agencies to meet a variety of medical, emotional, social, economic, and environmental needs

DISCHARGE HIGH RISK INDICATIORS

- Over 70 Years Old, Living Alone
- Not Documented/ No Insurance/ No Housing
- Child/ Elder Abuse or Neglect
- Limited or No Support System
- Limited Cognitive Ability
- Frequent Readmissions
- Progressive Chronic Disease
- End Stage Disease
- New or Terminal diagnoses
- Current Emotional or Psychiatric problems
- ETOH or Substance Abuse
- Needs Home Services / Home Medical Equipment/ Placement

DISCHARGE TIMELINE

Average Time Requirement to set up D/C Services

IVAntibiotics	1-3 Days
Wound Vacs (once paperwork is complete and faxed)	2-5 Days
Skilled Nursing Facilities (SNF)	2-5 Days
Long Term Acute Care (LTAC) – 3 facilities in IL	2-5 Days
Acute Rehabilitation (including the 5th Floor)	2-5 Days
Psychiatric Hospital Transfer from ED	8hrs
Psychiatric Hospital Transfer from the Floor	1-3 Days
Tube Feedings/ Trach Care	1-3 Days
TPN	2-5 Days
Home Care/ Hospice	1-3 Days
HMO referrals	1-3 Days

PLACEMENT AT FACILITIES

- What you need to know:
  - Patients and families must be offered a choice of facilities to transfer to for further treatment and rehab
  - Transfer to a facility cannot occur without patient and family consent
  - There are generally 3 types of placements a surgery patient may need at d/c from LUMC. The types are:
    - Long Term Acute Care (LTAC)
    - Acute Rehab vs. Sub Acute Rehab
    - Skilled Nursing Care (SNF)

LTAC PLACEMENT

- Patients generally transfer to LTAC from ICU/ IMC
- Patients often have:
  - Special ventilator care, need ventilator weaning or trach collar trials
  - Hard to heal wounds or complex wounds, generally with wound vacs
  - Chronic complex medical condition
  - Are no longer on any drips, such as fentanyl or insulin
- There are only 3 LTAC providers in the Chicagoland area:
  - RML – Hinsdale, IL
  - Kindred - Northlake, IL, Sycamore, IL, and two locations in Chicago, IL
  - Holy Family LTAC - Des Plaines, IL
- General length of stay is 30 days
- Patient often require acute or sub acute rehab after LTAC placement

PHYSICAL REHAB

- After all surgery PT/OT needs to be ordered to evaluate patients rehab needs
- If PT/OT recommend inpatient rehab services a PMR (Physical, Medical, Rehabilitation) consult should be ordered to evaluate level of rehab needed
- There are 2 levels of Rehab:
  - Acute
  - Sub Acute

ACUTE REHAB

- More intense rehab, with patients tolerating 3 hours of rehab per day
- Patient must meet insurance criteria to qualify for acute rehab
- Patients and families must be offered choice of which facility to receive acute rehab
- Do not promise patients an acute rehab bed at LUMC 5th Floor. Nothing is guaranteed until the day patient is accepted and a bed is available
- Patients on TPN will not be accepted at acute rehab
- General length of stay is 12-14 days

SUB ACUTE REHAB

- Less intense rehab, requiring patients to tolerate at least one hour of rehab per day
- Patient generally require sub acute rehab when they tire easily, and have current medical issues that hinder quick recovery
- Most often this type of rehab is provided in a Skilled Nursing Facility (SNF/ Nursing Home)
- Patients and families must be offered choice of which facility to receive sub acute rehab
- General length of stay is 20-30 days

SKILLED NURSING CARE

- Provided in Skilled Nursing Facility (SNF/ Nursing Home)
- Must meet insurance criteria to qualify for skilled nursing care, including 3 overnights for Medicare patient's
- Patients and families must be offered choice of which facility to receive skilled nursing care
- Services offered include:
  - PT/OT
  - Wound Care
  - Trach care, tube feeds, TPN, IV abx
  - Nursing and nurse's aid care

HOMECARE AND HOSPICE

- The aim of homecare is teach the patient or family how to take care of medical needs at home. Homecare will not come out every day to see patients at home
- Services at home can only be provided to patients who are homebound
- Patients and families must be offered choice of homecare and hospice providers
- Loyola offers homecare and hospice services
- Must meet insurance criteria to qualify for homecare or hospice
- Services offered include:
  - Nursing for dressing changes, wound vac changes, IV abx, TPN, tube feed, trach care, drain care, and with hospice administering of medications
  - PT/OT, Speech, Social Work

PHYSICIAN INVOLVEMENT IN DISCHARGE

- Physician communicates to patient/ family the continuing medical needs at discharge
- Discuss whether home care or placement will be needed
- Physician informs social work of the d/c needs and requests assistance with assessing and coordinating d/c services

PSYCHOLOGY OF PATIENT AND FAMILY

Change is difficult for most people because:

- We feel comfortable with what we know
- We want to remain in control

When admitted into the hospital patients/ families often:

- Lose sense of control because MD and medical team are making the medical decisions
- Feel overwhelmed with complexity of teaching hospital system

PSYCHOLOGY OF PATIENT AND FAMILY

- Hospitalization may be a time of crisis and extreme pressure. Rational people can become angry, frustrated, demanding, and emotionally unstable
- Sometimes it will feel you are being attacked. Patients and families may be looking for someone to blame or do not have appropriate coping skills to deal with complex medical issues

PSYCHOLOGY OF PATIENT AND FAMILY

How to help frustrated/ upset patients and family:

- Listen
- Try not to be defensive
- Show sympathy and understanding
- We give a lot of information at one time and it is overwhelming to families especially if it is unexpected or terminal news
- You will often need to repeat information on the patient's condition
- Discuss issues with medical team and social work to try and resolve situation

Impact of Reimbursement

- No reimbursable options for undocumented patients outside of acute care
- Medicaid pending can be accepted for acute rehab, some sub acute rehabs/SNFs, much more difficult for LTAC placement
- HMOs (just say no!), are contracted with only certain facilities, must have approval from pt's PMD to transfer

HOW TO COMMUNICATE WITH YOUR SOCIAL WORKER

- Daily phone rounds
- Page whenever you have a question or concern or a discharge need is identified
- WE ARE YOUR FRIENDS! TALK TO US! WE ARE HERE TO HELP AND WORK WITH YOU!