

# Guide to Discharge Planning

Western Governors University  
College of Health Professions  
Healthcare Management  
Office for the Public Domain

Brenda Felong, MA, RN, CCM  
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## Objectives

The purpose of this paper is to inform nurses about the discharge planning process so that they will provide effective discharge planning for their patients.

When you complete this paper, you will be able to:

- \* Define discharge planning
- \* Discuss the role of the discharge planner
- \* Identify high-risk patients using screening criteria
- \* Compare and contrast the Medicare and Medicaid programs
- \* Identify the essential components of the discharge planning process
- \* Identify community resources for discharge planning cases
- \* Discuss accountability as it relates to discharge planning.

## Chapter 1 What Is Discharge Planning?

Discharge planning has been part of nursing for a long time. However, it has been recognized as a vital aspect of the patient's care relatively recently and, in fact, has been labeled as a patient's right.

Discharge planning is the process by which the patient is assisted to develop a plan of care for ongoing maintenance and improvement of health care, even after he or she may be discharged from the acute care hospital. Sometimes referred to as continuity of care, discharge planning seeks to provide services that will enable the patient to become as independent as possible.

Early attempts at discharge planning usually involved notifying patients of their next physician's appointment and explaining medication schedules. It was felt that these two items were immensely important to the patient's continued good health, so they were addressed early on. Later, some discharge planning focused on liaison with home health care, particularly in hospitals where there were hospital-owned home health care agencies.

The *Omnibus Reconciliation Act of 1986* (OBRA) mandated that all hospitals participating in Medicare have a discharge planning program. Also, with changes in health care financing, mainly the

prospective payment system (PPS), it has become important to hospital administrators, boards, and medical staffs to move the patient through the acute hospital phase of illness as quickly as possible.

When a patient receives Medicare or other insurance payment for hospitalization, PPS is used to reimburse the hospital with a prenegotiated or predetermined flat rate per day of care or a fixed rate for each type of discharge diagnosis. Medicare uses **diagnostic related groups** (DRGs) to categorize patients into more than 500 diagnostic categories. These groups not only are broken down into such principal diagnoses as a fractured hip or congestive heart failure, but are further modified by the patient's age and the presence of complications.

The hospital is then paid a specific dollar amount to treat a patient of that age with that diagnosis, regardless of the cost of treating that patient. If the care can be provided for less cost than the PPS payment, the hospital is allowed to keep the difference. If it costs more to care for the patient, the hospital loses money on the case. The hospital is not allowed to bill the patient for charges not covered by the DRG payment.

It is easy to see then that even at facilities where there was not a great concern for providing continuity of patient care, there was a great concern for moving the patient out of the hospital as quickly as possible. Each hour the patient is in the hospital, he or she is utilizing staff, equipment, supplies, and other costs.

This shift in focus has occurred rather rapidly, over the last 20 years or so, making it difficult for patients and their families to understand what is happening to them. It is not uncommon for the elderly patient to have last been hospitalized at a time when patients were in bed for 14 days after an appendectomy or a week after childbirth. Suggesting to these people that they should leave the hospital in less than a week causes understandable anxiety.

It is because of these very concerns that Medicare has mandated that medical records be reviewed and sanctions be given for patients who felt they had a "premature discharge."

It is easy to see why discharge planning has become such a vital part of every Medicare patient's hospitalization, but those with other insurance are equally affected. Managed care providers are also very concerned about costs. We will discuss insurance in more detail in another chapter.

Medicare, JCAHO, and private insurance companies all have standards, regulations, and requirements for the early identification of patients who are likely to have problems maintaining or restoring good health upon discharge from the hospital if there is no discharge plan. The goal is to promote continuity of care, improve the quality of care, and maximize the use of health care resources.

Discharge planning is a multidisciplinary process. Ideally, the admitting nurse who first meets the patient starts the assessment and identifies needs. This plan is added to by staff nurses, the utilization review nurse, therapists, the physician, the social worker-virtually every discipline. However, it is usually the discharge planner's task to coordinate these activities for the patient's benefit.

The role of the discharge planner, then, is not to write the discharge order, but to ensure that every possible effort has been directed toward the best possible continuity of care for the patient.

These efforts can take many forms. Most hospitals today use case managers. The job description for a case manager encompasses a much broader role than simply discharge planning or utilization

review. In some facilities, the primary responsibility of the discharge planner is to arrange transfer to long-term care facilities. In others, it is to arrange for home health care. Most discharge planners, whatever their position or title in the health care team, will tell you that their job is much larger than most people realize and that it changes every day. It is seldom the same and is constantly evolving. This paper looks strictly at the discharge planning component of what may very well be a much larger responsibility.

One example might be Mrs. R., who is admitted to the hospital with a diagnosis of a fractured right hip. She is a 68-year-old widow who lives alone in a small upstairs apartment. The admitting nurse is the first to document a discharge planning problem because she can tell that Mrs. R. will not be able to return to her prior living arrangement immediately after discharge from the acute care hospital. Other members of the health care team (such as dietitians, pharmacists, physical therapists, social workers, and chaplains) will address issues involved in Mrs. R.'s plan, but the discharge planner will coordinate and facilitate the plan.

## **Chapter Two**

### **The Role of the Discharge Planner**

The role of the discharge planner varies from hospital to hospital, but there are certain commonalities. Here we will discuss the requirements for the position and what the work entails.

First of all, it must be understood that the discharge planner is not the only person in the hospital who is involved in the discharge plan. The JCAHO manual mentions discharge planning in all sections involving patient care: nursing, physical therapy, occupational therapy, speech therapy, and utilization review. The patient's discharge plan is a hospitalwide plan involving the patient, his or her family, the physician, the pharmacist, the nurse, the dietitian, the social worker, and on and on. It is usually the role of the discharge planner to initiate, coordinate, and facilitate these efforts.

At some hospitals, discharge planning is carried out by social workers as part of the social services department. In other hospitals, it is combined with the utilization review function. Variations have occurred in the background and role of the discharge planner, and in many cases the position has evolved from other roles in the hospital.

In some instances, a social worker saw a need for someone to coordinate care and took on that added responsibility. At other hospitals, a utilization review nurse with an interest in moving his or her patients quickly began encouraging the nursing staff toward discharge planning activities. At very few places did someone actually invent the role and decide on a job description without having a specific person in mind.

Many configurations of staff have been successful in different hospitals. In some small hospitals, there is a part-time social worker who supplements the work of a nurse who is provided by a home health agency as liaison nurse. In other facilities, social workers do strictly psychosocial counseling while nurses work as discharge planners with the assistance of the home health liaison nurses.

Because of the wide variations in hospital configurations, the various department titles may be:

- \* Discharge planning department
- \* Continuity of care department
- \* Clinical social work department
- \* Social services
- \* Patient management services

- \* Case management department
- \* Patient resources department
- \* Patient and family services
- \* Utilization management services
- \* Resource management department
- \* Variations in titles used by the staff may be:
- \* Clinical social worker
- \* Discharge planning nurse
- \* Continuity of care coordinator
- \* Home care coordinator
- \* Resource management coordinator
- \* Case manager

It is important when applying for a position in discharge planning to discuss which department has the responsibility for discharge planning. Is the department a part of the nursing department, finance, social work, or some other department? This will give you an idea of the focus of interest.

There are also several commonalities in the role of the discharge planner. To put it simply, the discharge planner assesses the patient for needs that may require assistance after discharge and arranges for those needs to be met. Discharge planning requires a person who is skilled in accurate assessment, is very well-organized, has good communication skills, and is aware of community resources. Some discharge planners also feel it helps to be part detective, as well.

### *Admission screening*

An initial screen is usually used to help with identification of patients who may need the services of the department. There are variations from hospital to hospital, but the following are some of the screens commonly used:

- \* Over 65 years of age and lives alone
- \* Developmentally disabled, regardless of age
- \* Suspected abuse or neglect
- \* Admitted from a nursing home, residential care home, or specialty hospital
- \* No known address or residence outside the area
- \* No insurance/unemployed
- \* Readmissions within 30 days
- \* Attempted suicide
- \* Diagnosis consistent with chemical dependency
- \* No identification (John Doe)
- \* Lack of support system (no significant other listed)
- \* Victim of violent crime
- \* Diagnosis of catastrophic illness or injury
- \* Multiple trauma
- \* Chronic disease or other diagnosis with long-term requirements
- \* Patient currently receiving home care or hospice services

These admission criteria will certainly not identify every patient that needs to be seen by discharge planning. And, conversely, every patient that fits these criteria does not need the services of a discharge planner. This does, however, give the discharge planner a way of prioritizing work. In addition, referrals are made by floor nurse, physicians, and other hospital staff.

It may seem apparent that an 80-year-old man who has no family listed on the face sheet and a diagnosis of CVA will need post-hospital care. It may also seem apparent that a 30-year-old woman admitted with a fractured ankle who has a job and husband listed would not need any services. The exact opposite may be the case. It is possible that the man suffered only a TIA, has no residual problems, and can return home, where he has live-in help to care for his needs. It is also possible that the woman with the broken ankle lives in an upstairs apartment with a husband who travels out-of-state most every day while she cares for their handicapped child. The job that is listed for her may be her one-day-a-week respite from her home responsibilities. This woman is much more in need of help than the man.

### *Assessment*

After the admission screen has identified a patient or a referral has been received, the discharge planner enters into the most crucial part of the discharge planning process: the assessment. An accurate assessment can save you time and energy. The assessment has many components, which include such considerations as functional ability, support system, financial position, and mental state.

The assessment begins with a medical record review, a patient interview, and family involvement. Only after these have been completed can efforts be made to properly help the patient with post-hospital continuity of care.

The medical record is a good starting point for assessing the patient. Here you can read the history and physical exam, emergency room report, physician progress notes, nurses' admission assessment, laboratory and radiology reports, and notes from physical therapy, respiratory therapy, the dietitian, and the pharmacist. You can begin to form a picture of the patient's abilities and disabilities and better see what needs exist.

Going to the patient's room for the interview is often the most enjoyable part of the day. I introduce myself and say that I am a nurse in the discharge planning department. I then add that I visit all patients early in their hospital stay to see how they were managing at home so that any extra help needed after discharge can be arranged. Although I say this slowly and clearly so that it can be easily understood, there are some patients who hear only that I said "discharge planning." They are then either ecstatic because they think I am there to send them home or they are angry for the same reason. In this interview, I have certain topics that I cover in an attempt to picture the home situation. Some of these are:

#### *Mental state*

Does the patient seem confused? Does the patient avoid answering simple questions? Does he or she follow instructions? Does he or she seem angry at or fearful of family members?

#### *Housing*

Does the patient live in a house, apartment, condo, farm, board and care facility, or senior citizens housing? Is the home one story or are there stairs? How close is the bathroom to the bedroom? Does the patient share a bedroom with others? Who is responsible for laundry, meals, and shopping?

## *Education*

Will the patient or caregiver need to learn diet, diabetic teaching, crutch training, or other therapy? Does the patient seem anxious about or interested in learning? Does the patient seem able to learn these skills?

## *Equipment*

Does the patient express a need for equipment in the home? Is the bed at home adequate for current needs? Has he or she previously had equipment in the home?

After talking to the patient, I should have an idea of how well he or she has been functioning in the current arrangement. I should know what help has been necessary and what changes may now be indicated by the patient's illness. If possible, I also try to see the patient walk and check the skin condition.

At this point, I contact the family or neighbor to verify the information that has been given. It is not uncommon, particularly among the elderly, to exaggerate the positive when describing the home situation. Many of the elderly are justifiably frightened by the prospect of losing their independence and being sent to a nursing home. They are fearful that if they are perceived as being unable to meet their basic ADL needs, they will be moved. Although they may indicate they are able to take care of all aspects of their own care at home, you may be suspicious because they need help just to walk to the bathroom in the hospital. After speaking with family, you may discover that the apartment or mobile home is so compact and well-situated that the patient actually takes very few steps to move from bed to chair to bathroom and indeed does get along just fine on his or her own. On the contrary, you may discover that the home is in disarray, the food in the refrigerator is spoiled, and the patient has fallen frequently. You may also discover that the family or neighbors who have helped the patient before hospitalization are overwhelmed by the demands for care and are unable or unwilling to continue.

Many people may very much desire to help ailing relatives stay in their own home and be independent. But their own health problems, heavy responsibilities in their own home, or an estrangement through the years may prevent their involvement.

Mr. Z. was a friendly, outgoing man who was admitted with severe end-stage COPD. He required continuous oxygen and assistance with medications as well as personal care. When interviewed, he insisted that he was able to stay in his own apartment. After persistent questions about how he would get groceries and prescriptions, he reassured the discharge planner that his daughter would be around daily to help.

The call to the daughter changed things a great deal. She said that her father had abandoned the family when she was small and that her mother, her siblings, and she had struggled terribly with no help from her father. She attributed her mother's early death to her father's abandonment. When he reappeared in town just a year before, she visited him on two brief occasions, but certainly had no interest at all in helping him in any way.

There are also parents who have given up on helping their drug-abusing children. Other parents are unable to face their gay children's lifestyle, even if they are dying of AIDS. Families are complex, and no one can ever assume that people are willing to help their ailing relatives.

For families struggling to deal with long-standing problems and feelings, the social worker can very often be helpful.

## *Problem identification*

After interviewing the patient, reviewing the medical record, and speaking with the patient's significant other, you can begin to identify potential continuity-of-care problems. Some of the questions to consider when formulating the plan are listed below.

- \* Will changes from the current arrangements be necessary?
- \* What does the patient prefer to do?
- \* Does the patient have significant others who will help with post-hospital care?
- \* Is the patient's residence compatible with his or her current problems? Can the patient realistically expect to return to the prehospital situation?
- \* What services can the patient afford? Are his or her financial resources adequate?
- \* Will there be a need for a teaching program after discharge? (diabetes, colostomy, IV antibiotics, etc.)
- \* Is there any indication of abuse or neglect in the current situation?
- \* What community services are available?

One method used with great success to identify potential discharge problems is the multidisciplinary discharge planning conference or rounds. This meeting includes the discharge planner, the social worker, the patient's nurse, the pharmacist, the dietitian, the physical therapist, the respiratory therapist, and in some places, the physician.

It is not uncommon for someone to suggest a problem that the discharge planner had overlooked. This is truly a group effort, and these types of programs are most successful.

## *Developing a plan*

After the patient has been assessed, the medical record has been reviewed, the family has been contacted, and the needs have been identified, it is time to develop a plan. Consideration must be given at this time to any special requirements of the payer. If particular agencies or vendors are specific to that insurance carrier, those are the ones that should be used.

The plan should meet the needs of the patient, include the patient and the family, be completed in a timely manner, and be completed before discharge. It is critical to assess the patient early in the hospitalization and frequently in the stay to allow for changes in condition and needs. Waiting until there is an order on the patient's chart stating something such as "Discharge planner to arrange SNF placement for today" is a total disaster.

I have had discharge planners tell me that they "place" patients in skilled nursing facilities in less than an hour and never have to see the patient. This is not discharge planning at all. This may accomplish a task, but it does not take into consideration the patient as a person with rights, the family, or the discharge planner's professional integrity.

Let's walk through the steps of an actual discharge plan. We will take a typical case, examine possible discharge plans, and see how they could be handled.

Mrs. C. is a 74-year-old retired nurse who is widowed, has three children living locally, and has been admitted to the hospital with a CVA. She has resultant right-sided weakness, aphasia, and dysphagia. Although she has been able to live alone up until this time, it is apparent upon admission that she will not be able to care for her own needs any longer.

After you visit the patient, who was nearly impossible to interview, the next step is to contact the family. A name and local telephone number are listed on the face sheet for a daughter. When you call this number, Angie C. tells you that her mother has been active and independent until now. Angie agrees that plans need to be started and suggests meeting the discharge planner when she and her two brothers visit later in the day.

Meeting with Mrs. C's children is encouraging for the discharge planner. She finds that they are intelligent, caring people who are very interested in doing whatever is best for their mother. The discharge planner then explains the variety of options that may be open to Mrs. C.

It is important for the family to know that although their mother will not be able to stay in the acute hospital until totally recovered, the discharge planner will be following to see how she is progressing and when she might be able to transfer. This is a good time to discuss preferences in rehabilitation facilities if there are several in the area so that initial inquiries can be made. It is also a good time to discuss financial resources.

Mrs. C. has Medicare and a complementary policy that pays the deductible on Medicare, but little else. This may be a time to explore the possibilities of applying for Medicaid with the family. If Mrs. C. eventually goes to a nursing home, this will help with the costs.

Long-term goals can also be discussed early in the patient's stay. It is helpful to at least be the catalyst of conversation among family members about Mrs. C's eventual desire. If she is not able to return home alone again, family members need time to think about their options for Mrs. C. These might be:

- \* Home with the assistance of full-time live-in help
- \* Home with home health care and a part-time caregiver
- \* Skilled nursing facility
- \* A family member's home
- \* Board and care residence
- \* Senior citizens apartments

The main thing this first conference will do is acquaint you with the family, give you an idea of their plans, and help you formulate a plan. It understandably may change several times, but it is a beginning. Now as the patient's needs change, you will know who to contact. It will also help to be aware of where the family lives when considering placement. Document what has transpired at this point and be sure to include:

- \* The patient's diagnosis and current problems
- \* Prior level of functioning
- \* Names and telephone numbers of family members contacted
- \* Names and contacts at any facilities contacted

## Chapter Three Understanding Insurance Plans

Unfortunately, the realities of life exert themselves where discharge planning is concerned. Financial realities can be a boon or a problem, so you need to be aware of the benefits available for your patients.

### *Medicare*

The federal program Medicare has many benefits available for the elderly and disabled, but it is not a panacea that will provide for all of the patient's needs. Understanding how it works can make your life as a discharge planner much simpler.

Medicare came into existence in 1965 as an amendment to the Social Security Act (Title XVIII). It is administered by the Health Care Financing Administration of the U. S. Centers for Medicare and Medicaid Services, or CMS.

Medicare is available to people who meet one of these requirements for enrollment:

1. Age 65 years or older and have paid into Social Security for a predetermined number of quarters
2. Disabled for two years or longer
3. People with permanent kidney failure requiring dialysis or a kidney transplant.

Medicare is not an automatic benefit. Some people mistakenly believe that Medicare automatically begins when a person reaches age 65. The individual must apply for the program, which often takes three months or longer to be effective. It is therefore advisable to encourage patients approaching 65 to visit their Social Security Administration office to apply before their birthday. Keep this in mind when assisting patients who have been disabled for almost two years.

Medicare is a health insurance program, and as such it has inclusions and exclusions, much the same as any health insurance. Its purpose is not to include every possible health expense an individual may incur, but rather to cover most of the costs of a broad group of people at a minimum cost.

There are two parts of Medicare. Since not all patients have both parts, it is important that you understand the difference.

*Hospital insurance (Part A)* helps pay for inpatient hospital care, some care in a skilled nursing facility, home health care, and hospice.

*Medical insurance (Part B)* covers outpatient services at a hospital, physician office, or laboratory, as well as medical supplies and home health care.

Neither part of Medicare is free to the recipient. There are premiums, deductibles, and co-insurance payments. The amount paid changes each year according to congressional guidelines. The increase goes into effect each Jan. 1. Discharge planners can stop by their local Social Security office at the start of each new year to pick up the most recent copy of the Medicare Handbook, which lists all the payments and costs.

Medicare reimburses the hospital for caring for a patient by a method called the prospective payment system (PPS). This refers to a prenegotiated or predetermined flat rate per day of care or a fixed rate

for each type of discharge diagnosis. Medicare's PPS uses DRGs to categorize patients into more than 500 groups. They then pay the hospital a predetermined fee to treat that patient for that diagnosis. If, for example, a patient is admitted to the hospital with urosepsis and the DRG payment for urosepsis is \$3,000, and if the patient could be treated and released prior to using up \$3,000 in services and supplies, the hospital stands to show a profit. But if the patient is in the hospital for a longer period of time and has charges totaling \$12,000, the hospital has suffered a financial loss.

It becomes apparent then that hospitals are interested in getting patients in and out as quickly as possible to maximize the reimbursement. It also is clear why Medicare monitors patient records looking for signs of "premature discharge" to discourage that sort of activity. As discharge planners, we find ourselves walking a fine line, trying to discharge as early as possible while also ensuring that patients are appropriate for discharge.

You may have heard of changes in Medicare caused by the Balanced Budget Act of 1997. This is basically a change that created new HMO types for Medicare recipients. With these plans, a person may select to designate an HMO as his or her managed care carrier. That HMO would then be paying the deductible costs normally paid by a Medicare patient.

Medicare contracts with state or regional professional review organizations to look at the medical record of Medicare patients for documentation of adequate discharge planning. In California, for example, the organization is called Lumetra (formerly California Medical Review Inc. [CMRI]). In the mid-Atlantic states it is Delmarva (Delaware, Maryland, and Virginia).

### *Medicare skilled nursing coverage*

The Medicare program covers care in a skilled nursing facility, and if you call the Medicare office to inquire about this benefit, you will be assured that, indeed, this is included. You must be aware, however, that Medicare pays only up to 100 days and then only if it is necessary for skilled nursing or rehabilitation. Medicare pays for the first 20 days in a skilled nursing facility at a rate that covers all charges, but for days 21 through 100 there is a daily co-insurance fee that is paid by the patient.

Also, "skilled nursing" is a term that means different things to different people. To Medicare, it means such services as rehabilitation, intravenous medications, or extensive wound care each shift by an RN. This level of care can also be called "subacute," but criteria for this vary according to the insurance carrier.

Since the Medicare skilled nursing benefit applies only to patients who meet the criteria and is time-limited, it is somewhat misleading to rely on Medicare to pay for placement for the average patient.

### *Medicaid*

The federal government provides partial funding to states for the provision of health care to low-income residents. The Medicaid (Title XIX) program is administered uniquely in each state. (In California, Medicaid is called Medi-Cal.)

The Medicaid program does not require the recipient to have paid into the Social Security system, as does Medicare. The groups of people who are considered eligible varies from state to state, but usually include the elderly, the totally disabled, and those with minor children in the home.

Although Medicaid is available primarily to those who are low income, some exceptions do exist. If a family has a disabled child, for example, and extraordinarily large medical bills, even though they may

have a good income, they may qualify. They may have to pay a monthly share of the costs before Medicaid pays the remaining amounts.

In 1997, the federal government started a program called State Children's Health Insurance Programs that helps families with too much income for Medicaid and too little for private insurance to receive health care benefits for their children. In California it is called Healthy Families, in New York it is Child Health Plus, and in Iowa it is hawk-i (Healthy and Well Kids in Iowa). For more information about a particular state's program, call (877) KIDS-NOW.

Some states require Medicaid recipients to receive care only at designated hospitals or convalescent homes. Other states have recipients enrolled in managed care plans. Still other states pay for only the barest minimum of emergency care and very little in preventive or nonemergent care. For details on your state's requirements, inquire at the Department of Social Services or speak with a financial counselor or social worker in your hospital.

### *Private insurance*

So many different types of plans are provided in the private insurance industry that it is difficult to describe all the possible variations. A few of the more common are described below, but be aware that before you make arrangements for home health, equipment, or other services, you should contact the insurance company and ask for the specific benefits available to this particular patient. Any one company may have several plans, all with different benefits and deductible amounts, so don't assume that because you have checked benefits for one Blue Cross policy (for example), that you know the benefits for all Blue Cross policies.

The standard, traditional indemnity plan provided by many employers has a payment of approximately 80% of charges, leaving 20% for the patient to pay. Often there is a limit to how much this 20% can reach, such as \$2,500, before the policy pays 100% of the charges. This policy probably also has a lifetime maximum benefit, such as \$500,000. Some of the more common variations in this standard plan include discounts for using certain health care providers, which can then reduce the amount the patient is responsible for paying.

The provider may be an HMO, such as Kaiser Permanente, or a preferred provider organization (PPO) or independent practice association (IPA), which authorize care only from certain groups of physicians or a certain hospital.

Whatever form of private insurance a patient may have, you should establish contact with the company early on so that you are aware of policy provisions and limitations. Most require prior authorization for all services except emergency care. Some have home health care benefits. It is unusual for a private insurance carrier to have a provision to pay for more than a short stay in a skilled nursing facility.

One of the more recent advances in private insurance practice is case managers. They are hired by the insurance company to coordinate the care the patient receives so that he or she gets the best care at the best price and can return to work quickly. They may be able to authorize a service for a patient even if that service is not a benefit of the patient's policy.

For example, a patient may need to have intravenous antibiotic therapy for six weeks to combat osteomyelitis. Because the patient lives alone and has diminished visual abilities, it is not possible for him to receive medication at home. Rather than pay for him to stay in the hospital for the entire six weeks, the case manager may approve a short stay in a skilled nursing facility (SNF), even though

the patient's policy does not have a provision for SNF care. This is the insurance company's way of reducing its costs while providing the patient with needed care.

### *Military health care*

You may have been familiar with CHAMPUS and CHAMPVA as health insurance programs for dependents of military personnel and retired military personnel. That entire system has been changed, and there is now a simpler method, called Tricare, of providing health care to these people.

Tricare is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and their survivors. It combines the health care resources of the Army, Navy, and Air Force with civilian health care in a manner that is similar to a standard nonmilitary health insurance policy.

Three types of health care choices are available for these beneficiaries:

- \* Tricare Prime, where military treatment facilities are the principal source of health care. It offers fewer out-of-pocket costs and is most similar to an HMO plan.
- \* Tricare Extra, a preferred provider-type option.
- \* Tricare Standard, a fee-for-service option similar to the old CHAMPUS program.

### *Veterans Administration*

Many people are under the false impression that any person who has served in the military at any time can get free health care for life at a Veterans Administration hospital. If this were true, it would be easier for discharge planners, but the costs would be prohibitive for taxpayers. Legislation is pending that would require veterans to pay an annual deductible.

In areas where there is a VA hospital, it is not uncommon to see a physician in the community hospital write an order for the discharge planner to transfer a patient to the VA. Usually, this is a patient who needs long-term custodial care, but does not have the funds for this, or even for the acute hospitalization.

Veterans hospitals have as their primary responsibilities the care of veterans already in their hospital, clinics, or elsewhere in the system and of veterans whose illnesses are service-connected. That usually keeps VA hospitals quite full, and there is seldom an opportunity to transfer even an acute patient to them. In the case of the SNF patient, there is usually a waiting list from within the VA hospitals themselves that keep the SNFs filled. Seldom is it advisable to wait for one of these beds.

Overall in the U.S. health care industry there has been a tightening of criteria for expenditures. In all types of health insurance you will see restrictions and limitations applied, as well as authorizations required for nearly everything. As a discharge planner, you can help your patient through this maze by thoroughly understanding what his or her particular insurance allows and working with the insurer to implement the discharge plan.

### *Long-term care insurance*

There are a variety of insurance plans that reimburse policy-holders for the costs of long-term care. Some have been created solely for paying for traditional nursing home care, but most are aimed at allowing clients to remain at home with the assistance of others.

When a policy-holder has an illness or injury requiring the services covered in the policy, the insurance company will have a registered nurse visit the home to make an assessment of the needs and suggest possible services. Services covered are generally those that are not paid for by Medicare or other traditional insurance carriers. This could be anything from personal attendants, housekeepers, or equipment such as grab bars in the bathroom or an elevator for the staircase.

An insurance policy of this type is generally quite pricey and is most often purchased by affluent people who do not have family to help them.

Example: Mrs. G. was a 75-year-old artist living in a spacious three-story house at the beach. She was widowed 20 years ago and has no children. When she was diagnosed with colon cancer, she had two major surgeries, went to a skilled nursing facility for a while, then was sent home. She was weak, had difficulty negotiating the stairs, wasn't eating properly, and had not had her prescriptions refilled. Her attorney remembered that she has a long-term care insurance policy, so he notified the company that Mrs. G. needed help.

The assessing nurse discovered that services had not been supplied even through her Medicare and Blue Cross. Those two policies could help with home physical therapy for strengthening and a bath aid. What the long-term care insurance provided, however, was a lift for the staircase and a companion to help with household chores, getting groceries, and picking up prescriptions. If these services hadn't been paid for, Mrs. G. would likely have ended up in some sort of facility.

### *Workers' compensation*

When an employee is injured at work, the medical costs are usually the responsibility of the employer. Although there are minor differences from state to state, there are more similarities than differences. The laws passed by the states are intended to be fair to the injured worker, the employer, and the health care provider.

If you have a patient in the hospital who is being treated for an accepted workers' comp claim, you need to be in contact with the claims examiner or the nurse case manager to arrange post-hospital care. They will be the ones to authorize equipment or services required to assist the claimant to health and a return to work. It is important to remember that these types of claims do not have specific services that are or are not covered; the rule of necessity is what applies.

## **Chapter Four Identifying Community Resources**

So many types of resources are available to assist your patient that it is impossible to list them all. What will be done instead is to clarify some of the common areas of confusion and encourage you to investigate the resources available in your community. This chapter will be divided into five parts: housing, home health, equipment, transportation, and food.

### *Housing*

Speaking to a patient about his or her prehospital living situation can help you better plan what is going to be feasible at the time of discharge. The interview needs to be thorough without sounding like an inquisition. Following is a list of questions that may be appropriate to consider asking your patient.

1. Do you live in a house or apartment or do you have some other arrangement?

2. Do you have stairs going into the house? Are there stairs inside the house?
3. Do you live alone or with others? How often are you alone?
4. Do you have your own bedroom? Bathroom?
5. Are there laundry facilities on the premises?
6. Who does the housework and prepares the meals?
7. If necessary, are doorways wide enough for a wheelchair, is there a ramp, will hand holds or seat risers be needed in the bathroom?

Now you will have a better idea of how the patient will be able to maneuver around his or her home. Remember, too, that when someone lives other than in their own home, it is possible that there are restrictions on how many people can live in the home.

If the person has been living alone, you may wish to ask who is helping out during this hospitalization. Particularly in the case of an emergency admission, there may be concerns about who is taking in the mail, watering the plants, or looking after pets. If this is a problem, the patient will rest much easier if you can contact someone to assist. There is a larger problem if there is no one to call, but most communities have agencies that will help with these types of chores.

Creative people have invented many more types of living arrangements than I can list here. But you can be aware of some of the more common ones and the differences between them.

### *Senior citizen apartments/assisted living*

One of the first changes a senior citizen or a disabled, nonelderly person may make in his or her living situation is to move into an apartment that is reserved solely for the elderly. Many of these are church or community owned, and they are often referred to as "assisted living."

Typically, the resident has his or her own small apartment. It may or may not include cooking facilities, but senior citizen apartments do offer at least some community meals that provide not only nutrition, but socialization as well.

The general policy for senior citizen apartments is that the patient be ambulatory; some also restrict the use of walkers or canes.

They customarily do not provide any personal care, but some of them do have a nurse on staff to provide emergency care and advise on health concerns that arise.

Often children of the elderly worry that their parents have no one around should they fall or become sick. We have all known patients who were on the floor for hours before help was available. It is comforting for concerned relatives, and for seniors themselves, to know that someone is nearby in an emergency or that they will be missed if not seen regularly, yet they do not have to relinquish their independence.

Senior citizen apartments vary widely in cost, depending on the funding source and the quality and roominess of the apartment. Payment is the responsibility of the tenant, but rent assistance may be available in the community. The social worker may be able to help with applications for these programs.

## *Board and care facilities*

The old-time boarding house has been altered a bit today as board and care facilities gain in popularity. Some places are simply large homes with the bedrooms rented out while others are large facilities built specifically for this purpose.

They offer a room, which may be shared. Meals are served in a common dining room. They also usually have transportation available for physician appointments and shopping. They may have several types of recreational activities going on each day.

Board and care facilities are usually limited to patients who are able to ambulate unassisted and do not include bed patients, although some are licensed for "nonambulatory" residents. Most have nurses available to assist with *medications* and may therefore be appropriate for patients who have difficulty managing medications and diet restrictions.

One variation on the board and care facility is the guest home. Most of these are simply a typical family neighborhood house, but they accommodate perhaps five or six elderly residents. Usually, they will be all female or all male, and these residents often have an early form of Alzheimer's disease or other dementia. They have 24-hour attendants and provide meals, housekeeping, and other basic services in a home-like setting.

Costs of a board and care may be covered by Supplementary Security Income (SSI), which is a cash benefit program for low-income persons 65 or over, blind, or disabled. The facility will accept this payment and leave a small "allowance" for the patient's personal expenses.

Nomenclature varies, but whether called a nursing home, extended care facility, convalescent hospital, convalescent center, or rest home, these facilities provide similar levels of custodial care. New variations are constantly appearing, one of the most recent being residential care centers for Alzheimer's patients.

The main differences in these places involve the types of care provided. Skilled nursing, as defined by Medicare, may include all or part of the beds in a facility. This is the level of care that would encompass intravenous medications, frequent complex wound care, NG tube feedings, or similar procedures that only a licensed nurse can provide. Many provide physical therapy in varying levels. You want to be sure to know whether a SNF has daily in-house physical therapists or whether it has PT aides who ambulate patients under the direction of an outside physical therapist.

Custodial care is the most common service SNFs provide. They are homes for those unable to care for themselves, with meals, medications, and nurses available, whether the patient is ambulatory or bedbound.

It is difficult to be familiar with every SNF, ECF, or nursing home in your area, but it is extremely important that you try. For the most part, the patients that you will send there will be dependent people who are unable to care for themselves. You want to be sure in your own mind that the facility meets an acceptable level of quality.

I like to go unannounced to the SNFs in my immediate area, thus avoiding any special preparations. I want to see it as it is on a typical day. Whenever I visit a SNF whose staff seem reluctant to show me around or have certain areas that they do not want me to see, I become suspicious.

Your personal visit to a facility can tell you a great deal. Try to go at meal time to observe a wider variety of activities. Tour slowly and carefully, asking questions as you go. Tour with your eyes, ears, and nose. Here are some hints on what to examine.

1. Is the current year's license prominently displayed?
2. Are you allowed to see every part of the home/yard?
3. Are rooms clean, odorless, and comfortably warm or cool?
4. Do rooms and bath facilities allow privacy?
5. Are intercom signals convenient to residents in rooms?
6. Is food warm when served, ample, attractive, varied, and adjusted for individual needs? Are residents provided assistance with eating? Are ethnic or religious dietary restrictions honored?
7. Is there fresh water within reach of all bed patients?
8. Are there activities and recreational materials in evidence?
9. Are religious services available to the residents, or is transportation available for residents to attend religious services?
10. Is staff respectful? Are residents treated like adults?
11. Is there evidence that residents are being overmedicated or physically restrained?
12. Are residents dressed, well-groomed, and up and moving?
13. Are fire alarms and sprinklers in evidence?
14. Are there handrails in the corridors and grab bars next to bath, tubs, toilets, and showers?

As mentioned earlier, Medicare may pay for skilled care for a maximum of 100 days. Medicaid will pay for custodial care for its patients, but other costs are borne by the residents and families. The facility will usually require a responsible party, such as a family member, to visit the SNF and sign that he or she will be responsible for providing payment. It is important to know the rates being charged at homes in your area since families will ask you about the charges.

### *Retirement hotels*

Most larger communities have hotels that are advertised as "retirement hotels." They cater to the elderly by providing a room at a reduced monthly rate, and like all hotels will provide maid service for changing linens regularly. Some of them have restaurants, but rarely do they have any cooking facilities other than coffee makers or hot plates residents provide for themselves.

Costs of retirement hotels can vary widely. Some are quite grand and offer more services, others are very inexpensive and can be located in seedy parts of town. This latter group is always a safety concern and often is a "red flag" for possible home health follow-up.

### *Half-way houses*

Group homes or half-way houses are similar to board and care facilities, but are usually designated for a particular group of patients. They may offer specialized services for people who are developmentally disabled, people with mental illness, or recovering alcoholics and drug abusers. Costs for care may be covered by Medicaid or private funding.

### *Battered family shelters*

Most communities have a shelter for the victims of domestic violence. If your patient has suffered spousal abuse and wishes to relocate temporarily to a safe home, she and her children may be eligible for battered family shelters. Unfortunately, often these places are filled, so it is advisable to reserve a space for your patient as soon as you think that she may wish to participate.

The addresses of homes for the battered family are secret, and you will probably not be told where your patient will be going. It is not uncommon for the facility to send a worker to the hospital to transport the patient and her family to the shelter personally. These are generally charitable homes that exist on donations from the public.

Not all victims of domestic violence are women, but by far the majority are. Because of this, shelters are equipped to handle women and children, but there are few, if any, that house men.

### *Missions*

One of the few places available for the homeless are the religious missions in nearly every larger community. They traditionally offer meals and dormitory-style living with showers. It is important to remember, though, that they do not provide any medical care for the patient who needs supervision.

The missions are usually filled early in the day, so it is advisable to call early in the day to reserve a place for your patient. You can always cancel later if the discharge does not materialize. There is no charge for missions, but they often request that the resident attend religious services, which may be objectionable to some patients.

### *Homeless*

The most difficult patient for a discharge planner is one who is homeless, particularly if he or she also needs assistance of some sort, such as dressing changes or diabetic teaching. We tend to think that there must be something we can do for every patient, but not every patient wants our help. Some homeless people are desperately seeking a place to live, but some refuse all attempts to place them in any kind of facility at all. As long as people are not incompetent, they are free to make their own decisions. This is often very hard for a nurse to accept.

Tony G. was a 46-year-old diabetic who lived in his car. Tony received a small check each month, but several years ago decided that if he spent his check on a room, he could never go anywhere or see anything. If he spent his check on his car, he would never be bored. So Tony lived and slept in his car, although this meant that he was unable to ever lie down flat. As a result, he spent most of his days walking or sitting in his car with his feet down and circulation decreasing. Since he had no bathroom facilities, his hygiene was poor, and foot ulcers developed quickly.

Tony would come into the hospital frequently, complaining of foot pain because the ulcers on his feet were deep and extensive. He would be treated with intravenous antibiotics and wound care, but as soon as there was talk of discharge, Tony would disappear. As his feet worsened and osteomyelitis developed, Tony relented and was transferred to a nearby skilled nursing facility. He knew he needed a short course of antibiotic therapy. We were successful only in that Tony just left from the SNF, called a cab, and rode over to the hospital parking lot to pick up his car.

Tony was back soon, and his physician reiterated the warning that his feet would require amputation soon. But Tony was adamant in maintaining his unusual lifestyle.

There are no wonderful solutions for patients like Tony. They try our patience, deplete our creativity, and increase our frustrations. But the truth is that in this country a person who is not judged to be incompetent has the freedom to live in less-than-ideal circumstances if he or she chooses.

### *Adult day care*

When searching for the ideal alternate living situation for your patients, you may want to keep in mind the adult day care centers available in many communities. They are often a solution to the problem of adult children wanting to care for a parent in their home, but needing to work or to get respite. In these instances both goals can be met if the parent can attend an adult day care center. Most are open days only and can care for seniors during normal working hours. The centers customarily provide recreational therapy, physical therapy, meals, and assistance with medications. There is a fee for the service, but it is invaluable to certain families.

### *Home health care*

Home health care workers can today provide nearly any service that can be provided at any other level of care. We are fortunate that a wide range of services and professionals are able to help our patients and their families in their own homes. Most hospitals have a nurse provided by a home health agency working in the hospital to coordinate the care patients need when they return home. These liaison nurses do not refer strictly to their own agencies, but also to the agencies the patient or their insurance carrier request. These liaison nurses are great resources to help you know what services are provided by each agency.

Traditionally, if a patient needed intravenous fluids or medications, that was felt to be criteria for acute hospitalization. This is no longer the case. Those fluids or medications can be given in a skilled nursing facility, or better yet, in the patient's own home. The RN sent to the patient's home will administer the medication and teach the patient or family member how to do it. What a wonderful feeling it is for the patient to achieve this level of independence and how much nicer it is to be able to recuperate at home rather than in a hospital or nursing home.

The same can be said for patients with dressing changes to be done. They can be simple dressings for a patient with limited vision or dexterity, or they may be more extensive dressings. Whatever the scenario, the home health nurse can usually devise a plan of care that encourages rapid healing of the wound while he or she also does teaching for the patient and the family.

"Assessment" of the home is an order that home health nurses frequently see. One situation may involve a patient who seems to understand diet and medications, yet repeatedly requires admission to the hospital with flare-ups of diabetes, congestive heart failure, or asthma. Since lifestyle can so dramatically affect the patient's health, it is important for the physician to have a better idea of what everyday life is like.

During a home assessment, the nurse visits the patient and asks about his or her daily routine. Just being there to see the condition of the home can tell a nurse a great deal. Perhaps there are many steps that the patient failed to mention while in the hospital; perhaps the home is very poorly kept, and the patient is not in a clean environment; perhaps the cupboard is stocked with canned soup high in sodium that the patient eats every meal because it is inexpensive and easy to prepare.

Example: Angela S. was a 13-month old baby who was being frequently readmitted to the hospital with exacerbations of asthma. Her condition was worse with each admission despite extensive teaching given to her teen-age parents. The nurse in pediatrics felt that the child was at the least neglected, at the most abused. She was ready to report this case, but the pediatrician suggested that a home health nurse be sent out for a home assessment first.

The parents were frightened when the nurse arrived, but showed her their small home with pride. The baby had her own room that was pink and lacy and filled with stuffed animals. However, the home was in back of an oil refinery, directly behind a pipe burning off fuel. This thick, black smoke was falling on the house all day and caused soot throughout the neighborhood. Although the house was clean and well cared for, all the stuffed animals in Angela's room were full of dust.

Once the nurse explained to Angela's mother that the smoke and dust were probably exacerbating the baby's condition, she immediately removed the toys. The family moved within the month, and Angela improved immediately. Angela's parents were not neglectful nor abusive; they just were not aware of the danger their immediate environment could be to their baby.

Probably the most common activity of a home health nurse is to provide teaching to patients. The physician orders may read "to monitor blood pressure or cardiovascular status," but in the visit the nurse also does a great deal of teaching about diet, exercise, medication compliance, and related issues. Diabetic teaching is one of the more frequently ordered teaching interventions. The activity level and meal preparation in the hospital are so different from in the home that the patient should be followed for a while to be sure he or she thoroughly understands the many aspects of care.

The types of care provided at home are endless. They range from postpartum mom and baby checks to terminal care for the aged. Other than the RN visit we have just discussed, there are others who may be needed. Some of these are listed below:

- \* Physical therapist-to assist with continuing skills in ambulation, instruction in home traction, strengthening exercises, or safety in the home.
- \* Speech therapist-to continue therapy that may have been started in the hospital after a stroke or an injury.
- \* Occupational therapist-to assist with feeding skills, upper body strength, and dexterity.
- \* Enterostomal therapist-to provide wound or ostomy care as well as to instruct new ostomy patients on the care of their body.
- \* Dietitian-for nutritional assessment and help with meal planning and parenteral nutrition.
- \* Social worker-for counseling as well as assistance with applications for financial assistance or benefits.
- \* Home health aide-for assistance with personal care, such as bathing, laundry, and meals.

Insurance coverage can vary a great deal from policy to policy. Policies usually require the patient to be home-bound before receiving home health, but exceptions are often made, as in the case of a one-time assessment of the home, as was done with Angela.

They also generally pay only for intermittent visits, the type mentioned in this chapter, when a health professional comes into the home for a short time, generally an hour or less, provides a brief service, and leaves. It is extremely rare for a policy to cover longer services, but occasionally when a patient is ventilator dependent, for example, they may allow an eight-hour shift or 24-hour care. Generally, however, if this sort of care is desired, it is the responsibility of the patient to pay privately.

One major exception to this occurs when the insurance company's case manager looks at the case and decides that it would be less costly to pay for nurses at home than to continue hospitalization for months. This is most common for patients seriously injured at work or perhaps in an accident, and the party to blame is paying for the care.

Medicare provides payment for home health care under both parts A and B, but again, the patient must be home-bound. Medicaid may have a home health care benefit, but generally does not provide

for as many visits as Medicare. Private insurances may or may not have home health benefits. If you feel a patient is appropriate for home health care, you should refer it to the home health care liaison nurse, who can then have his or her office check out the coverage on the patient's particular policy.

### *Hospice*

Hospice services are one of the more wonderful services to be provided for a patient. There is sometimes confusion over whether hospice refers to a place or a service. There are a few (very few) places that are actually physical retreats to which the dying patient goes for terminal care and support. More commonly, however, hospice is a service provided by a hospital or home health agency in the patient's home.

The care is multidimensional, serving not only the patient but the family or other caregivers, as well. Teaching is provided, comfort measures are given, psychosocial intervention is provided, and a great deal of warmth is spread about by nurses, social workers, chaplains, and volunteers. Often the volunteers come in to relieve the caregiver while the caregiver runs errands, sleeps, or just gets out of the house for a few hours respite. Unlike regular home health, there is no limit on the number of hours or visits.

There are various requirements for hospice depending on the type of insurance the patient has. If you think a patient may be appropriate for this service, first contact the intake coordinator at the hospice, who will use screening criteria for the insurance involved.

There are other requirements of a hospice patient, however. First, the physician must be willing to document that the patient is expected to live six months or less. This does not mean that if the patient lives seven months, care will end after six. It is just a guideline for the selection of patients.

Secondly, most hospices require a caregiver. Most often, it is family that steps in to care for the patient, either spouse or children. However, the caregiver may be a friend. Whatever the case, there must be someone in the home for the majority of each day for the patient to be eligible for hospice. The hospice workers are there to help with care, but their purpose is not to provide the basic care themselves.

### *Equipment*

Nearly any piece of equipment from a hospital can be rented to a patient for use at home. Patients and families can always pay privately for items not covered by their insurance. Often churches, synagogues, and community organizations have a supply of donated health care equipment that they loan to members. Be sure to tell the patient or family about this if they seem to have a problem paying for health care equipment. Part of the job of a discharge planner is to try to get an accurate picture of the home situation to help in planning for possible equipment needs. Insurance companies vary on what they will pay for equipment, but the most standard rule is that they require medical justification and a prescription from the physician before they will pay. In addition, there may be special criteria for certain items (like oxygen or special mattresses.)

Listed below is some of the equipment most often used:

#### *Hospital bed*

If the patient does not have a solid bed or his or her own bed and will be spending all or part of each day there, a hospital bed may be helpful. Keep in mind such beds are large and take up more room

than an average bed, so not every home can accommodate one. They come with electric control, crank controls, or mixed. They can have side rails added if needed for safety or help in turning. They can also have a trapeze or traction attached as is necessary. Special air flotation beds are also available to prevent pressure sores on patients with delicate skin.

### *Overbed table*

Many families find it helpful to have an overbed table to use while helping the patient eat or bathe or just to have a place for books to rest.

### *Bedside commode*

Some of the nicest homes have a major problem: The rooms are so large that the distance to the bathroom is too great for the patient to negotiate. A bedside commode can help a weak patient who finds a walk to the bathroom difficult.

### *Wheelchairs*

There are all types and styles of wheelchairs, so it is important to determine very specifically how a wheelchair will be used before ordering one from an equipment company. If the patient is permanently and significantly disabled, he or she will most likely want to purchase a wheelchair for excursions out of the home. Very often the wheelchair is so bulky and cumbersome that it is not that helpful around the house, although some patients who live in large houses may feel they would like one. Wheelchairs come plain or electric, with removable sides and arm rests, with adjustable and removable foot rests, with high backs for help with head control, and in different sizes to accommodate doorways and people of different sizes. A wheelchair for a 6-foot-3-inch man weighing 300 pounds would be larger and sturdier than one for a 5-foot woman weighing 100 pounds. Be prepared to supply the patient's height and weight when ordering. You may wish to consult with the physical therapist for recommendations.

### *Mobility assistive devices (MADs)*

Sometimes called power scooters, these chairs do not require someone to push them, but rather allow the patient to be independent. You have probably seen the ads on television showing people able to move about their homes and communities. One type is available in grocery stores for use while shopping. Some are covered by insurance, depending upon the patient's diagnosis. Contacting the companies directly will be helpful since they are well-informed about insurance protocol for their MADs.

### *Walkers*

These very common pieces of equipment are often issued to the patient in the hospital. They come in different models and sizes with or without wheels. Customarily, the physical therapist will give a lesson in the safe use of the walker before the patient is discharged from the hospital.

Other equipment that can be rented includes suction machines, IV poles and pumps, and apnea monitors. If your patient needs specific equipment, you should discuss it with your suppliers, because chances are it will be available.

## *Oxygen*

If your patient requires oxygen in the hospital, you should ask whether it was required at home prior to this hospitalization and whether the physician feels it will be necessary when the patient is discharged.

You should be familiar with the different types of oxygen used. (If you are not, speak with a respiratory therapist or an oxygen supplier. Suppliers often give literature describing the types of oxygen available.) In the hospital, most oxygen is in the wall, but unfortunately most people do not have such amenities at home. Some of the forms you may see are:

Cylinders: Large green metal tanks that contain oxygen have been around a long time, and most people are familiar with them. Cylinders are bulky and not that attractive, plus they have to be replaced as they are used up. They are often used as back-up for electrically run systems, in case of a power failure. Smaller "E" tank cylinders are often loaded onto a wheeled carrier for patients to use when walking, shopping, or driving.

Concentrator: One of the most popular forms of oxygen therapy is the concentrator. This machine, which often looks like an end table with dials, is electrically run. It takes room air and processes it to become oxygen. Some of these machines are quite noisy.

*Liquid oxygen*: This system is preferred by many patients because they can fill a small portable tank from the larger one, thus allowing them more freedom out of the home.

Most oxygen suppliers also rent ventilators, handheld nebulizers, IPPB machines, and other similar respiratory equipment. Most insurances pay quite well, but they do vary. Most, if not all, however, require verification of need by arterial blood gas readings. It is advisable to have the ABGs drawn after the patient has been ambulating because that is generally when they desaturate and are a truer measure of home oxygen requirements.

NOTE: If the patient requires continuous oxygen in the hospital and at home, arrange for oxygen to use during the trip home from the hospital.

## *Transportation*

When transportation is considered, think not only about how the patient will get home from the hospital. Also consider the patient's requiring transfer to another acute care hospital or transportation to obtain groceries or keep physician appointments. When making transportation arrangements, it is important to keep in mind why the patient is being transferred. Is it to receive needed but unavailable services, or is it for convenience or insurance carrier preference? Do the physician, patient, family, and payer all agree? What will the patient require during the transfer? (Oxygen? IV fluid?) Who will meet the patient on the other end? Will transportation be required there?

## *Ambulances*

Ambulances usually come to mind first for transportation of the discharged, infirm patient. Generally, this is the preferred method for transfer to another hospital or nursing home, but some patients may need ambulance transport to their own homes at discharge.

Ambulances include regular ambulancez with attendants who transfer the patient but do not render medical care or mobile intensive care unit (MICU) ambulances staffed with an RN who can assist with

breathing needs, IVs, monitoring, and medications. The latter usually requires a longer time to schedule and should be ordered as soon as possible.

### *Vans*

Some hospitals have their own vans for transporting patients, as do some communities. Become familiar with what is available in your community. You should be aware that city vans often have strict borders within which they must remain, which is difficult if the patient, the hospital, and the physician office are in different communities.

There are also restrictions on who may use these vans and when and where they run. Some do not run daily; some run only in certain areas on certain days. Most have a nominal charge, just to cover their expenses, and most require reservations. Many can accommodate a wheelchair, but it is best to ask first to be certain.

### *Private autos*

In some communities, civic, religious, and charitable groups may provide free transportation to the aged and infirm. Group members use their own cars and may provide transportation to the hospital for radiation or chemotherapy treatments, for example, but not for any other reason. Because of insurance concerns, this is not a very widespread service, but check locally.

### *Helicopters*

Acutely ill patients needing to be transferred to another hospital for personal reasons or to receive treatment not available in the sending hospital often go by helicopter. Many of these helicopters are owned by hospitals, but there are some private ones, as well.

### *Air transport*

Occasionally you will encounter a patient who needs to be transferred long distances, and air transport is probably the only resource available. Most often the patient was on vacation when he or she became ill or was injured and now needs to return home.

Several air ambulance services are available. They vary according to the type of aircraft and the number and type of staff. You will need to ask a number of questions of any air ambulance before you consider using the service.

Air ambulance services are extremely expensive, but they do have a couple of cost-savers that you should be aware of when talking with a family. First of all, most planes are large enough to accommodate one or more family members accompanying the patient. This will save family members air fare home on a commercial plane. Also, the plane charges the patient for fuel and other expenses, round trip, so if you can coordinate the patient with another patient going the other way, they can share costs. Be sure to ask the air ambulance agent about this possibility.

Most insurances, including Medicare and Medicaid, will pay for standard or critical care transport (also called mobile intensive care unit) ambulance charges when necessary and when prescribed by the physician. Be sure you have a physician order before the patient is discharged.

As with all patient transfers, it is important to consider what needs to be arranged at the destination. Will an ambulance need to be waiting? Or will other transportation be provided? Will oxygen be

required? Who will meet the patient? Is there a physician to accept care of the patient upon arrival? If the patient is going to a hospital, is the name, address, telephone number, and contact person provided for the air transport staff?

### *Taxis*

Most hospitals will provide a free taxi voucher to patients needing a ride home who have no other means of transportation. Each hospital varies in its requirements; check your own policy manual for specifics.

### *Food*

Obtaining and preparing food is often a problem for patients who live alone. They may be able to handle the other aspects of their care, but getting out to shop is just too much for them. Other patients may just not have the money to buy enough food for their needs. There are programs that can assist these people, and you can be helpful, as well.

### *Meals on Wheels*

Meals on Wheels is a well-known program available in many communities, sometimes under another name. The programs usually provide a well-balanced, hot noon meal and a smaller, cold meal that can be refrigerated and taken out at dinner time.

Many patients are pleased with the Meals on Wheels program, some of them just for the chance to have a visitor each day. There is often a waiting list for the service, so you may have to find another resource to fill the gap until Meals on Wheels begins. Remember, too, that in most communities meals are provided Monday through Friday only and not on weekends or holidays. There is usually a small fee for the service.

### *Food stamps*

Low-income patients are probably eligible for food stamps. They can apply for them at the Department of Social Services at the same time they are applying for Medicaid. The "stamps" are actually coupons the size of paper money that can be used as cash when buying food at the market. Some areas are using a plastic card similar to a gift card instead of the traditional coupons.

### *Grocery delivery services*

Some supermarkets deliver groceries to the home for a small charge. There are also some privately owned errand services that will do the same thing. Take note of computer-accessed "Web grocers" operating in your area.

### *Food banks*

Communities, churches, and other charitable organizations often have food banks or pantries open to those in need of canned or packaged foodstuffs. The food is donated by the members of the group. There may be restrictions on the recipients, such as location of residency for city-owned food banks.

## *Missions, kitchens*

There are more missions and charitable "kitchens" open to feed the poor than there were a few years ago. As we have become aware of the large numbers of hungry people in our midst, groups have sprung up to help meet this need. The food is cooked and served up as a meal in most of these places, but a few also give out groceries to take home. You should be aware of what is available in your community and keep those names, addresses, and telephone numbers handy to share with your patients.

Throughout this chapter, I have referred to services that are "generally" or "usually" available. That is because the communities vary, yet problems stay the same from town to town and so the solutions are similar. What this means is that you, as discharge planner, must constantly be aware of services and programs that are starting up or closing down. You will find that newspapers have occasional listings of some of these programs, good things to cut out and save. Some other resources that you may not have considered are listed in Chapter 5.

## **Chapter Five Discharge Planning as a Profession**

If a nurse is interested in discharge planning as a profession, there are many aspects he or she may wish to investigate. There are very few training programs, but reading, attending workshops, and looking for places where there might be on-the-job training are all good starting points.

Discharge planning is not a distinct profession with certification as such, but many become case managers. This is a broader role, but it includes a discharge planning component. More information about certification as a case manager is available through the Commission for Case Manager Certification ([www.ccmcertification.org](http://www.ccmcertification.org) or 1835 Rohlwing Road, Suite D, Rolling Meadows, IL 60008).

A discharge planner's most valuable possession is probably the "resource file." The ability to find any needed telephone number, name, or address at any given time greatly eases the daily tasks and leaves more time for patient intervention.

The resource file is most likely not a file at all, but is more apt to be a smaller notebook that can be carried around all day and a large file cabinet filled with much more extensive information.

The smaller notebook contains the telephone numbers and addresses that are used nearly every day. Included are nursing homes, home health agencies, equipment dealers, oxygen companies, physicians, and more. If you use a PDA or laptop computer for storing this information, you need to be aware that HIPAA (Health Insurance Portability and Accountability Act of 1996) says you cannot have information that would reveal patient identities or health-related information. If you have information that is protected under this privacy law, you must use encryption to prevent theft or misdirection.

However, you also will receive many brochures, fliers, and packets from the agencies with which you deal. You can't carry all of this around with you, but it is nice to be able to give appropriate reading materials to a patient or family members. Nursing homes, for example, will often give you large color brochures of their facilities. People like handouts since this helps them remember facilities' features as they decide where to send a loved one.

Consider the case of Mrs. L., a 92-year-old registered nurse who prided herself on being able to live alone. Years before she had asked her two daughters to promise her they would never place her in a

nursing home. When I met her, she had suffered burns of both lower extremities from hot coffee that she had spilled. She needed help for a few weeks while she required dressing changes and intravenous antibiotics. The physician requested that arrangements be made for short-term care at a subacute facility. The daughters agreed on one especially nice facility, but Mrs. L. was adamant. One daughter was particularly wise when she opened the color brochure to show her mother a beautiful photo of the rose garden at the facility they had chosen. Mrs. L. loved roses, and that was all it took to help her feel she would be willing to go "just for a little while."

Some discharge planners take snapshots of the most popular transfer sites in their area and mount them in a photo album to show patients and families.

Family members usually look for a facility within a certain driving distance from their home so that they can visit more frequently. This is not always near the patient's home or near the hospital where the patient is being treated. Therefore, most discharge planners like to have lists of nursing homes in several different areas, divided up by location.

For example, I work in the Los Angeles area, so I have sheets with such headings as Fairfax, West Los Angeles, and Santa Monica; Hollywood, Gardena, Long Beach, Lakewood/Bellflower; and South Bay/San Pedro. Each list specifies the geographical boundaries of the area, giving the facility by name, with address and telephone number included. (I also have a small disclaimer printed on the bottom that states that this a geographical list only and does not constitute endorsement by the hospital.)

When searching for possible assistance for your patient, it is often necessary to be quite creative as well as being a detective. You must also be a bit of a pack rat and have stored the name and number of all sorts of possible resources. There will come a day when it all comes together for you, and you will be glad of it.

Listed below are some resources that may not be familiar to you, yet are great sources of help in the proper situation.

### *AIDS services*

Patients with AIDS often have a great deal of difficulty obtaining health care and other services. There are several programs available to help these patients, and you should know the ones in your area.

In the Los Angeles area, we have the AIDS Project Los Angeles, which helps with counseling, groceries, and other day-to-day practical needs of the AIDS patient. Other communities have similar programs.

### *The American Red Cross*

If your patient has been the victim of a disaster, whether large or small, he or she may be eligible for aid from the Red Cross for food, housing, medications, and other needs. The Red Cross helps when there has been a fire, tornado, earthquake, plane crash, or any number of other disasters. If in doubt whether the Red Cross can help your patient, contact your local branch.

## *Unions, professional organizations*

When seeking financial or other assistance for patients, it may prove helpful to discuss their occupations, interests and clubs, lodges, and similar groups. It is not uncommon for such groups to help their members or former members as part of their charitable activities. Some examples are:

\* **Motion Picture and Television Hospital**, 23388 Mulholland Drive, Woodland Hills, CA 91364, (818) 876-1888, [www.mptvfund.org](http://www.mptvfund.org). It provides acute and long-term care for union and nonunion workers in any aspect of the entertainment industry. The hospital also will accept the spouse/partner, parents, and in-laws.

\* **Nurses House Inc.**, Driscoll Center for Nursing, 2113 Western Ave., Suite 2, Guilderland, NY 12084-9559, (518) 456-7858. This organization will provide guidance and temporary financial assistance to RNs who are ill or unemployed and not able to meet their living expenses.

\* **Baseball Assistance Team (BAT)**, 245 Park Ave., 34th Floor, New York, NY 10167, (866) 605-4594, [http://mlb.mlb.com/NASApp/mlb/mlb/official\\_info/community/bat.jsp](http://mlb.mlb.com/NASApp/mlb/mlb/official_info/community/bat.jsp). This group is comprised of professional baseball players who care for the health and financial needs of their brother players. If a patient has ever been a professional ballplayer, this group may help in some way.

There are similar groups for actors, lawyers, Masonic Lodge members, Elks, college fraternities, and other affiliations. Don't overlook these possibilities.

## *Communication skills*

The discharge planner needs several qualities to be successful, but paramount among them is excellent communication skills. Both written and oral communication occurs almost constantly, so it is important that the discharge planner be skilled in each.

The initial assessment may be documented on a separate sheet of paper that will go in the chart. Some hospitals have such a form, others do not. In any case, you will want to address the patient's condition now, the arrangements that were in place before admission, any new functional losses, and needs you have identified. An example might be:

"Discharge Planning Note: Patient seen due to routine screening. He is an 80-year-old patient with a fractured left hip. He is alert and able to tell me that he lived alone prior to admission. He has been able to care for himself, but does have his grandson, John Smith, (213) 333-3333, drive him to the supermarket weekly for shopping. He is aware that he will need some short-term placement for rehab, but would eventually like to be able to return home again. Will verify situation with grandson and check with physician regarding rehab plans."

While working on a case, it is important to continually keep the chart updated on work being done. As in other parts of nursing, "if it is not charted, it wasn't done." This documentation should include whom you have talked to, their relationship to the patient or the agency they represent, their telephone number (if you called), and the results obtained. Some examples might be:

\* Telephone call to Susan at Allied Equipment, (213) 555-5555, who verifies hospital bed to be delivered to patient's home before noon today."

\* Spoke with patient's daughter, Mary Smith, who was visiting her mother this morning. She wishes to look for a SNF in her neighborhood (Torrance). Gave her the Torrance list; she will visit and let me know tomorrow. Her telephone number is (213) 444-4444."

Such notes will let the physician know just how the case is progressing and will give others on the team the necessary follow-up numbers if you are not available when questions arise (such as in the evening or on the weekend).

Interfacility transfer forms are another area in which it is important that your communication skills be excellent. Whenever you transfer a patient to another facility, the form is the lifeline or link from one nurse to another to ensure the best in continuity of care. It is important that this form be completed thoroughly to present all needed information about the patient.

The role of the discharge planner in completing this form will vary from institution to institution. It is best when the nurse caring for the patient, the physician, and the discharge planner all complete their specific sections. Some hospitals ask the discharge planner to do the entire form, but that is probably not best for the patient. The nurse caring for the patient knows him or her the best of all.

Most facilities also request that certain parts of the medical record be photocopied and accompany the patient being transferred. Be sure you ask the receiving hospital for any specifics before the patient is sent.

**Oral communication** is just as important as written. You have probably already surmised that tact is crucial for anyone in the role of discharge planner. You are involved in a patient's life at a time when major, difficult decisions must often be made. It takes a great deal of tact to elicit the proper responses to questions without seeming simply "nosey." It also takes a great deal of tact to encourage families to select a nursing home without seeming pushy, when all the while the utilization review nurse wants you to hurry. Hard questions have to be asked, and it is important that your concern and warmth show through without your seeming so sympathetic that you are not effective.

**Verbal communication** skills are also important when you are working with physicians. There may be an occasion when the physician feels the patient should go to a skilled nursing facility, but the patient and family insist on returning home. You must be able to work as an advocate for the patient, without jeopardizing his or her health and retaining a good working relationship with the physician.

You will also come into contact with a great number of outside facilities and agencies. A good working rapport with them is also vital. There may be a time when you would like them to bend the rules just a bit for your patient, and they will be more likely to do it, just because it was you who asked.

It goes without saying that your relationship with the hospital's nurses must be one of mutual respect. They must know that you are doing the best possible job for their patient, and you must be able to work with them to develop that plan.

## **Chapter Six Accountability**

As in every other part of the health care delivery system, we in discharge planning have to be aware of the problems that occur and work to solve them with the help of an active quality assurance program. Plans do not always work out, people and agencies do not always fulfill the expectations we had for them, and patients do not always follow through the way we would prefer. Negative experiences are opportunities for growth and improvement. If we can record these problems and use them to our benefit, they are not so negative after all.

## *When discharge plans fail*

Occasionally, despite all our hard work and good intentions, a patient is discharged and you feel uncomfortable about the post-hospital care that he or she will receive. Sometimes the best resources are just not available, and sometimes patients refuse the help that they require. What can you do?

First of all, you need to be sure to clearly document in the medical record all your efforts on the patient's behalf. If the patient really needs to go to an outpatient drug rehabilitation program, but you have called every place within a 100-mile radius and there are no openings available, you need to record those efforts in detail in the patient's chart. Be sure to include the name of the facility, its telephone number, your contact person, and his or her response.

Secondly, you need to give the patient options. Let's say Mr. R. has been readmitted to the hospital in congestive heart failure because he has not been following a low-salt diet or taking his medications correctly. He and his wife promise to "be good" from now on, but will not consent to allow home health nurses visit him at home. Again, document his refusal and explore any possible reasons for it. But failing all else, give Mr. R. the telephone number of the home health agency and your telephone number and document that. He then has an opportunity to change his mind later on.

Mrs. F., at 77, lived in her own home with her son, her only living relative. She came to the hospital for a minor surgical procedure. She also had a history of frequent falls that had resulted in her staying in bed most of the day, which in turn had greatly decreased her muscle strength and ambulatory abilities. When she was admitted, her clothing and body were heavily soiled, and her lab work indicated poor nutrition. She had ample personal financial resources and was definitely not mentally incompetent. She did, however, seem in obvious need of either help at home or placement in a facility where she could receive some help. Because Mrs. F. or her son would have to pay privately for this help and they would not do this, the discharge planner was left with a dilemma.

The law provides a partial solution to situations such as this. If we feel that a patient is returning to a situation that is potentially unsafe or could pose a threat, we can call the county office for adult protective services. They will visit the home, and if they find the patient's safety is in jeopardy, they have the legal power to immediately remove the person from the home. This service is available for the elderly as well as other adults who are sufficiently physically or mentally impaired to be unable to remove themselves from a dangerous situation.

If you follow these four steps-provide the patient with options, offer help even after discharge, call adult protective services when necessary, and document your efforts-you will sleep better at night knowing that you did all that anyone could and that you have protected yourself legally against accusations of inadequate discharge planning that could arise later.

## Complaints

Nothing is quite so disheartening to a discharge planner as to hear from family members that they are unhappy with the arrangements made for a patient. Complaints are never welcome, of course, but they help you determine how to continue to improve your work.

The most common complaints are usually about nursing homes. Although many complaints are valid concerns, a certain number are a reflection of guilt and unrealistic expectations. However, all must be discussed, recorded, and investigated.

Adequate preparation for the transfer can often help prevent these problems. When the patient and family all agree that a nursing home is necessary, have visited several, and agreed on one, complaints are less likely. When the move is unexpected and not agreed on by all parties, there are often accusations, blame, and guilt spread about. When this occurs, complaints soar as families try to "prove" their love by defending the patient against everyone else.

Also, no matter how excellent the care may be, no nursing home is like being at home. There is not the individualized attention nor are there the amenities of home. If the patient is in the mood for chicken, but meat loaf is on the menu, no matter how wonderful that meat loaf may be, it is just not as good as chicken would have been.

This does not mean that families don't raise valid concerns. Unfortunately, we have all heard of instances when the care is not optimal and signs of physical abuse are present.

For example, if several families tell me that their loved one is not given adequate water and I see patients from that same facility being admitted to the acute hospital with dehydration, I am going to suspect that the facility does not provide adequate hydration for their patients.

There are several courses of action. First, you need to speak to the administrator or director of nursing at the facility, who needs to be aware a problem has surfaced. If you have a working relationship with a physician who is on staff at the facility or who owns the facility (many are physician-owned), you can also present your concerns to him or her. It is also important to include a report to the long-term ombudsman in your area.

Secondly, if you have a working relationship with a physician who is on staff at that facility or is the owner, as many are physician-owned, you can present your concerns to him or her. Again, the physician does not want a facility with which he or she is connected to get a bad reputation.

Thirdly, you can report your concerns to the long-term care ombudsman in your area. This agency is charged with monitoring the care received in skilled nursing facilities and with ensuring that patient rights are not being violated. The agency will send an investigator to the facility to look for problems. If problems are found, the agency has the power to notify licensing agencies.

Fourth, you can scratch that facility's name from your listing of local SNFs that you give to families. I try never to recommend an SNF, just for this reason. If a patient or family insists a patient be returned to a facility where there are concerns about safety, you can voice your concerns to them, but be sure to be tactful and neutral in what you say. They have a right to choose to return there. Document what you have done, but you may also wish to contact the ombudsman and the Department of Health so monitoring can take place.

Just by doing a careful, thoughtful job of discharge planning, you can avert many complaints before they begin. Communication is always important, but never more so than when considered in the context of complaints.

One complaint heard from families is that they were not informed before their loved one was transferred from one facility to another.

Example: Mrs. J. was a 97-year-old woman admitted from a nursing home with the diagnoses of congestive heart failure, organic brain syndrome, and old CVA. The discharge planner reviewed the medical record and visited the patient, who was not able to respond appropriately. A telephone call was placed to the daughter, Mrs. D. The discharge planner wanted to determine if the daughter was

happy with the care at her mother's facility and if she wanted her to return there upon discharge from the hospital. Mrs. D. was upset by the telephone call because no one from the nursing home had called to tell her that her mother had become ill or had been transferred.

The same problem sometimes occurs in hospitals when a physician writes the order to transfer a patient, someone calls the ambulance, and the order is carried out without the knowledge or participation of the patient or family. These are the events that upset families and hurt the reputations of fine hospitals.

In many respects, the discharge planning department does a great deal of the public relations work of the hospital. Patients and their families appreciate your being considerate and being conscientious about keeping everyone involved, aware, and informed. If you are transferring a patient to a rehabilitation facility, it is helpful for him or her to know what type of clothing to take. Families enjoy "doing something" for the patient and would usually be more than happy to bring in clothes.

You have a patient who refuses to go home once discharged? A conversation may indicate that he or she is afraid to be alone. Having the home health nurse visit for a few days or perhaps even hiring a companion for a day or two will help that patient to feel more secure.

Thoroughly checking the skin condition of a bed-bound patient before transfer will yield documentation and pictures of any skin ulcers so that there are no questions later if a decubitus ulcer develops.

### *Quality assurance*

Since quality assurance activities are required of all departments, the items mentioned in this chapter can be the core of your QA plan for the discharge planner. You are most likely already monitoring problems, identifying trends and patterns, and establishing programs to improve. By simply recording these activities, you can meet your QA requirements, as well.

Quality assurance is the business of a discharge planner. If we are truly trying our best to provide for the best continuity of care, we are working for improved quality of care.

## **Chapter Seven Resource Guide**

The following government and private resources may prove helpful as you work to provide effective discharge planning for your patients.

### **AGING**

- \* American Association of Retired Persons: (888) 687-2277, [www.aarp.org](http://www.aarp.org)
- \* Elder Care Locator: (800) 677-1116, [www.eldercare.gov/Eldercare/Public/Home.asp](http://www.eldercare.gov/Eldercare/Public/Home.asp)
- \* Medicare Hotline: (800) 633-4227, [www.medicare.gov](http://www.medicare.gov)
- \* National Institute on Aging Information Center: (800) 222-2225, [www.nia.nih.gov](http://www.nia.nih.gov)
- \* Social Security Administration: (800) 772-1213, [www.ssa.gov](http://www.ssa.gov)
- \* Medicare Nursing Home Information: (800) 442-2620, [www.medicare.gov/NHCompare/home.asp](http://www.medicare.gov/NHCompare/home.asp)

## AIR TRANSPORT COMPANIES

- \* AeroCare: (800) 823-1911 or [www.aerocare.com](http://www.aerocare.com)
- \* Air Ambulances: (800) 327-1966 or [www.airambulancenetwork.com](http://www.airambulancenetwork.com)
- \* Corporate Angel Network: (914) 328-1313 or (866) 328-1313, [www.corpangelnetwork.org](http://www.corpangelnetwork.org)

## HOSPICE

- \* Children's Hospice International: (800) 242-4453, [www.chionline.org/](http://www.chionline.org/)
- \* Hospice Foundation of America: (800) 854-3402, [www.hospicefoundation.org](http://www.hospicefoundation.org)

## SPECIALIZED HOSPITALS

- \* City of Hope National Medical Center: (866) 434-HOPE or (626) 256-HOPE, [www.cityofhope.org](http://www.cityofhope.org)
- \* Motion Picture and Television Hospital: (818) 876-1888, [www.mptvfund.org/index.htm](http://www.mptvfund.org/index.htm)
- \* Shriner's Hospitals for Crippled Children: (800) 237-5055, [www.shrinershq.org](http://www.shrinershq.org)
- \* St. Jude's Children's Research Hospital: (866) 278-5833, [www.stjude.org](http://www.stjude.org)

## MISCELLANEOUS

- \* Alzheimer's Disease Education and Referral Center: (800) 438-4380
- \* American Cancer Society: (800) ACS-2345, [www.cancer.org](http://www.cancer.org)
- \* American Kidney Fund: (800) 638-8299, [www.akfinc.org](http://www.akfinc.org)
- \* Guide Dog Foundation for the Blind: (800) 548-4337, [www.guidedog.org](http://www.guidedog.org)
- \* National AIDS Hotline: (800) 342-2437, [www.ashastd.org](http://www.ashastd.org)
- \* Ronald McDonald Houses: [www.rmhc.com](http://www.rmhc.com)
- \* State Children's Health Insurance Program: (877) KIDS-NOW
- \* U.S. Department of Labor: [www.dol.gov](http://www.dol.gov)
- \* Veterans Administration: [www.va.gov](http://www.va.gov)

*Brenda Felong, RN, MA, CCM*, is a consultant specializing in discharge planning and case management. She also works as a nurse case manager for a workers compensation carrier. She is a member of state and national associations for case management professionals. (The author has declared no real or perceived conflicts of interest that relate to this educational activity.)