Mail Tribune
ASHLAND EDITION

Get expert advice on what's best after hospital

By Ellen Waldman
October 26, 2015

Recently, I had several calls from people needing assistance whose family members were being discharged from either a local hospital or a skilled nursing facility. I recommended they speak to someone at the facilities first. In both of these types of medical settings, there is a professional with whom patients and their families can discuss all the options for a successful, full recovery. That person is known as the discharge planner or sometimes, nurse case manager. These professionals have a very important job, and we are grateful for what they do.

To find out more, I spoke to Athera DeAngeles, RN, who is utilization review/case manager/discharge planner at Asante Ashland Community Hospital (AACH). She is truly an expert in the field. Here's what I found out.

Q: What is the role of the discharge planner at the hospital?

A: The discharge planner is responsible for identifying and coordinating the discharge plan for patients (who) need services after discharge. (EW: Almost everyone wants to go home, of course, but it takes real skill to know what the best placement and plan is to enhance recovery.)

Q: Are there special tasks that need to be done specifically for the older patients?

A: When planning for older patients, it is important to consider several factors, such as living situation, family/friends/community support and resources, prior level of function, and anticipating other needs, in order to facilitate a safe discharge. (EW: In some cases, the needs are quite high and require a vast knowledge about how to access these supports. Many go home with a spouse or partner who themselves might have medical conditions. It's not always practical to expect them to do the requisite follow-up care. One consideration is to employ the services of an Aging Life Care Professional. On the website aginglifecare.org, you will find several in this vicinity. Being able to see the big picture, long-term as well as short-term needs, plus minimizing the odds for another hospitalization, their services are extremely helpful.)

Q: What are the options for discharge, and how does the discharge planner decide where patients should go after being discharged?

A: The discharge plan is a multidisciplinary approach at AACH. Each morning, we conduct a team meeting in which the hospitalist, charge nurse, pharmacist, social worker, physical therapist, nutritionist and discharge planner, meet to discuss the current hospital patients and their potential discharge plan. Depending upon their clinical course, (EW: how things are going for them), we anticipate when a patient may be medically stable for discharge and begin to plan for a potential date.

Q: If a patient is independent and not meeting homebound criteria to warrant home health, then an appointment is scheduled for follow-up with their primary care physician (PCP) or a specialist. If the

patient is functionally at their baseline (prior level of function), but would benefit from home health follow-up and meets criteria, then home health is suggested. An agency of their choice is contacted.

If a patient is not at their baseline and is requiring moderate to maximum assistance of one or two people with their mobility and daily activities, there are other options. A patient would then meet the criteria for going to a skilled nursing facility for rehab. If they are able to financially afford it, and if the assistance of only one other person is needed, they can return home with 24-hour-a-day caregivers. If the patient's family is available and present in their life as a support system, the family would then come to a decision about which would be most feasible for the patient.

(EW: Another idea to assist with a favorable outcome at discharge and beyond is an adult foster care home. I wrote a column about these care homes that appears in the Nov. 17, 2014, Tidings. Kathy Petersen, who owns two homes here in Ashland, was featured as an expert in the field. Please refer to this column, online at http://bit.ly/1S2QZA5, for more information on this choice.)

Q: What can patients and their supporters do to maximize their healing after discharge?

A: What is needed is to assist the patient in making sure that they pick up and take their prescriptions as directed; keep their follow-up appointments; work with home health to optimize their services in assisting patient to return to their prior level of mobility and function; and seek out community services for additional support and education.

Relying on the guidance of the discharge planner is key to a successful return from a hospital or skilled nursing facility. If you have some sense of what each of these options means ahead of time, you will feel more empowered, knowing the right decision is being made with your preferences in mind.