Discharge Planning

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Goals of Recent Initiatives

CARE MANAGEMENT PLAN

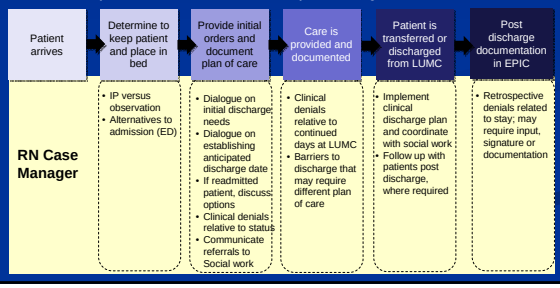
- Right class / status, right level of care, right care at the right time in the right setting
- Smooth the discharge planning process / coordination of care
- Improved patient satisfaction scores:
  - Better communication regarding discharge / transition plan of care
- Regulatory Compliance and Health Plan Guidelines
- Improve communication among members of the health care team
- Quality / transparency / public reporting
- Appropriate reimbursement for services rendered

Role Delineation

Role of the Social Worker	Role of the Case Manager
Consultation Role	**Responsible for:**
Responsible for Assessment, Evaluation and providing supportive recommendations for patients with:	Initial Discharge Planning Assessment (within 24 hrs of admission)
Suspected or actual abuse, neglect	Nursing home/group home returns
Substance abuse / mental health	Home Care / DME / Infusion
Adoption, protective services	**Utilization Review/Management**
Guardianship	**Evaluating level of care and utilization of acute care beds**
All new facility placements due to psycho social barriers to facilitating this with families	**Translating and communicating physician documentation and / or clinical information into payor criterion language**
End of life decision making and facilitation	**Denial management**
Financial and social barriers to transition from LUMC	**Coordination of Peer-Peer requests from the health plan**
Patient counseling / adaptation to illness	Management / Oversight Role
Early involvement due to RN assessment within 24 hours of admission	Team Rounds
Team Rounds	Coverage on weekends with social workers
Coverage on weekends with RN care managers	

Your Case Manager…….

- **Involved with 100% of patients**
- **Completes a Discharge Planning assessment for all patients within 24 hours of admission**
- **Works with the multidisciplinary team members, to coordinate the plan of care – and assure timely transition to the appropriate next level of care**
- **Assures timely care coordination with family members, insurance companies, and all others, to assure most optimal use of resources to move the patient through the healthcare continuum**



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

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 a few LTAC providers in the Chicagoland area:
  - RML – Hinsdale, IL, Chicago 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 case manager/social worker of the d/c needs and requests assistance with assessing and coordinating d/c services

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 OR CASE MANAGER

- Check Yellow Box in Order Summary for Contact info
- Social Workers are service line based, case managers are unit based
- All carry pagers
- We want to work with you to coordinate safe and successful discharges

Background

- Of patients dying in hospitals, one-half are cared for in an ICU within 3 days of their death
  - One third spend more than 10 days in ICU
- most deaths in ICUs are due to withdrawal of therapy
- in ICUs most patients cannot communicate regarding death decisions

Background

- Clinicians are oriented to saving lives rather than helping people die
- families rate ICU clinician communication skills as more important than clinical skill
- > 50% of families do not understand the basic information on the patient's prognosis, diagnosis and treatment after a conference

Background

- Medical patients with debilitating illness
  - majority have thought about EOL care
  - less than half have communicated it
  - some patients want to make own decision
    - most want to do it in conjunction with physician
- patients say they prefer to die at home

Legal and Ethical Background

- 1991 Patient Self-Determination Act
  - patient autonomy
  - informed decision making
  - truth telling
  - control over the dying process
- assumes the individual is the decision maker

Key Differences in State Surrogate Laws

Priority of Surrogates

- Spouse, adult child, parent, sibling (3)
- "nearest" or "other" relative (16)
- Include adult grandchildren (8)
- Include grandparents (5)
- Include close friends (17)
- Include Aunts, Uncles, Nephews, Nieces (2)

Key Differences in State Surrogate Laws

Priority of Surrogates

- In Michigan: "Immediate Family or Next of Kin priority not specified"
- In California, Domestic Partner #2
- In Indiana, A "Religious Superior"
- In Mississippi, A LT Facility Employee
- In Florida, LCSW selected by bioethics committee

Illinois Surrogate Law

Priority of Surrogates

- Spouse
- Adult child
- Parent
- Sibling
- Adult grandchild
- Close friend

Illinois Surrogate Law

Limitations on Types of Decisions

- Mental health
- Must be considered "terminal" or "incurable" to withdraw care

Illinois Surrogate Law

Disagreement Process Among Equal Priority Surrogates

- Majority Rules

Life in the ICU

- Physicians duty to
  - preserve life
  - Ensure and acceptable quality of life
  - When medically futile, ensure comfortable and dignified death.

Palliative Care

- Affirms life and regards death as a normal process
- neither hastens or postpones death
- provides pain and symptom relief
- integrates psychological and spiritual aspects of care
- offers a support system for living actively until death
- offers family support to cope with illness and bereavement

Quality End of Life

- Good death: "One free from avoidable distress and suffering for patients, family, and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards"

Quality Assessment for the Dying

- Adequate pain management
- Avoiding inappropriate prolongation of dying
- Achieving a sense of control
- Relieving burden
- Strengthening relationships with loved ones

Discussions

- Death and Dying
  - what will it look like
  - symptoms, process of care, location, spiritual support
  - directly raise possibility and likelihood of death
  - Closing
    - give family control over timing, time for private conversations, implementation
    - assure patient comfort
    - discuss continuity, further discussions

Communication

- Current studies show quality of communication is poor
- early discussions with families shorten ICU stay prior to death
- giving the right data helps families make the informed decisions
- poor communication is associated with increased malpractice suits

Communication Style

- Be direct about information in general and dying specifically
- elicit questions/solicit information
- confirm understanding
- summarize
- allow discussion among family members
- express concern/value
- acknowledge caring/complexity/difficulty
- ask about spiritual support
- acknowledge team members

Communication

- Dying people know they are dying
- fear abandonment/loneliness
- want to talk to people they know
  - resolve issues
  - families may feel uncomfortable, guilty, embarrassed
  - may want to change subject or withdraw from patient's situation
- dying patients want to talk to their doctor

Communication

- Perception is selective
- stress may alter what families hear
  - can't discern relevant information
- verbal and nonverbal communication need to be congruent to establish trust
- culture may influence communication patterns
  - be aware of cultural differences but do not avoid interactions

Futility

- Persistent vegetative states
- less than 1% chance of success
  - continued dependence on intensive care
- VERY poorly defined
- mostly in non-trauma settings
- does not include QUALITY of life
- best definition: "treatment that will only prolong the final stages of dying"

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Principles on Guiding Care at the End of Life

- Respect dignity of patient and caregivers
- be sensitive and respectful to patient/family's wishes
- use appropriate measures c/w patient's choices or legal surrogate
- ensure alleviation of pain and mgt of physical symptoms
- recognize assess and address
  - psychological, social and spiritual problems
- ensure continuity of care
- provide access to therapies that may improve quality of life
- provide access to appropriate palliative and hospice care
- respect the patient's right to refuse treatment
- recognize the physician's responsibility to forego futile treatment

Cases

- 80% TBSA flame burn injury to a 45 year old, all full thickness, 24 y/o daughter who pt has not spoken to in seven years is the decision maker, no POA, pt lives with "significant other", how should we handle consent? Should we treat?
- 70% TBSA flame burn injury to a 34 year old female, self inflicted, history of chronic mental illness, survivable injury, should we treat?
- 20% TBSA flame burn, grade III smoke inhalation injury to an 83 year old male with a history of COPD, has a living will, should we treat?