Discharge Planning and Care Coordination during the COVID-19 Pandemic

Maintaining Services for Adults with Disabilities Who Live in Community Settings

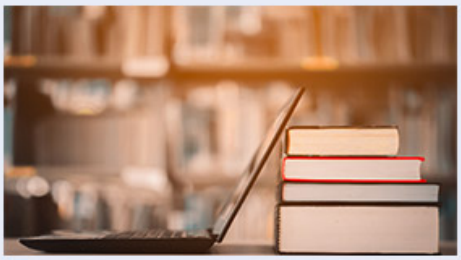
This tool is designed to support nurses, social workers, case managers, and others conducting effective discharge planning and care coordination for adults with disabilities who received care or treatment for COVID-19 illness in an acute care setting, are no longer COVID-19 positive, and require continuation or reconnection to supports and services. While not exhaustive, the resources and considerations proposed in this tool comprise promising practices to be addressed when practicable.

Adults with disabilities who live in community settings often have an established network of long-term supports and services (LTSS), home and community based services (HCBS), and other supportive service programs for independent living. During the COVID-19 pandemic, individuals may become separated from these supports and services if they move to alternate settings for isolation, quarantine, or medical care due to COVID-19 illness (see the journey map for potential paths people may take).

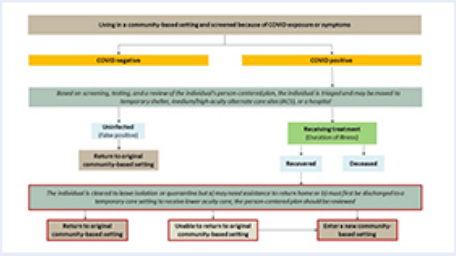
As a nurse, medical social worker, or case manager, you may be responsible for discharge planning of adults with disabilities during the COVID-19 pandemic.[1] This resource will provide you with strategies to consider and resources to leverage for care coordination during the discharge planning process. It also includes a brief summary of the laws protecting individuals with disabilities and related requirements. These strategies can facilitate the reestablishment of needed services upon discharge home, to temporary care settings, such as a nursing home or swing bed hospital, or to new housing.
The resource also includes contact information for connecting to community-based aging and disability network organizations, which may be helpful partners in supporting people with disabilities returning home post-discharge.

This resource provides tips for healthcare providers developing person-centered discharge plans for adults with disabilities who required treatment for COVID-19 illness in acute care settings. These tips include using a suggested framework, as well as an overview of state-level programs, national resource centers, and federal contacts to support discharge planning and care coordination.

Key Terms



Know the Law



Journey Map

CMIST Framework

Person Centered Planning

Returning Home

Temporary Care Settings

New Housing

Additional Resources

[1] An individual with a disability is someone who has a physical or mental impairment that substantially limits one or more major life activities. Note that persons with cognitive, vision, hearing, and speech impairments may have specific communication needs.

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Returning Home

When discharging an adult with a disability from the acute care setting in which they received treatment or were quarantined for COVID-19 illness, implementing the CMIST Framework using person-centered principles can help you facilitate the individual's return home to the most integrated setting of their choice. Examples of promising practices for person-centered discharge planning using the CMIST Framework are outlined in the table below. This is not an exhaustive list of care coordination practices. It is unlikely that every consideration described below will apply to an individual's discharge plan. For individuals with intellectual and developmental disabilities who use decision-making supports, the discharge planning process should include input from their support system.

Communication

The Individual…	Your discharge planning process should…
…has limited English proficiency (LEP)	▸ Provide a translator to facilitate appropriate person-centered planning, either in-person or virtually ▸ Have written materials in multiple languages that convey necessary information in plain language ▹ For additional guidance on addressing LEP, please see Ensuring Language Access and Effective Communication during Response and Recovery: A Checklist for Emergency Responders
…is deaf, hard of hearing, or is unable to fully use verbal speech.	▸ Provide an ASL translator, either in-person or virtually ▸ Have written materials to convey necessary information in plain language or use two-way texting devices ▸ If other auxiliary speech or hearing devices, such as hearing aids, are needed, ensure the individual has access to functioning devices ▹ For assistance obtaining technology, see the State Grant for Assistive Technology (AT) Programs ▸ Acquire specialty PPE (if needed) such as clear face masks to facilitate lip reading
...is blind or vision impaired	▸ Provide written materials in Braille and/or through spoken word

Maintaining Health

The Individual…	Your discharge planning process should…
	▸ If the individual was already receiving HCBS or LTSS prior to admission to the hospital, ensure that they are still able to receive these services in-person when they return

…requires LTSS and/or HCBS	home ▷ If not, can they transition to virtual services, or do they need another form of assistance? ▸ If the individual needs HCBS or LTSS, work to establish those services, either in-person or virtually ▷ For assistance in establishing these services, see the Aging and Disability Resource Centers (ADRCs) / No Wrong Door System, or your established local referral source.
…has one or more chronic conditions	▸ Ensure they have access to appropriate medications or other therapeutics, including DME, as individuals with underlying chronic conditions are at increased risk for severe illness from COVID-19.
…requires nutrition services	▸ Connect them with programs for home-delivered meals and/or groceries. For examples of programs, please see Information on Federal Programs to Sustain Nutrition for At-risk Individuals
…requires infection prevention and control measures	▸ Facilitate access to PPE for both the individual and direct service workers (DSWs; if applicable) to reduce the risk of infection ▸ Provide regular screening for COVID-19, and testing for the individual and DSWs (if appropriate) ▸ If the individual is discharged while still COVID+ follow the CDC Guidance on Disposition of Patients with SARS-CoV-2 Infection

Independence

The Individual…	Your discharge planning process should…
…has a service animal	▸ Ensure the service animal remains with the individual throughout the discharge process and upon returning home. For more information on accommodating service animals, please see Understanding How to Accommodate Service Animals in Healthcare Facilities
…requires DME	▸ Ensure the individual has access to any necessary mobility devices, such as wheelchairs or walkers, and other DME ▷ For an assessment to address functional needs, see the State Grant for Assistive Technology (AT) Programs

Support

The Individual…	Your discharge planning process should…
…has been separated from family or support	▸ The individual may experience increased anxiety or other psychological distress and therefore need additional behavioral health supports that are delivered in an accessible, culturally competent manner

providers due to social distancing requirements	▷ For social programs and technologies, see the Aging and Disability Resource Centers (ADRCs) / No Wrong Door System, or other local coordinating entity.

Transportation

The Individual…	Your discharge planning process should…
…requires transportation services for groceries, prescriptions, medical appointments, etc.	▶ Connect the individual to transportation services that support their independence such as accommodations for DME, mobility devices, or service animals ▷ To connect with transportation services, see the Aging and Disability Resource Centers (ADRCs) / No Wrong Door System, or other local coordinating entity.

<< Previous Page >> **<< Next Page >>**

This page last reviewed: August 27, 2020