Discharge Planning with Older Adults in Minnesota Hospitals:
Summary of Findings
Charissa K. Eaton, MSW, PhD

This study was supported by a grant from Care Providers of Minnesota.

In 2008, over 200,000 people age 65 and older were discharged from hospitals in Minnesota (Minnesota Hospital Association, 2010). Many seniors leave hospitals with on-going care needs whether they return to home with services or relocate temporarily or permanently to an assisted living, rehabilitation center, or a nursing home. The current literature does not explain how health care professionals assist elders to make decisions for post-hospital care. Indeed, little is known about how hospitals currently conduct the process of discharge planning and who, if anyone is responsible for this task. Most of the research conducted on hospital social work was done over 25 years ago, prior to health maintenance organizations (HMOs), diagnosis related groups (DRGs), and home and community based care (HCBS) initiatives. Thus, the purpose of this research was to describe and explain two related areas in the context of modern day healthcare: hospital discharge planning and decision counseling with older people leaving hospitals. It is important to note that decision counseling is defined as helping “clients to use their own resources for arriving at their own decisions, to make the best possible choice with respect to whichever personal values and objectives they want to maximize” (Janis & Mann, 1982, p. 47).

This research examined the discharge planning process as practiced in all hospitals serving older people in Minnesota. It addressed two research questions: 1) How, if at all, decision-making help for hospitalized seniors is structured and what predicts that structure? and 2) To what extent, do professionals who help with decisions deliberately engage in processes that help elders and their families explore alternatives and reach decisions consistent with their own values, and what predicts whether that process takes place? The data for this study was collected via telephone
interviews with hospital administrators and professionals who work with older adults to determine a discharge plan in Minnesota hospitals.

In Minnesota, 130 acute care hospitals serve persons over age 65. The majority (112) of these hospitals are small hospitals (less than 199 beds) whereas only four are medium sized (200-299 beds) and 14 are large (more than 300 beds). More than half of these hospitals are located in rural areas, critical access designations, are private nonprofit, and are affiliated with a health care system. One hundred twenty-three out of the 130 hospitals chose to participate in the first part of this study.

Despite the commonly held belief that hospitals are downsizing their use of social workers, eighty-one percent of the participating hospitals reported employing social workers in some capacity. Not only are most hospitals in Minnesota employing social workers, but the majority also reported having an actual social work department. Additionally, social workers were primarily responsible for discharge planning in half of the hospitals, nurses in a quarter and either a nurse/social worker team or both nurse and social workers separately in a quarter. Thus, in the majority of Minnesota hospitals, social workers were the profession responsible for discharge planning. However, in some rural hospitals the role of the bedside nurse included the specialized function of the discharge planner.

Multinomial logistic regression identified only one variable, critical access, as a statistically significant predictor for the profession primarily responsible for discharge planning. It was determined that in critical access hospitals, nurses are more likely than social workers to be the profession primarily responsible for discharge planning.
In the second phase of this study, 106 decision counselors from 93 of the 130 hospitals in Minnesota that serve older adults were interviewed. The majority of these decision counselors were female, in her 40s, social workers by profession, with a bachelor's degree. Over half had worked as discharge planners for 10 years or less. Almost all indicated that over half of their caseload is comprised of people 65 years of age and older and was comprised of 20 or less patients on the day of the interview. Over half indicated that their area of responsibility is not a specialized care area which typically in small hospitals consists of a medical, surgical type unit and potentially an emergency department and a clinic. All of the participants except one in this phase of the study were employees of the hospital. Additionally, the majority of decision counselors reported typically using a deliberate approach to decision counseling. The deliberate approach to decision counseling was defined by utilizing a scale created by the researcher based on Janis and Mann’s (1977) decision making framework. Multivariate analysis determined that profession is a statistically significant predictor of the customary use of a deliberate decision counseling approach. This analysis suggests that social workers score higher than nurses on the deliberate decision counseling scale.

During the interviews with the decision counselors, they were asked about their most recent challenging case related to discharge planning. The majority of the clients in these cases were over 70 years of age. The most frequent diagnoses were for cardiac, neurological, and orthopedic issues. Almost all the patients in the challenging cases have Medicare and most had a private insurance supplement. Over half had a length of stay between 1 and 10 days and received between 1 and 10 hours of care from the decision counselor. Overwhelmingly, the decision counselors reported using the items encompassing the decision counseling approach with these patients. Despite these cases being deemed the most challenging regarding decision making for
discharge planning, the majority of the decision counselors reported "good" or "excellent" level of satisfaction in the outcome of the case.

The qualitative findings identify that decision counselors utilize a process for assisting older adults with discharge planning. However, the process is not consistent among decision counselors. Decision counselors vary in how they operate within the medical model specifically related to the characteristics of "the physician as the technically competent expert" and the "minimal standard of the restoration of health". These two characteristics of the medical model are also intertwined with the ethical dilemma between safety and self determination. Some decision counselors function as an extension of the physician's authority. Others oppose the physician's authority, but still maneuver within the medical model to carry out the physician's orders. Still other decision counselors utilize outside systems such as the legal system (the county) in opposing the physician's orders. Additionally, decision counselors often utilize the "minimal standard of the restoration of health" characteristic of the medical model to influence older adults discharge plans. This characteristic involves the health care team including the decision counselor defining what a "good" discharge plan is for the patient. In determining the "good" discharge plan, decision counselors appear to differ in the value that informs the decision, safety or self determination.

References

