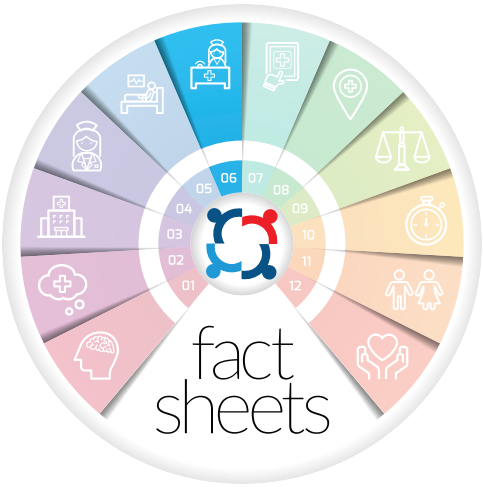
circle OF CARE



06: Hospital Discharge Planning

Introduction

When a mental health crisis occurs, time seems to stand still and yet everything happens in the blink of an eye. The moments from the beginning of a mental health crisis that results in treatment in a health care facility to the discharge can be an extremely isolating time for mental health caregivers. This is true whether the treatment was in an emergency department or involved a stay in a facility.

When it seems as if the person you care for has been sent home too early, it can be even more frustrating. In a recent study, when caregivers were asked about discharge situations, 70% report that when the care recipient went to a facility in crisis they were sent home too early or quickly.[24]

The time following a crisis is one of the most critical times for both the caregiver and their care recipient. How this is handled can make all the difference in the transition from hospital to home. Being fully aware of your choices as well as the challenges, opportunities, and resources is critical and can help to mediate the challenges you may face in your role as caregiver in this situation.

Background: Mental Health Caregivers and Discharge Planning

Knowing what is necessary to support the person you care for needs as they transition from a health care facility to home is the key to success. But, how do you know what support is needed? More importantly, how do you know what programs and services are available in your community? Unfortunately, many mental health caregivers report that services are either not available or hard to locate.[25] Discussions with health care professionals should start early: we suggest starting the discussion about plans for discharge at the time of admission. There are many terms related to what is known as 'discharge planning' and educating yourself is key to advocating for a successful transition for your care recipient. When a care recipient is admitted to the hospital, or spends time in the emergency department, some medical professionals may use terms such as *continuity of care or care transitions*. Both terms refer to the time and the process between preparing to leave a hospital setting and going home. This process should be person-centered and driven by outcomes related to a successful transition for the

[24] National Alliance for Caregiving *On Pins & Needles: Caregivers of Adults with Mental Illness.* (2015)

[25] Ibid.

06: Hospital Discharge Planning

person with the mental health condition and for you as the caregiver. Armed with information and awareness, you can be sure to make this process a smoother transition.

Your Role in Planning for Discharge and Ensuring a Successful Transition

Many individuals experience challenges after being discharged from the hospital. Research suggests that these situations can be avoided or minimized through proper planning.[26] The discharge process requires open communication, knowledge of the health care system, and information related to local services and supports. Most importantly, caregivers should be advocates for themselves and the care recipient.

The Centers for Medicare & Medicaid Services (CMS) suggests considering the following when preparing to leave the hospital:

- ***What's Ahead?***
  - What services and programs are available?
  - Who can help?
- ***Your Care Recipient's Health***
  - How can they help themselves?
  - Activities of daily living
  - Medications
- ***Recovery and Support***
  - Psychiatric rehabilitation programs
  - Support groups
  - Peer counseling
- ***Your Health***
  - Education and training
  - Getting the help and support you need

The Agency for Healthcare Research and Quality (AHRQ) developed a discharge planning overview that provides a roadmap for successful transitions and continuity of care. The elements of a successful discharge planning process are outlined below. It is critical that you are: 1) involved; 2) included in the discussions; and, 3) educated. As the caregiver, you should expect and insist that the following occurs between you, the person you care for, and the discharge planning team:

- ***Include:*** You and the person you care for should be included as full partners in the discharge planning process.
- ***Discuss:*** You and the person you care for should discuss five key areas to prevent problems at home:
  - describe what life at home will be like;
  - review medications;
  - highlight warning signs and problems;
  - explain test results; and
  - make follow-up appointments.
- ***Educate:*** You and the person you care for should learn about the mental health condition, the discharge process, and next steps throughout the hospital stay.

[26] Agency for Healthcare Research and Quality, Guide to Family Engagement (2014).

06: Hospital Discharge Planning

Helpful Websites

Agency for Healthcare Research and Quality (AHRQ) IDEAL Discharge Checklist
www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf

Family Caregiver Alliance
www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers

Mental Health.Gov
www.mentalhealth.gov

National Alliance for Caregiving
www.caregiving.org

National Alliance for Mental Illness
www.nami.org/Find-Support/NAMI-Programs

Your Discharge Planning Checklist (CMS)
www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf