What do you believe are the most significant current challenges/problems in relation to safe, efficient and smooth discharge from hospital following a trauma?

COMMUNICATION

- Timing of arranging services/supports
- Communication between all parties—hospital/insurance/rehab company/solicitors
- Communication between service providers
- Poor and/or inconsistent communication with families regarding the inpatient program model of service delivery, discharge process, plan and timeframe
- Fragmented team-providers from different community organizations
- Communication and understanding the limitations of accident benefits
- Hospital staff are not educated regarding private case manager's roles and how we can work together. The huge barrier is also the need for OCF3s and recognizing levels of care.
- Each insurance company, case manager and lawyer seems to do things differently. Some set up services, some don't Some send the disability certificates to the doctors directly, some don't. It makes it difficult to have a streamlined process or to know what to expect.
- Communication between health care workers (also between patient and nurses) and other services involved
- Getting all the stakeholders involved to be on the same page regarding the ultimate or best plan (could include medical team vs. Allied Health; rehab facility vs. private providers; family vs. teams)
- Organization of equipment for safe discharge home
- Could be more communication between hospital staff and private sector workers
- mixed messages from team to patient
- team and patient hearing about the discharge with little notice = little time to organize care
- communication with patient and family – especially when sudden changes occur in a plan of care i.e. when a patient is moved off-service (out of the unit) or repatriated back to a sending hospital with little notice to the current team
- for complex trauma patients – coordination of all medical teams involved in patient's care e.g. orthopaedics, plastic surgery, vascular team and spinal status re: activity status, weight bearing restrictions and follow-up appointments
- communication is key for discharge and not all clients have family meetings. This puts a lot more on the community team and sometimes leads to miscommunication.
- TRI therapists are not able to email. Leaving VM at the OT / PT joint VM is much slower. With timelines as they are this causes more chance of miscommunication or less timely communication. It is more difficult to be proactive and responsive without email and not all staff have pagers.
- hospital is generally not very helpful with finding discharge locations, writing equip memos quickly (as we need it for adjuster approval) but expect us to keep their usually rushed timelines.

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- Lack of communication with the team
- Not forwarding important and necessary documentation to the community providers
- Not able to gain access early enough to meet with client to put together necessary discharge plans.
- issues of where to place client if community discharge site is not ready.
- Access to hospital documents required for completion of OCF forms ie: GCS score
- Access to reviewing charts
- Early communication of discharge dates in order to complete necessary work
- Some patients are hesitant to speak with outside providers; need some assistance from hospital staff to explain the MVA process so patients understand that we are there to help them
- Confusion on role of SWer versus discharge planner
- When client does not go to rehab, community therapists have difficulty accessing doctors once a patient has been discharged and there is a delay in paperwork process.
- Changes to legislation re: signing of treatment plans, we need help from hospital providers to get this step completed; hesitant to get involved.

PAPERWORK

- Completing necessary application/forms to start a claims process (related to MVCs and WSIB claims)
- Follow up from insurance companies with regard to claims being processed
- Getting approvals from insurance agencies for services/equipment to facilitate discharge
- Sometimes there are delays establishing the patient's claim with the insurance company, even when the OCF forms have been submitted promptly
- There can also be a delay by the insurance company in the appointment of an occupational therapist. When the family secures a personal injury lawyer during the patient's acute care stay, this is not a problem. We often want to involve the OT to assist with discharge planning from hospital
- Patients and families haven't made MVC claims in timely fashion or delays in adjusters/lawyers to assign staff (ex. OT) or arrange equipment
- Patients family do not recognize that follow up with hospital (i.e. SW) is essential to ensure that OCFs 3 and 19 are completed long before discharge

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FINANCES

- Financial concerns being addressed, applying for sickness benefits/income replacement benefits
- Financial resources (lack of)
- Cost of equipment and rehab services for patients without accident benefits
- Initial payment of equipment (i.e. if family has no money to pay up front)

CLIENT/FAMILY NEEDS

- Family members need more education re: injuries (i.e. brain injuries)
- The emotional expression of trauma for clients and families makes it incredible anxiety provoking for clients/families to think about managing at home and the community. Related to this is the grief clients/families experience when they realize they are being discharged without reaching 100% recovery
- Patient unclear/overwhelmed with decisions (different players offering differing suggestions)
- Available supervision at home for children post discharge
- Other family members injured in the MVC limits who is there to support the child
- Not anticipating the needs of the child/family with respect to psychological impact of the trauma and how that will affect their activities of daily living upon return to home
- Ensure patient/family is prepared/educated before discharge and has an idea of further course of recovery (i.e. when is expected date for full weight bearing? Will scars form? How will I manage those?)….ensuring they aren't surprised or unprepared
- Sometimes limited insight post ABI which can impact safety
- Patient/family concerns with change in caregivers
- Support for patients after discharge/community support
- Caregiver burnout/stress
- Patient anxiety preventing discharge, feeling "not ready"
- Families nervous about "risks" at home (ABI patients)
- Families feeling overwhelmed at extent of preparations and needs for patients upon discharge home (equipment, appointments, transportation, home care)
- lack of education for patients and families
- patients do not know what comes next and what questions to ask – they have not been down this road before
- lack of a supportive family and/or family conflict impairing progress of a claim
- patient's believe that lawyers are expensive and that large retainers will be necessary before any help can be organized - as a result they do not reach out for this support

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EXTERNAL FACTORS

- That individuals receive proper medication post discharge, as well as equipment needs
- Delays occur when the insurance company takes too much time to approve a home safety assessment and equipment
- Delay in receiving insurance information (for example, if investigation is pending
- Language barrier—funding limited
- Transportation barrier-funding limited
- Timeliness of equipment availability and delivery especially over weekends
- Lawyers chosen by family without PI or AB experience. Causes MUCH more work for social worker and transitional care coordinator due to their lack of experience
- Underserviced areas for rehab services/equipment (i.e. geographically)
- Existing home set up (e.g. basement apartments)
- Pressure re: shorter lengths of stay
- Challenging discharge destination (ex. no fixed address or not able to go back "home")
- Patients who have no places to go and limited support
- metal illness, substance abuse masks cognitive impairment and sometimes are overlooked in critical care environment
- Environmental barriers-need to see client in order to assess for safety at home

ACCESS TO SERVICES/RESOURCES

- Accessing services-can be challenging/difficult to navigate through the system
- Family and patient need more post discharge resources available to them (lots of support in hospital then very little at home)
- Limited resources/supports in the community
- On some occasions, the OT has a differing view from that of the hospital team, regarding the patient's readiness for discharge home. This can cause a delay, as the OT has an influence on the family and he/she may take longer to make the necessary arrangements
- Discharges, or transfers to another acute care facility can be delayed when a case manager has not yet been appointed for patients who have been deemed catastrophic. We often transfer these patients to the community hospital within our catchment area that is closest to their home. The transition is much easier for the receiving hospital, patient, and family, when there is a case manager who can provide additional resources, and support to the family. Sometimes these patients return at a later date to our regional rehab programmes at this site.
- Poor response time from law firms or delay in getting services set up

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- Hospital staff needing to find services for the family when the insurance company or law firm won't (i.e. they say family must find the services, but families are often in no place to do this type of search)
- Non AB patients have less resources all round. This impacts the ability to discharge them safely
- Limited community supports (e.g. CCAC home care hours, housing options)
- Logistics – how patients get home from hospital
- Lack of CCAC resources - wait lists, not enough funding
- Clarification of CCAC vs. third party insurance (MVC or WSIB) – not always clear to hospital, patient and family as to which body will fund patients' needs (not always consistent, either)
- lack of accessible services for families – especially those not covered by MVC insurance
- access to resources > those without MVA don't always have the same opportunities to access community services
- lack of a comprehensive network of support when patients go home to await rehab.

HOSPITAL SPECIFIC/INTERNAL FACTORS

- Lack of clear follow up appointments
- MDs deciding to do more procedures when discharge plans are made
- Having a proper plan for the patient that is explained to the patient clearly by the MD
- MDs not easy to get in touch with to clarify orders and write discharge orders
- Weekend discharges are sometimes incomplete
- Medical information completion in regard to submitting applications and when patient is ready for transfer, often issues
- Continuity of medical care can cause increase in length of stay and lack of medical care on the ward after transfer there from other units
- Pressure to discharge patients may contribute to readmissions
- Unclear plans between Allied Health and MDs
- SW referred early but unable to connect with visiting family due to evening visits
- rush for discharge(organizational push)
- inability to refer to experienced personal injury lawyers and an inability to intercept/refer when patients and families choose law firms that appear to be not coordinating care in a manner sufficient to get results for the patient
- timely rehab availability