Workers' Comp

# Discharge Planning - A Vital Component for RTW

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## Nicole Usher

**Sr. Director of Operations, Apricus, an Enlyte company**


**Tom Kerr (TK)**: Hospital discharge planning is an integral part of an injured employee's recovery. Whether transferring to a different facility or home, without the appropriate care and support, numerous factors can complicate an injured employee's return to work. To speak more on this, I have Nicole Usher, Sr. Director of Operations, Apricus, here today. Nicole, thanks for joining us.

**Nicole Usher (NU)**: Tom, thank you for having me. I appreciate the opportunity to talk about hospital discharge planning processes.

**TK:** Nicole, hospitals typically have set rules that they follow for discharge, but what could they be missing in that planning process?

**NU:** This is a great question. We often see that at the point of discharge, we really want to do a full 360. So not just what the patient needs immediately, such as medication, it's about transitioning them to their home environment. So, do they need support or assistance, with any type of transfer benches or walking aids? Those

kinds of things allow us to really support the patient in the home after they no longer have the clinical staff there at the hospital to support them.

So, that's one thing that we really do focus on. And after that, it's education. Making sure that the patient understands who they can really rely on or what they need to know and where they can go when they don't have that information after they've been sent home.

**TK:** So, what are some of the problems that occur when an injured employee is released without proper discharge planning?

**NU:** We often see that when someone doesn't have the proper post?discharge support it can, and often does, lead to potential readmissions. It could be additional costs with overnighting supplies or items. And it can increase the patient's anxiety throughout the process, which can lead to unforeseen risk with the patient returning back to the hospital because he or she doesn't know where to get the right supplies or those kinds of things.

So, we do see that when a strong post?discharge plan is not in place, it can put the patient at risk for readmissions or higher cost associated with the care.

**TK:** OK, great. And what are the main things you account for when developing a hospital discharge plan?

**NU:** We really account for not only the patient, but the care team at home, so any of the caregivers, what is really needed, what is their ability to support. So, that could mean having a home health aide if there's not someone who can primarily be there to support over the needed time. If there's special needs that need to be addressed, such as wound care or IV infusion, those are the things that we assess.

Also, any type of equipment that may ease the needs or servicing of the patient at home. So, that could be a wheelchair, that could be a ramp to get in and out of the home for a short period of time or, over the course of a long period, depending on the prognosis for this patient.

So, we look at from something as simple as ensuring they have any supplies that are needed at home, all the way to additional equipment that would make it easier if to transport, such as if they need to get around in a wheelchair. Those are the kind of things that we work with the discharge coordinator and the clinical staff at the hospital to really understand and be ready when we're creating our discharge plan to support post discharge.

As we're establishing the plan of care for our patients, we really want to take into consideration everything from the time that they are leaving the hospital all the way through the post?care plan. That includes any type of home health needs from a clinical standpoint, equipment that would be required either for the patient directly to ease mobility, supporting in the home, as well as home modification grab bars, wheelchair ramps, those kinds of things.

**TK:** And how does cooperative hospital discharge affect an injured employee's return to work?

**NU:** So, Tom, that is a great question. We have found that having a very strong post?discharge plan in place really does increase the overall confidence in the care that the patient is receiving. And we've seen better outcomes such as the patient showing up to post-discharge appointments, maintaining their medications, knowing where to get support when it's required. It overall increases the satisfaction and confidence of the patient and the care that they're receiving. Especially with hospital discharge, there's no one-size-fits-all, but having a very strong post scheduling plan and the support that comes with it allows for quick responses when an issue does arise, really tracking outcome-based successes.

And, if there's something that's deviating from those norms, we're able to engage the clinical staff much quicker following that. So that those post-discharge plans really set us up for success or we can really intervene very quickly with the patient and their care teams if something is going not as planned.

So, it does allow us to really engage with all facets of the care team to really encourage the overall return to work for our patients.

**TK:** Can you give an example of a challenging case that was impacted positively by effective hospital discharge planning?

**NU:** We recently had a patient that was critically injured in a motor vehicle pinning accident. He was hospitalized for a four?and?a?half?month period. But, during that time, as his clinical teams and his case management team were assessing the needs of the patient, it really allowed us to step in and work with the teams as they were identifying items that would be needed at home. We were able to work with the case manager, and that allowed us a head start.

So, really engaging earlier in the process of discharging, even if it's over a prolonged period of time, we can really help identify the potential needs for the patient. When we have that, we can work with the case manager as well as the clinical team to validate those needs. When it is confirmed that this is needed, it allows us to get that in place prior to the patient coming home. In fact, impacting the overall, long?term health of the injured employee.

So, in this specific case, they were going to need a wheelchair, a ramp, bariatric walker. So, a whole host of those standard items that included home health, IV infusion. And then, after the patient was at home, he realized there was a need for additional antibiotics. So quickly, the case manager was able to contact us. So, in that post-discharge plan that we have set in place, the care team knew exactly who to contact so that we could get medication out immediately and increase the home health services. So, having those things in place, this patient didn't need to be readmitted to the hospital to get those needs met. We were able to secure services for this patient without them being readmitted.

We quickly got a new line and set up for IV therapy in the home, preventing the need for the patient to go back to the hospital. And when we can do that, it really does increase, as we said before, the overall confidence in the care that the person is receiving without having to go back to the hospital, without having to contact multiple sources.

It's one point of contact that's embedded with the care team that really makes the difference. And with this patient, we were able to see the benefits of having a very strong discharge plan in place and where to go when things may not go as planned.

**TK:** What's the case manager's role in the discharge planning process?

**NU:** They're a critical part of the discharge planning process. They're typically assigned to an injured employee early on when the need is there, they can assess quickly what is exactly needed. They are in touch with the clinical teams in the hospital to understand the needs to assess the patient as well as the home life.

The case managers get an early view of the support the patient will have in the home and they give us that critical bit of information that allows us to really know who we should be contacting on behalf of this injured employee.

They fill us in on the home dynamics, the clinical components. They've talked with the doctor and understand the outcomes that are needed clinically to achieve successful return to work, so we include them every step of the way. And then, they're also critical in our outcomes, in our successes, by giving us that needed information.

It's pivotal that we have regular open communication to ensure that we're meeting the clinical needs as well as once they've gone home.

**TK:** Thanks, Nicole. And we'll be back with another podcast soon. Until then, thanks for listening




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