"The Hospital", series "The Small Miseries of War" by Jacques Callot. Courtesy National Gallery of Art, Washington.

Patient Discharge Decision Flowchart: Streamlining Disposition Management after Acute Hospital Stays

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Throughout medical school, you begin to acquire a more comprehensive understanding of the appropriate approaches to patient care in various settings. While you gain expertise in the intricacies of both inpatient care and outpatient care, there is little guidance on bridging the gap between the two for patients who have recently undergone hospitalization. Since every patient has unique functional capacity and rehabilitation requirements, this process can be entirely distinct for each person. Although Case Management and Social Work teams are often responsible for making decisions on rehabilitation needs, it is our responsibility as future physicians to be knowledgeable about the available options and assist in decision-making. To this end, my colleagues and I collaborated with a team of case management specialists to design an educational handout for students, physicians, and patients that outlines and simplifies post-discharge care and rehabilitation options. This project aims to improve awareness of rehabilitation options to ensure a more seamless transition for patients who require continued care of therapies outside of the inpatient settings. We believe that this will enable providers to assist in making better informed decisions on long-term planning and encourage more personalized care.

DISCHARGED FROM HOSPITAL STAY: WHAT COMES NEXT?

A guide to Case Management

01 LONGTERM ACUTE CARE HOSPITAL

For those patients who require complex management but do not require intensive care.

- Physician must supervise care and perform daily examination.[1]
- 24/7 nursing services available.[2]
- Coverage[1,3]
  - Medicare
  - Private insurance
  - Long-term care plans
  - Out-of-pocket payment

Average length of stay: 26.6 days[1]

02 ACUTE REHAB FACILITY

For those patients who require short-term intensive therapies to aid in recovery.[1,2]

- Patient requires therapy from 2 or more disciplines (PT, OT, ST, etc.).[4]
- Patient must be able to tolerate minimum of 3hrs/day 5day/wk of PT/OT/ST.[1,2]
- Nursing care available 24/7 with at least 3 in-person physician visits per week.[1,2]
- Coverage[1,3]
  - Medicare
  - Private insurance

Average length of stay: 13.1 days[1]

03 SKILLED NURSING FACILITY

For those patients who require direct skilled-nursing supervision or therapies that are too complex for the home setting.[5]

- Physician provides initial assessment within 30 days of arrival and is only required to see patient once every 30 days.[2]
- Ongoing nursing care.[2]
- Patient receives 1-2 hours of therapy per day.[2]
- Coverage[1,5]
  - Medicare
  - Private insurance

Average length of stay: 27 days[1]

04 ASSISTED LIVING FACILITY

For those patients who do not require therapy but need help with ADLs.[6]

- Patient must be ambulatory but may need assistance of cane or walker.[6]
- Patient must not require 24/7 skilled nursing care.[6]
- Facilities provide personal care (bathing/dressing), meals, transportation, social/recreational activities.[6]
- Coverage[1,6]
  - Majority out-of-pocket

05 HOME HEALTH CARE

For those patients who are able to maintain some independence but require minimal assistance for ADLs or intermittent nursing care.[7]

- Patient must be home-bound[7]
- May have home health aides, nurse visits, and/or skilled therapist visits[7]
- Coverage[7]
  - Skilled services paid for by Medicare and private insurance
  - Aides typically paid for out-of-pocket

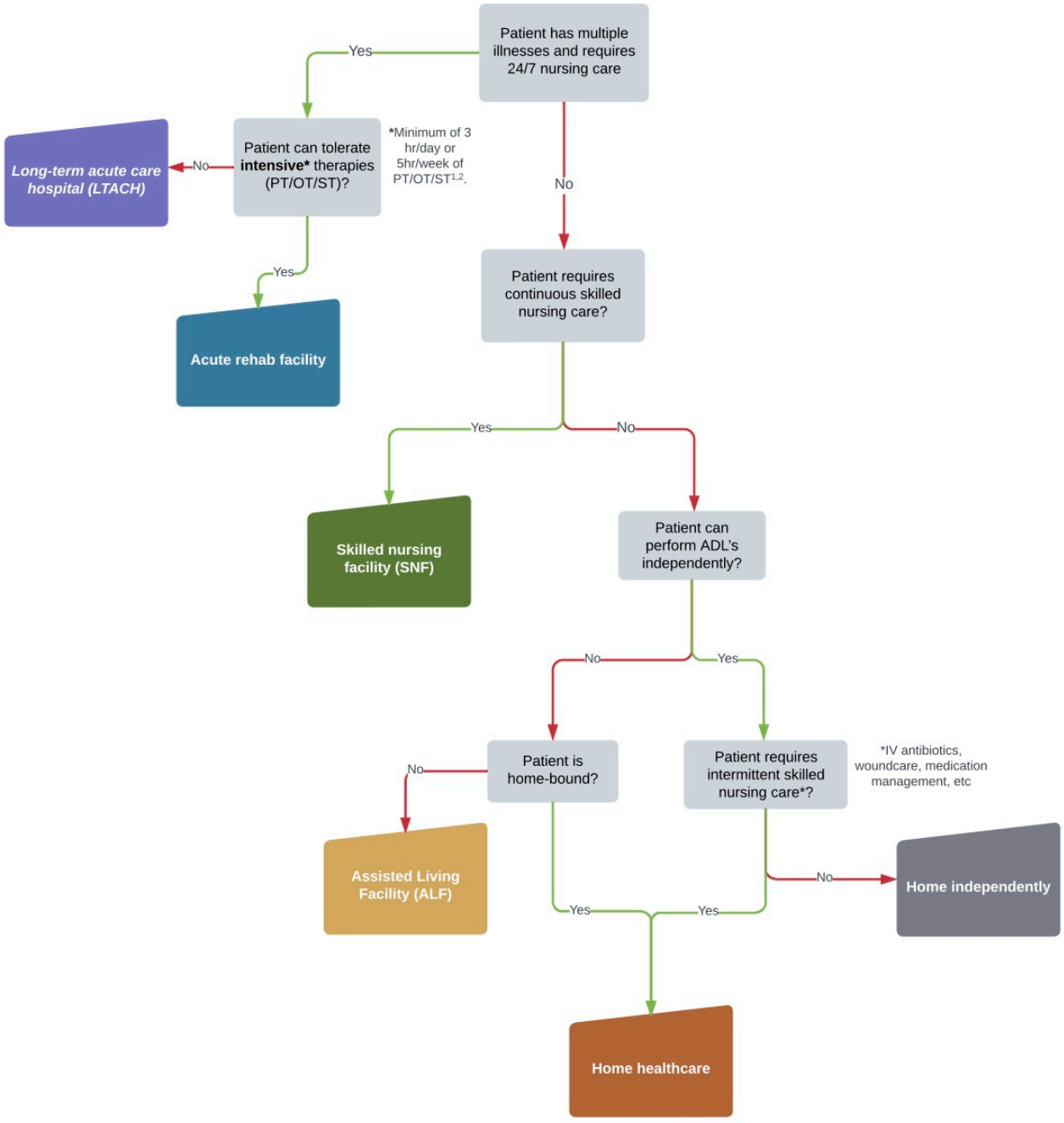
Average length of service: 45-69 days[8]

06 HOME SWEET HOME

If none of the above applies

- Independently returning home to self or with family support
- Managing self-care without additional formal nursing assistance

Rehabilitation Decision Aid: A Simplified Guide for Post-Discharge Care



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