

DISCHARGE PLANNING MODEL



Editor's Summary: In *Discharge Planning Model* a team from The Ottawa Hospital describes an initiative designed to provide safe and timely discharges for hospital patients in transition to the community. Social Work has the lead role in developing and carrying out discharge plans for patients who have complicating factors. Advanced social work skills, a proactive approach and concrete information are combined to effect discharges. The result is safe, timely and effective discharge from hospital to the most appropriate community setting. Discharge plans are achieved within the context of a relationship among the social worker, patient, family and multidisciplinary team.

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Purpose:	<p>The objective of discharge planning is to provide safe and timely discharges for hospital patients in transition to the community. It is a complex process of enabling patients and their caregivers to make the transition from hospital to community.</p> <ul style="list-style-type: none">• Is a quality link between hospitals, community-based services, non-government organizations, families and carers.• Involves assisting patients to return to the community safely with necessary supports in a timely manner.• Facilitates admission to the most appropriate level of care in the community.• Begins prior to admission or as soon after admission as possible.• Prevents readmission to hospital.• Supports the patient and family in the discharge process
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Context:	<p>In Ontario and at The Ottawa Hospital (TOH), the facilitation of hospital discharges occurs within a challenging context.</p> <ul style="list-style-type: none"> • aging population • increasing complexity of patient cases • rapid advances in health care/technology • increasing operational costs • hospital bed pressures • increasing volume of Alternate Level of Care (ALC) patients • need for flow through hospital beds to maintain availability of acute care beds for those who require them <p>In Ottawa the demand for LTCH (Long Term Care Home) beds is higher than the provincial average and:</p> <ul style="list-style-type: none"> • Supply of LTCH beds is aligned with provincial average • Occupancy of LTC home beds is higher than the provincial average • Every LTC home in Ottawa has a waitlist • Champlain LHIN has 2nd longest median waiting time for placement in a LTCH in Ontario
Resources:	<p>New or separate funding was not required as social work staff involved incorporated this initiative into their current work hours.</p>
Source of resource:	<p>New or separate funding was not required as social work staff involved incorporated this initiative to their current work hours.</p>
Population group:	<p>Hospital patients who require complex discharge planning and who are often frail elderly with cognitive illnesses who require residential placement; population also includes patients who require convalescent care or rehab prior to returning home; patients who have psychiatric and behavioral conditions that prevent them from returning to the community; patients who are homeless but who now require a supervised setting; patients who are returning home but need additional supports.</p>
Patient flow entry and end points:	<p>Complex discharge planning begins on admission or prior to admission if the patient is seen in a preadmission clinic. Discharge planning is not complete until the patient has discharged in a safe and timely manner. It is patient centered and is viewed on a continuum from home to palliative care based on patient needs and incorporating the maximum number of patient options available.</p>
Description/ approach:	<p>A collaborative process with the medical team. Patients with routine discharge plans have these led by nursing however Social Work has the lead role in the developing and carrying out of discharge plans for patients with complicating factors. Safe, timely and effective discharge from hospital to the most appropriate community setting is the goal. Discharge plans are achieved within the context of a relationship among the social worker, patient, family and multidisciplinary team.</p>

Tools and tactics:	<p>At TOH, Social Work has the lead role in developing and carrying out discharge plans for patients who have complicating factors. Advanced social work skills, a proactive approach and concrete information are combined to effect discharges. The negative impact of illness affects the social functioning of patients, exacerbates existing problems and affects the patient/family's ability to solve psychosocial problems and Social Workers assist with transitions, work with grief/loss issues, rely on expertise within the multidisciplinary team and liaise with the community to accommodate patient/family need. Use of Social Work knowledge, skill, training and expertise is essential as patients become more and more complex with increasing medical and psychosocial needs. Social Workers are supported by the Discharge Planning Coordinator who acts as consultant to assist in resolving complex discharge plans; reviews ALC issues and supports the necessity of patients accepting transfer to the first available long term care home bed or a reasonable alternate discharge plan.</p> <p>First Available (most appropriate) Bed developed in 1998 to deal equitably with transfers to LTC and CCC. Social Worker discusses the policy with patients/families</p> <p>Written information</p> <ul style="list-style-type: none"> - LTC information package - Letter containing the logos of all Ottawa area acute care hospitals <p>All communication regarding LTC bed offers goes to the patient/family through the hospital Social Worker.</p> <p>In addressing non compliance with this policy, social worker involves the Discharge Planning Coordinator to meet with the patient/family to review the policy and discuss appropriate discharge options.</p> <ul style="list-style-type: none"> • Focus is agreeing on a d/c plan as opposed to choosing a particular destination. • Every effort is made to explore other suitable discharge locations for the patient. • Majority of patients/families who work with the Discharge Planning Coordinator agree to accept the bed offered or pursue other options. • Process is highly labour intensive and requires considerable conflict resolution and negotiating skills. • Complex and advanced Social Work skills are used to achieve agreement.
Measurement approach:	<p>Daily ALC stats, monitoring of discharge plans by the Discharge Planning Coordinator</p> <p>GOALS:</p> <ul style="list-style-type: none"> • Finding the right bed at the right time in the right place • Timely and safe discharges. • Reducing LOS • Avoiding Readmissions <p>SOCIAL WORKER INCORPORATES:</p> <ul style="list-style-type: none"> • Psychosocial Assessment • Patient's Medical Condition and Functional Status • Patient/Family's Wishes • Incapable Patient's Prior Expressed Wishes • Finances • Criteria for Various Destinations/Resources
Impact/ evaluation:	<p>Resolved complex discharges; safe and timely discharges reduce hospital pressures and maintain bed flow so that acute care beds are available when patients require them; discharge planning, if monitored and executed properly, can decrease patient length of stay and reduce the cost of continued medical care. Feedback from patients/families is</p>

	consistently positive regarding social work's role.
Observation/ Discussion:	Need to continue to articulate the benefits of the social work role in discharge planning as we make it look so easy.
Critical success factors/ lessons:	Team of TOH social workers dedicated to safe and timely discharges; Discharge Planning Coordinator role; supportive management; supportive LHIN and CCAC; adequate access to resources; ALC working group comprised of hospital, CCAC and LHIN representatives; orientation of new social workers to this area of practice.
Limiting factors:	Resource development in the community including access to long term care homes for hospital patients; better collaboration with the LHIN on the needs of ALC patients in hospital.