Health Neighborhood

February 21, 2018

Discharge Care Transitions

- Family members not educated/in denial - assume person is "ok to go home"
    - Transport home
- Patient was expected to stay at home alone
- Assume patient will be exactly the same as before
- Family want to save a dollar – grandson had "look of terror"
- "whatever mom wants", person was always independent
- Discharge planners don't take time
- Hard to know the patient
- People don't think about things like food
- Patients are sicker, length of stay shorter, insurance dictates, financial (24hrs)
- Branford Hills calls agency to verify care – doctors start and leave
- Family has to take responsibility
- People don't know how insurance works
- Find out patients goal and use that to help better their health
- Patient/family goal may be different from ours
- Use MI – where are they
- Patient is not considered a lot
    - Things set up and leave it – no coordination
- Special packaging meds – nobody to administer, won't pay
- Families not around
- Money comes into play. The more money will be frugal. Fear of running out and no money to leave to children
- What will a home caregiver do?
- Clients will talk to home caregivers and not family. Watch them caring themselves.
- SNFs communicate better – Hospitals not so much
- Families are unrealistic – gap before homecare starts. "services fall from the sky"
- Don't know their homecare agency name and get sent to a new one
- Explaining KHPE program
- Talk about "what if" "worst case scenario" What are your biggest concerns
- Adult children have their own agenda for mom
- Health department looking for ways to educate
- Seeing a change in collaboration – SNFs discharge planners, need it to be done more/better
- Proactive assessment on discharge – VNA assesses before going to assisted living
- Problem with discharge planners in hospital – don't too quick spend time – get hospital to participate

- Call from hospital “he is going” – no discussion – sent to a less ideal facility
- Maybe not enough resources – not making people decisions
- Nobody is looking at the whole picture of the patient
- Senior housing – people have no family, hospital just put her in a taxi
- People from all areas of the system trying to figure it out
- Younger ER doctors called the facility to be sure we’ll take mother back
- Younger doctors willing to be called – give cell phone numbers
- Inside poor communication within the internal system
- Many people can’t advocate for themselves – talks to patient, not family
- CARE act – how it works
- Could we get YNHH here
- HIPPA and releases
- Families don’t want to spend down assets
- Many older people don’t know about programs – many people don’t know
- How to get info out
- Ambassador visits – meetings with SNFs
- SCAAA – gets all from public
- LOS – too short
- Huge lack of information – how to get out
- Things changing – less long term care insurance
- Entitlement mentality – somebody else should take care of it – it’s cultural
- Involve case management service early – who is coordinating?
- Adult children are elderly themselves

To Dos:

- Prep work for the family before discharge
- Information for discharge – send out what to ask
- Invite YNHH Care Coordinator
- Know other resources – community to prep them for future