What is Discharge Planner Certification?

People dealing with extreme medical circumstances and their loved ones must often visit medical facilities—from hospital to hospital, to different doctor’s offices, care centers, hospices, or nursing homes. Through all this movement, it’s important for a person going through the aging process or as a primary care giver, that patients and their families feel comfortable and understand the means and level of care the patient received during their stay in a facility.

Be sure that facilities have discharge planner certification. It is important that all information involving one’s health care and treatment be made available, so that a patient or their legal representative can have opportunities for further treatment and support. In the case of many disadvantaged individuals, proper discharge planner certification helps prevent against recurring illness, negative side effects, and even helps to prevent homelessness.

Discharge planning is a complex activity that comes at what can be an emotional and busy time for many patients and family members. Approaches to discharge planner certification differ from facility to facility. Sometimes, the discharge must be conducted by a physician or physician’s assistant. Other times, the process is the responsibility of nurses. In others, it is the responsibility of social workers or administrators.
Most facilities use computer systems that provide quantifiable, standardized forms in which the discharge planner describes its contents.

What is Discharge Planner Certification?

Discharge Planner Certification means that a facility is qualified to process and dispense discharge planning. Different states and local jurisdictions have specific qualifications, but generally, end-of-life care facilities must have a discharge planning certification with a process in place that accounts for the prospect of a change in health—that a patient’s condition might change so that they are no longer ill.

The discharge planning certification process includes counseling, educational, and other services, and the receipt of a discharge summary. Generally, this summary includes a description of the patient’s stay (including symptoms, medical procedures, treatments, medication, etc); whether the patient was quarantined, secluded, or physically restrained; changes in medication or treatment; the patient’s plan of care; the patient’s latest physician’s orders; and any other medical information deemed necessary for the patient’s future clinical record. This summary is available to the patient, or to anyone on consent of the patient, including the wishes of a patient’s legal representative.

Why Discharge Planning?

People dealing with extreme medical circumstances and their loved ones visit several different medical facilities, including physical therapy, doctor’s offices, care centers, hospitals, hospices, and nursing homes. As patients move from facility to facility, proper discharge planning is like
passing the baton in a relay race—the patient is able to transfer care from one provider and setting to another. This provides a more unified system of care and leads your medical team to give the patient best care. The best prepared patients have all their information because they recognize that knowledge is power, and the key to successful care is in seamless transitions from one provider to another.

What to Expect in a Discharge Plan

The discharge planning process can be full of information and, at times, confusing. It’s important to know that a patient’s discharge plan and information can be given orally but is always provided in writing. If the patient, their loved ones, or legal representatives feels like any concerns are not met, they should feel comfortable asking their discharge planning certification team for more direct answers.

Bring a paper and pencil or pen with the patient, so that if any questions or concerns arise, the proper answers can be written down for better understanding later. These notes would act in addition with the written discharge planning notice.

The Discharge Planning Notice

The discharge planning notice is a grouping of printed information that includes answers to key concerns regarding a patient’s discharge plan. This important document should include several key components in order to best provide information: the anticipated dates of discharge; clearly outlines processes for challenging a proposed discharge, and should include such factors as where to file a challenge, the review agencies
involved, and any relevant addresses, telephone numbers, and email information.

The written plan should also include:

- Options for where and how a patient should follow up for further care after the discharge
- Plans for recovery process
- Healthcare concerns
- Medication information
- Medical equipment instructions and information
- Literature meant to deal with coping with illnesses and the cost of care.
- While a discharge plan does not necessarily have to follow a particular format, it should be understandable to the patient or their representatives, with clear instructions and concise language. The discharge plan should be in the language which the patient feels most comfortable. It should be known to all relevant caregivers and family members and included in the patient’s medical record. Understanding key concepts about one’s health care directly impacts the level of care they seek in the future.

Remember to take notes and write down any questions so that patients or their legal representatives can seek the information to best represent his or her healthcare needs.

**Reading A Discharge Plan**

The patient should take time to carefully read all the documents in the discharge plan. If the patient is unable to do so, they should have family members, friends, or legal representatives read them out loud.

The oral presentation of the discharge plan should be understandable to the patient and their representatives. If a translator is requested, one should be provided, as to present
best care. This is an important time because, unless follow-up is scheduled, this may be the last instance in which a patient will receive care instructions before returning home.

Take time to write down concerns, and ask questions to any staff members. Treating floor physicians, nurses, social workers, home health care providers, and other care providers should be available to answer any key concerns. These staff members have experience treating the patient and are knowledgeable about the terms of care, any possible side effects, and other treatments. In most cases, the staff will discuss all concerns about care, making sure that the primary directive and opinions of the patient are voiced followed through by law.

At this time, it is recommended that the patient or their representative ensure all questions are asked and fears are assuaged. If medication or treatment is required, make sure all appointments or prescriptions are a part of the discharge information.

**Remember...**

State, federal, and local facilities may be involved with different professional organizations and require standards be met across a wide variety of insurers and government systems. Be sure that the patient or their legal representative feel comfortable with the discharge planner certification and that the process runs as transparently as possible to ensure safe staff and patients.

When moving from one level of care to another, discharge planning is an important and vital process that uses a team of medically-trained professionals to best provide care instructions based on the patient’s past and treatment options, their needs, and future plans for the healthcare process, including plans for future treatment or care. The patient and their family should ask a lot of questions,
letting identify available community resources, and following up to ensure that acceptable services and supports are arranged and that the patient is suited for a healthier future.