Aging and Disability Resource Connections
Options Planning Hospital Discharge Referral Protocols

Purpose

The protocols contained herein guide the process of hospital discharge staff to refer individuals who are in the process of discharging from a hospital stay and could benefit from receiving Options Planning on Long-Term Services and Supports through the Aging and Disability Resource Connections, Division of Adult Services and Aging, Department of Social Services.

Options Planning

A service offered through the Aging and Disability Resource Connections, Division of Adult Services and Aging to provide information and decision support to individuals and their family/friends about the services, supports, and resources that are available to meet their individual long term care needs at home and in the community.

Hospital Discharge Planning

Assisting the individual and his/her family in identifying and coordinating post-discharge care

- identifying healthcare problems to monitor
- understanding medications and listing medications
- managing an individual's illness
- making arrangements for necessary equipment, supplies, services

Cross Training and Information

Training on Options Planning, information and resources on Department of Social Services (DSS) programs and Options Planning/ADRC brochures are available to hospital discharge staff.

***Target Population** Individuals, regardless of income level, age 60 years and older or 18 years and older with a physical disability, who want information and/or assistance following discharge on long-term services and supports.	**Hospital Discharge Staff**	**ASA Specialist**
1. Individual lives alone with no immediate family support (spouse, son, daughter, sibling, or parent) and was admitted for *"observation only"* due to a lack of supports necessary to meet activities of daily living. 2. Individual lives alone with no immediate family support (spouse, son, daughter, sibling, or parent) and has had hospital re-admittance within 30 days due to an inability to successfully manage self-cares independently at home without supports, i.e., bathing, managing medications, wound care. 3. Individual has a need for long-term services and supports that would not be covered by Medicare.	Hospital staff will initiate a referral to ASA providing information per the ADRC referral form. Hospital staff will ask the individual if he/she wants to be contacted by telephone following hospital discharge to learn information on available services and supports (Options Planning) • Inform individual an ADRC/ASA Specialist will contact him/her by telephone within 5 business days following hospital discharge date;	ASA Specialist will telephone the individual within 3 to 5 business days from individual's date of discharge and offer information on available services and supports (Options Planning) • Immediately on the telephone; or • Complete intake screen and follow up as needed.

***Individual is discharging home with an appropriate discharge plan to meet individual care needs. Discharge staff will provide the individual with an Options Planning or ADRC brochure. If the individual contacts the ADRC/ASA, Options Planning and/or assistance to access available services and supports will be provided.**

Target Population Individuals, regardless of income level, age 60 years and older or 18 years and older with a physical disability, in need of information and assistance on long-term services and supports but **do not** want assistance following discharge.	**Hospital Discharge Staff**	**ASA Specialist**
1. Individual is discharging home on Medicare in-home skilled care and does not want continued care but would clearly benefit from continued in-home services when skilled care ends. 2. Individual is discharging and is not expected to follow the hospital's proposed discharge plan. 3. Individual could benefit from in-home services upon discharge but declines.	Hospital staff will provide an Options Planning or ADRC brochure to individual at discharge. Note: Hospital staff will continue to contact ASA for Adult Protection referrals as appropriate to each situation.	When the individual contacts the ADRC/ASA, information on available services and supports (Options Planning) will be provided.

Responsibilities	**Hospital Discharge Staff**	**ASA Specialist**
Release of Information forms	Hospital Consent forms authorize the hospital to release information for the purpose of making a referral on the individual's behalf for continuing care.	When there is a need, ASA will obtain a Release of Information form for the purpose of accessing the individual's health care information.
Communication and Documentation	Complete referral by telephone or fax to the local ADRC/ASA Office. The Options Planning Referral form can be used to share referral information. Note in individual's discharge plan that a referral was made to the ADRC/ASA. Request training on Options Planning, OP/ADRC brochures and DSS/ASA program brochures.	Receive and process referral information. Offer Options Planning training, OP/ADRC brochures, and DSS/ASA program brochures.

Aging and Disability Resource Connections Referral		FAX to ASA: _____ From: _____ Phone: _____
Name:	**Telephone Number(s):**	
Address:	**Individual has been informed that the ADRC/ASA will contact him/her by telephone within 5 business days from hospital discharge:** ☐ **Yes** ☐ **No**	
Date of Birth:	**Physician's Name:**	
Primary Medical Diagnoses:	**Recent hospitalizations or placements and anticipated discharge date (if applicable):**	
Current health problems or issues:		
Services and supports the individual requests or needs:		
Additional information about the individual's situation or care needs:		
Family Contact Information:		

Aging and Disability Resource Connections/Division of Adult Services and Aging/Department of Social Services