Discharge to Community: Safe Transitions to Reduce Hospitalizations

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SKILLED NURSING FACILITIES OFTEN FAIL TO MEET CARE PLANNING AND DISCHARGE PLANNING REQUIREMENTS

OBJECTIVES

1. To determine the extent to which skilled nursing facilities (SNFs) met Medicare requirements for care planning.
2. To determine the extent to which SNFs met Medicare requirements for discharge planning.
3. To describe instances of poor quality care provided by SNFs.
Table 3: Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirements, 2009

<table>
<thead>
<tr>
<th>Discharge Planning Requirement</th>
<th>Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of beneficiary’s stay and status at discharge</td>
<td>16.0%</td>
</tr>
<tr>
<td>Post-discharge plan of care</td>
<td>23.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30.9%</strong></td>
</tr>
</tbody>
</table>


Note: The rows do not sum to the total because some stays did not meet either requirement.
### C-3: Estimates for Stays in Which the Beneficiaries Were Discharged

<table>
<thead>
<tr>
<th>Estimate Characteristic</th>
<th>Sample Size</th>
<th>Point Estimate</th>
<th>95-Percent Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stays in which SNFs did not meet discharge planning requirements</td>
<td>83</td>
<td>30.9%</td>
<td>21.2%–42.6%</td>
</tr>
<tr>
<td>Payment for stays in which SNFs did not meet discharge planning requirements</td>
<td>83</td>
<td>$1.9 billion</td>
<td>$1.1 billion–$2.7 billion</td>
</tr>
<tr>
<td>Stays in which SNFs’ discharge planning did not include summaries of the stays or statuses at discharge</td>
<td>83</td>
<td>16.0%</td>
<td>9.0%–26.9%</td>
</tr>
<tr>
<td>Stays in which SNFs’ discharge planning did not include post-discharge plans of care</td>
<td>83</td>
<td>23.3%</td>
<td>15.0%–34.4%</td>
</tr>
</tbody>
</table>

National Health Expenditures, 1960 to 2009

The Cost of a Long Life

Average Life Expectancy

Per Capita Spending (International Dollars)

Life Expectancy

Per Capita Spending (International Dollars)
Affordable Care Act
Brought to You by:
<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)</td>
<td>Medicare FFS claims</td>
</tr>
<tr>
<td>Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)</td>
<td></td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure</td>
<td></td>
</tr>
</tbody>
</table>
National Quality Strategy and CMS Quality Strategy

• Health and Care that is Person-centered
• Provides incentives for the right outcomes
• Is sustainable
• Emphasizes coordinated care and shared decision-making
• Relies on transparency of Quality and Cost information
CMS Quality Strategy Goals

- Goal 1: Make care safer by reducing harm caused in the delivery of care
- Goal 2: Strengthen person and family engagement as partners in their care
- Goal 3: Promote effective communication and coordination of care
- Goal 4: Promote effective prevention and treatment of chronic disease
- Goal 5: Work with communities to promote best practices of healthy living
- Goal 6: Make care affordable
CMS

• Know the criteria for discharge
  • Expected Length of Stay for condition
  • Expected Discharge Resources- Note
  • Follow up
  • Beginning the process of meeting the patient’s identified pre-and post-discharge needs

• Know the Expected Treatment Course for the condition
  • Well executed discharge planning have NO unavoidable complications, or unrelated illnesses or injuries

• Know Unexpected Outcomes
  • Related Interventions for each negative outcome with education
Bundled Payment Initiatives

- Know the criteria for discharge
  - Expected Length of Stay for condition
  - Expected Discharge Resources
  - Follow up
- Know the Expected Treatment Course for the condition
- Know Unexpected Outcomes
  - Related Interventions for each negative outcome with education
Managed Care Plans

- Know the criteria for discharge
  - Expected Length of Stay for condition
  - Expected Discharge Resources
  - Follow up

- Know the Expected Treatment Course for the condition
  - Interventions to be based on resolving the condition within an expected timeframe without additional complications

- Know Unexpected Outcomes
  - Related Interventions for each negative outcome with education
  - Anticipate and implement interventions for complications resulting from the initial condition
483.21(c) (1) Discharge Planning Process

The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.
Discharge Planning Process must:

- Ensure that the discharge needs of the resident are identified and result in the development of a discharge plan for each resident.
- Include regular re-evaluation of the resident to identify changes that require modification of the discharge plan.
- Involve the Interdisciplinary Team
- Consider caregiver/support person availability, capacity and capability to perform required care
- Involve the resident and resident representative in the development of the plan and inform the resident and resident representative of the final plan.
- Address the resident’s goals of care and treatment preferences
Discharge Planning Section Q

Q0400: Discharge Plan

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Is active discharge planning already occurring for the resident to return to the community?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Skip to Q0600, Referral</td>
</tr>
</tbody>
</table>

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to a resident’s health and quality of life.
- For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There are improved community resources and supports that may benefit these residents and allow them to return to a community setting.
- Being discharged from the nursing home without adequate discharge planning occurring (planning and implementation of a plan before discharge) could result in the resident’s decline and increase the chances for rehospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.
MDS – Section Q
Participation in Assessment and Goal Setting

- Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Q0300- Resident's overall goal established during assessment process

- **Purpose:**
  - Identifies the resident’s general expectations regarding return to the community and goals for nursing home care.
  - Focuses on exploring the resident’s expectations; not whether or not staff or family members consider them to be realistic.
  - Residents may not be aware of their options for discharge and that services and supports may be available in the community to meet long-term care needs.
  - When a resident’s goals for care are not understood, his or her needs, goals, and priorities are not likely to be met.
  - The resident’s goals should be the basis for care planning.
MDS – Section Q0300

- Ask the resident about his/her overall expectations regarding return to the community and goals for care.
- Ask the resident to consider their current health status, expectations regarding improvement or worsening, social supports and opportunities to obtain services in the community.
- Provide the resident with options, as well as access to information that allows them to make the decision.
- Encourage the involvement of family or significant others in the discussion.

Coding
- Expects to be discharged to the community;
- Expects to remain in this facility;
- Expects to be discharged to another facility;
- Unknown/uncertain (resident is uncertain; resident is unable to participate in the discussion and there is no designated representative)
MDS - Section Q0400 & Q0490

- Section Q0400 - Is Active Discharge Planning already occurring for the resident to return to the community?

- Section Q0490 – Does the resident’s clinical record document a request that this question be asked only on comprehensive assessments?
  - This can be asked to the resident/designated representative with your initial MDS and then part of the care plan.
MDS – Section Q0500 – Return to the Community

- Q0500-Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?

- **Purpose**
  - To ensure that all residents have the opportunity to learn about home and community based services and have an opportunity to receive long term services in the least restrictive setting.
  - Identifies the resident’s desire to speak with someone about returning to community living.
Explain to the resident that answering *yes* does not commit the resident to leaving the facility at a specific time, nor does it ensure the resident will be able to return to the community.

Explain that answering *yes* entails making a referral to a local contact agency for further discussion.

Explain to the resident that answering *no* is not a permanent commitment.

Explain to the resident that he or she can change their decision at any time.
When a resident/designated representative responds with a “yes” this will trigger a referral to your designated local contact agency.

- Must be done within 10 business days

- Care plan should be updated to reflect the date, time, referral location and any follow-up.

- New York Association on Independent Living can be contacted at: (518) 465-4650 or at their website, www.ilny.org.
Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

- Directs the Secretary of Health and Human Services to specify quality provisions to submit standardized patient assessment data in several domains including:
  - Resource use measures
    - Including Medicare spending per beneficiary
    - Discharge to community
    - All-condition risk adjusted potentially preventable readmissions
Discharge to Community: Measure Rationale

• Measures outcomes for Short-stay patient/residents with rehabilitation goals including:
  • Optimizing functional improvement
  • Returning to previous baseline of function
  • Avoiding long-term care in a SNF, or another post-acute care setting
Discharge to Community: Measure Rationale

- Returning to Community is an important outcome for:
  - Patients/Residents not expected to have functional improvement
  - Patients/Residents expected to continue with a decline due to their medical condition
Discharge to Community-PAC SNF QRP

- Claims-based outcome measure
  - No unplanned rehospitalizations and no death in the 31 days following discharge from the SNF
Discharge Planning Exclusions

- Under 18 years of age
- No short-term acute care stay within 30 days preceding an IRF, SNF, LTCH admission
- Discharges to psychiatric hospital
- Discharges against medical advice
- Discharges to disaster alternative care sites or federal hospitals
- Discharges to court/law enforcement
- Patients/residents discharged to hospice and those with a hospice benefit in the post-discharge window
- Patients/residents not continuously enrolled in a Part A FFS Medicare for 12 months prior to the post-acute admission date, and at least 31 days after post-acute discharge date
Discharge Planning Exclusions

- Patients/residents whose prior short-term acute care stay was for a non-surgical treatment of cancer
- Post-acute stays that end in transfer to the same level of care
- Post-acute stays with claims data that are problematic
- Planned discharges to an acute or LTCH setting
- Medicare Part A benefits exhausted
- Patients/residents who received care from a facility located outside of the United States, Puerto Rico or a U.S. territory
- Swing Bed Stays in Critical Access Hospitals (SNF setting only)
Against Medical Advice - AMA

• Capacity - different than Competency
  • Is it documented who is making medical decisions?
• The person signing out against medical advice must be able to state why the medical provider does not want them to leave
• The patient/resident must understand specifically what risks are associated with leaving against medical advice and state them
Against Medical Advice- AMA

- Are there alternatives, which would encourage the person to stay at the facility?
  - Are you meeting their needs?
- With the AMA form, there needs to be specific documentation for what the patient/resident is refusing
- With an AMA, medical providers and the facility should attempt to make the AMA as safe for the patient/resident as possible- then document everything provided
Where do we start?
What condition brought them to the hospital?

How do you plan a discharge to eliminate or reduce the incidence of the condition reoccurring?

What other conditions have the potential to cause readmission to the hospital? (Remember all-cause)
Discharge Planning SNF

• There must be complete discharge planning when you anticipate discharging a resident to a private residence, another SNF, or another type of residential facility.
• There must complete discharge planning when the resident/patient is being transitioned from STR to LTC
Key Points for Discharge Planning

- Know Social and Physical Factors that affect functional status at discharge
- Identify appropriate community-based services, supports, and facilities that can meet the patient’s post-discharge clinical and social needs
- Knowledge of the patient’s unique medical and other service and support needs
Discharge Planning Process includes:

• Implementing a complete, timely, and accurate discharge planning evaluation process, including identification of high risk criteria- Potentially Preventable Conditions.
• Maintaining a complete and accurate file of appropriate community-based services, supports, and facilities where the patient can be transferred or referred.
• Coordinating the discharge planning evaluation among various disciplines responsible for patient care.
Potentially Preventable Readmission Conditions - Clinical Rationale

- Inadequate Management of Chronic Conditions
- Inadequate Management of Infections
- Inadequate Management of other Unplanned Events
- Inadequate Prophylaxis
- Inadequate Injury Prevention

### Table 1. High-volume conditions ranked by rate of readmission for all causes within 30 days, 2013

<table>
<thead>
<tr>
<th>Rank</th>
<th>Principal diagnosis for index hospital stay</th>
<th>Number of index admissions</th>
<th>Number of all-cause readmissions</th>
<th>Aggregate cost of readmissions, $ millions</th>
<th>Rate of all-cause readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total index admissions for any cause</td>
<td>28,124,889</td>
<td>3,900,556</td>
<td>52,398</td>
<td>13.9</td>
</tr>
<tr>
<td>1</td>
<td>Congestive heart failure, non-hypertensive</td>
<td>782,079</td>
<td>183,534</td>
<td>2,728</td>
<td>23.5</td>
</tr>
<tr>
<td>2</td>
<td>Schizophrenia and other psychotic disorders</td>
<td>366,256</td>
<td>83,245</td>
<td>772</td>
<td>22.7</td>
</tr>
<tr>
<td>3</td>
<td>Respiratory failure, insufficiency, arrest (adult)</td>
<td>290,892</td>
<td>62,955</td>
<td>961</td>
<td>21.5</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes mellitus with complications</td>
<td>486,886</td>
<td>99,108</td>
<td>1,204</td>
<td>20.4</td>
</tr>
<tr>
<td>5</td>
<td>Acute renal failure</td>
<td>431,452</td>
<td>87,537</td>
<td>1,190</td>
<td>20.3</td>
</tr>
<tr>
<td>6</td>
<td>Chronic obstructive pulmonary disease and bronchiectasis</td>
<td>570,077</td>
<td>114,067</td>
<td>1,834</td>
<td>20.0</td>
</tr>
<tr>
<td>7</td>
<td>Complication of device, implant or graft</td>
<td>581,289</td>
<td>111,836</td>
<td>1,973</td>
<td>19.2</td>
</tr>
<tr>
<td>8</td>
<td>Alcohol-related disorders</td>
<td>261,072</td>
<td>50,081</td>
<td>366</td>
<td>19.2</td>
</tr>
<tr>
<td>9</td>
<td>Sepsis</td>
<td>1,011,496</td>
<td>191,156</td>
<td>3,164</td>
<td>18.9</td>
</tr>
<tr>
<td>10</td>
<td>Fluid and electrolyte disorders</td>
<td>358,640</td>
<td>65,704</td>
<td>839</td>
<td>18.3</td>
</tr>
<tr>
<td>11</td>
<td>Complications of surgical procedures or medical care</td>
<td>426,917</td>
<td>76,292</td>
<td>1,212</td>
<td>17.9</td>
</tr>
<tr>
<td>12</td>
<td>Pancreatic disorders (not diabetes)</td>
<td>271,749</td>
<td>47,111</td>
<td>563</td>
<td>17.3</td>
</tr>
<tr>
<td>13</td>
<td>Gastrointestinal hemorrhage</td>
<td>328,428</td>
<td>55,173</td>
<td>741</td>
<td>16.8</td>
</tr>
<tr>
<td>14</td>
<td>Urinary tract infection</td>
<td>470,448</td>
<td>73,933</td>
<td>654</td>
<td>15.7</td>
</tr>
<tr>
<td>15</td>
<td>Intestinal obstruction without hernia</td>
<td>314,811</td>
<td>48,753</td>
<td>696</td>
<td>15.5</td>
</tr>
<tr>
<td>16</td>
<td>Pneumonia</td>
<td>824,700</td>
<td>127,601</td>
<td>1,809</td>
<td>15.5</td>
</tr>
<tr>
<td>17</td>
<td>Mood disorders</td>
<td>747,020</td>
<td>114,385</td>
<td>930</td>
<td>15.3</td>
</tr>
<tr>
<td>18</td>
<td>Acute myocardial infarction</td>
<td>485,402</td>
<td>71,300</td>
<td>1,043</td>
<td>14.7</td>
</tr>
<tr>
<td>19</td>
<td>Dysrhythmia</td>
<td>651,831</td>
<td>94,883</td>
<td>1,225</td>
<td>14.0</td>
</tr>
<tr>
<td>20</td>
<td>Coronary atherosclerosis and other heart disease</td>
<td>433,782</td>
<td>55,265</td>
<td>793</td>
<td>12.7</td>
</tr>
</tbody>
</table>

Notes: Only conditions with greater than 250,000 index stays are shown. Principal diagnosis is based on the Clinical Classifications Software (CCS). Costs include those of the readmission only, excluding the cost of the index stay.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Readmissions Database (NRD). 2013
Trends in readmissions for AMI, CHF, COPD, and pneumonia, 2009–2013

Figure 1 presents trends in the rate of readmissions for any cause within 30 days, per 100 index stays, overall and for four high-volume conditions from 2009 through 2013.

Figure 1. All-cause rate of readmission, by principal diagnosis of index admission, 2009–2013

Note: Principal diagnosis grouped according to the Clinical Classifications Software (CCS)
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), 2013 Nationwide Readmissions Database (NRD), and weighted national estimates from readmissions analysis files derived from the 2005–2012 State Inpatient Databases (SID)
Potentially Preventable Conditions for Hospital Readmissions for 30-Days Post-Acute Discharge

- Asthma
- COPD
- Congestive Heart Failure
- Diabetes
- Hypertension
- Influenza
- Bacterial Pneumonia
- Aspiration Pneumonitis
- Acute Renal Failure
- Pressure Ulcers

- Urinary Tract Infection
- Kidney Infection
- C. difficile
- Septicemia
- Skin and Subcutaneous Tissue Infections
- Dehydration/Electrolyte Imbalance
- Adverse Drug Events
- Arrhythmia
- Intestinal Impaction
Nursing Role

- During Nurse to Nurse report prior to admission, important information can be obtained that will lay the groundwork for the initial assessment.
- What additional diagnosis are there that place the resident at high risk for re-hospitalization?
- What is the plan of care to prevent re-hospitalization?
- Assessment of the residents cognitive function and how this will or will not impact their discharge plan.
Nursing Role

- Medication Reconciliation - Process that identifies and resolves unintentional discrepancies between patients' medication lists across transitions in care.
  - Should be done upon admission, after any transfer and at discharge.
  - Discrepancies place residents at increased risk for adverse drug events.
  - Adverse drug events are one of the most common reasons for post discharge complications.
Nursing Role

• Medication Education to the resident and or caregiver
  ❖ Medication name, dose, purpose, frequency, side effects

• Self Administration of Medication-what are your policies and procedures?
Nursing Role

• Diagnosis Management-CHF, Diabetes, COPD, Infections-”What to do When…..”
  • What are the symptoms the resident should be watching for and what do they do if they experience them?
  • Are there new conditions or diagnoses the resident needs education on?
Nursing Role

- Fall Risk Education
- Skin Care
- Skilled Nursing Needs & Education
- Caregiver Education- Identification of caregiver
Therapy Role

- Assessment and determination of what is the goal to achieve a safe and functional level for discharge
- Based upon that goal, what services and equipment may be needed upon discharge
- Completion of a Functional Assessment
- Safety Education
- Caregiver Education
Dietary Role

- Pre-hospital nutritional status
- Diet Counseling
  - Low sodium Diets
  - High Triglycerides
  - Carbohydrate Counting
- Diabetes Education
- COPD
- Weight Concerns
- Hydration Issues
Social Services Role

- Initial Discharge Assessment
  - What is their discharge goal?
  - Previous Services Used - if prior agencies were used, we should be contacting them ASAP for background information, concerns, will they accept the resident back.
  - DME already in place and what might they need upon discharge.
Social Services – Initial Discharge Assessment

- Are there concerns of non-compliance that need to be addressed.
- Who is the PCP and when was the resident last seen?
- How do they manage meals, medications, shopping, transportation?
- Are there any environmental concerns?
  - Is there 220 wiring to support special equipment
  - Is the home clean, free of hazards, has running water
  - Are there stairs or any ramps?
- What is the resident concerned about when they are discharged.
Social Services Role

- Educates the resident and family in regards to the STR process, discharge options
- Facilitate discussions at morning meeting regarding discharge planning
- Ensure the Day-3 team review is completed
- Making appropriate and timely referrals for services and equipment.
Social Services Role

- Ensuring the discharge summary and plan of care is received by the PCP or other medical providers as indicated.

- Assisting the resident in the development of the discharge plan, but also supporting them with the transition process.

- You are the Coordinator of the plan and the process!
Team Review

- The day after admission, the team should be reviewing all new admissions at morning meeting.

1. Preferred Discharge Location reviewed.
2. Are there issues of pain, is there a plan in place?
3. Diagnoses, medications, treatments reviewed.
4. ADL’s verified with nursing and therapy.
5. Financial data reviewed-ELOS, insurance, authorizations.
6. What education should be started now?
7. What equipment, services will be needed?
8. What are the barriers to a safe discharge?
9. What can we do to address the identified barriers?
Team Review

- By Day 3 there needs to be a team meeting with the resident.
  - Review the discharge plan
  - Barriers to a safe discharge, education needed

- Weekly Medicare Meeting-How is the resident progressing, what are the barriers, how are we overcoming the barriers, is the discharge plan still appropriate, services/equipment/education needed, current level of function vs safe functional level for discharge reviewed, where are we in the ELOS, anticipated discharge date.

- Daily Morning Meeting-discharge barriers and plan reviewed
### IDEAL Discharge Planning Process

The elements of the IDEAL Discharge Planning process are incorporated into our current discharge. The information below describes key elements of the IDEAL discharge from admission to discharge to home. Note that this process includes at least one meeting between the patient, family, and discharge planner to help the patient and family feel prepared to go home.

#### Initial nursing assessment
- **Identify the caregiver who will be at home along with potential back-ups.** These are the individuals who need to understand instructions for care at home. Do not assume that family in the hospital will be caregivers at home.
- **Let the patient and family know that they can use the white board in the room to write questions or concerns.**
- **Elicit the patient and family’s goals for when and how they leave the hospital, as appropriate.** With input from their doctor, work with the patient and family to set realistic goals for their hospital stay.
- **Inform the patient and family about steps in progress toward discharge.** For common procedures, create a patient handout, whiteboard, or poster that identifies the road map to get home. This road map may include things like “I can feed myself” or “I can walk 20 steps.”

#### Daily
- **Educate the patient and family about the patient’s condition at every opportunity, such as nurse bedside shift report, rounds, vital status check, nurse calls, and other opportunities that present themselves.** Use teach back.  
  **Who:** All clinical staff
- **Explain medicines to the patient and family (for example, print out a list every morning) and at any time medicine is administered.** Explain what each medicine is for, describe potential side effects, and make sure the patient knows about any changes in the medicines they are taking. Use teach back.  
  **Who:** All clinical staff
- **Discuss the patient, family, and clinician goals and progress toward discharge.** Once goals are set at admission, revisit these goals to make sure the patient and family understand how they are progressing toward discharge.  
  **Who:** All clinical staff
- **Involve the patient and family in care practices to improve confidence in caregiving after discharge.** Examples of care practices could include changing the wound dressing, helping the patient with feeding or going to the bathroom, or assisting with rehabilitation exercises.  
  **Who:** All clinical staff
Prior to discharge planning meeting

When: 1 to 2 days before discharge planning meeting. For short stays, this meeting may occur at admission.

- Give the patient and family the Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet.
  Who: Hospital to identify staff person to distribute, for example a nurse, patient advocate, or discharge planner.

- Schedule the discharge planning meeting with the patient, family, and hospital staff.
  Who: Hospital to identify staff person to distribute, for example a nurse, patient advocate, or discharge planner.

Discharge planning meeting

When: 1 to 2 days before discharge, earlier for more extended stays in the hospital

- Use the Tools 2a and 2b: Be Prepared to Go Home Checklist and Booklet as a starting point to discuss questions, needs, and concerns going home.
  - If the patient or family did not read or fill out the checklist, review it verbally. Make sure to ask if they have questions or concerns other than those listed. You can start the dialogue by asking, “What will being back home look like for you?”
  - Repeat the patient’s concerns in your own words to make sure you understand.
  - Use teach back to check if the patient understands the information given.
  - If another clinician is needed to address concerns (e.g., pharmacist, doctor, or nurse), arrange for this conversation.
  Who: Hospital to identify staff to be involved in meeting, for example the nurse, doctor, patient advocate, discharge planner, or a combination. Patient identifies if family or friends need to be involved.

- Offer make follow-up appointments. Ask if the patient has a preferred day or time and if the patient can get to the appointment.
  Who: Hospital to identify staff person to do, such as a patient advocate or discharge planner.

Day of discharge

- Review a reconciled medication list with the patient and family. Go over the list of current medicines. Use teach back (ask them to repeat what the medicine is, when to take it, and how to take it). Make sure that patients have an easy-to-read, printed medication list to take home.
  Who: Hospital to identify staff person to review the medication list with patient and family. Because this involves medications, we assume it would be a clinician — nurse, doctor, or pharmacist.

- Give the patient and family the patient’s follow-up appointment times and include the provider name, time, and location of appointments in writing.
  Who: Staff who scheduled appointment.

- Give the patient and family the name, position, and phone number of the person to contact if there is a problem after discharge. Make sure the contact person is aware of the patient's condition and situation (e.g., if the primary care physician is the contact person, make sure the primary care physician has a copy of the discharge summary on the day of discharge).
  Who: Hospital to identify staff person to write contact information, for example a nurse, patient advocate, or discharge planner.
# IDEAL Discharge Planning Checklist

Fill in, initial, and date next to each task as completed.

Patient Name: ________________________________

<table>
<thead>
<tr>
<th>Initial Nursing Assessment</th>
<th>Prior to Discharge Planning Meeting</th>
<th>During Discharge Planning Meeting</th>
<th>Day of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Identified the caregiver at home and backups</td>
<td>_____ Distributed checklist and booklet to patient and family with explanation</td>
<td>_____ Discussed patient questions</td>
<td><strong>Medication</strong></td>
</tr>
<tr>
<td>_____ Told patient and family about white board</td>
<td>_____ Scheduled discharge planning meeting</td>
<td>_____ Discussed family questions</td>
<td>_____ Reconciled medication list</td>
</tr>
<tr>
<td>_____ Elicited patient and family goals for hospital stay</td>
<td>_____ Scheduled for</td>
<td>_____ Reviewed discharge instructions as needed</td>
<td>_____ Reviewed medication list with patient and family and used teach back</td>
</tr>
<tr>
<td>_____ Informed patient and family about steps to discharge</td>
<td>_____ at [time]</td>
<td></td>
<td><strong>Appointments and contact information</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>_____ Used Teach Back</td>
<td></td>
</tr>
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</tr>
</tbody>
</table>
# IDEAL Discharge Planning Daily Checklist

Fill in, initial, and date next to each task as completed.

**Patient Name:** ____________________________

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Educated patient and family about condition and used teach back</td>
<td>_____ Educated patient and family about condition and used teach back</td>
<td>_____ Educated patient and family about condition and used teach back</td>
<td>_____ Educated patient and family about condition and used teach back</td>
</tr>
<tr>
<td></td>
<td>_____ Discussed progress toward patient, family, and clinician goals</td>
<td>_____ Discussed progress toward patient, family, and clinician goals</td>
<td>_____ Discussed progress toward patient, family, and clinician goals</td>
</tr>
<tr>
<td></td>
<td>_____ Explained medications to patient and family</td>
<td>_____ Explained medications to patient and family</td>
<td>_____ Explained medications to patient and family</td>
</tr>
<tr>
<td></td>
<td>_____ Morning</td>
<td>_____ Morning</td>
<td>_____ Morning</td>
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<tr>
<td></td>
<td>_____ Noon</td>
<td>_____ Noon</td>
<td>_____ Noon</td>
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<tr>
<td></td>
<td>_____ Evening</td>
<td>_____ Evening</td>
<td>_____ Evening</td>
</tr>
<tr>
<td></td>
<td>_____ Bedtime</td>
<td>_____ Bedtime</td>
<td>_____ Bedtime</td>
</tr>
<tr>
<td></td>
<td>_____ Other</td>
<td>_____ Other</td>
<td>_____ Other</td>
</tr>
<tr>
<td></td>
<td>_____ Involved patient and family in care practices, such as:</td>
<td>_____ Involved patient and family in care practices, such as:</td>
<td>_____ Involved patient and family in care practices, such as:</td>
</tr>
</tbody>
</table>

**Notes**
# The 8P Screening Tool

## Identifying Your Patient’s Risk for Adverse Events After Discharge

<table>
<thead>
<tr>
<th>The 8Ps</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for ensuring intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with medications (polypill, diabetes, chronic conditions, history of adverse events)</td>
<td>□ Medication specific education using Teach Back provided to patient and caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Monitoring plan developed and communicated to patient and all prescribers, where relevant (e.g., warfarin, digoxin, and insulin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Specific strategies for managing adverse drug events reviewed with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Elimination of unnecessary medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Simplification of medication scheduling to improve adherence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td>Psychological (depression screen positive or history of depression, recent diagnosis)</td>
<td>□ Assessment of need for psychiatric care if not in place</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Communication with primary care provider, highlighting this issue if new</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Involvement/awareness of support network insured</td>
<td></td>
</tr>
<tr>
<td>Principal diagnosis (cancer, stroke, DM, COPD, heart failure)</td>
<td>□ Review of national discharge guidelines, where available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Disease specific education using Teach Back with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Action plan reviewed with patient/caregiver regarding what to do and who to contact in the event of worsening or new symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Discuss goals of care and chronic illness model discussed with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td>Physical limitations (dependency on others, financial, medication, other physical limitations that impact their ability to participate in their care)</td>
<td>□ Engage family/caregivers to ensure ability to assist with post-discharge care assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Assessment of home services to address limitations and care needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place</td>
<td></td>
</tr>
<tr>
<td>Poor health literacy (inability to do Teach Back)</td>
<td>□ Committed caregiver involved in planning/administration of all discharge planning and general and risk specific interventions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Post-hospital care plan education using Teach Back provided to patient and caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Link to community resources for additional patient/caregiver support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td>Patient support (social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care)</td>
<td>□ Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Follow-up appointment with appropriate medical provider within 7 days after hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Involvement of home care providers of services with clear communications of discharge plan to those providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Engage a transition coach</td>
<td></td>
</tr>
<tr>
<td>Prior hospitalization (non-elective, in last 6 months)</td>
<td>□ Review reasons for re-hospitalization in context of prior hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Follow-up phone call at 72 hours to assess condition, adherence and complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Follow-up appointment with medical provider within 7 days of hospital discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Engage a transition coach</td>
<td></td>
</tr>
<tr>
<td>Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness? “No” to 1st or “Yes” to 2nd - positive screen)</td>
<td>□ Assess need for palliative care services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Identify goals of care and therapeutic options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Communicate prognosis with patient/family/caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Assess and address concerning symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Identify services or benefits available to patients based on advanced disease status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Discuss with patient/caregiver role of palliative care services and the benefits and services available to the patient</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Concerns Affecting a Safe Discharge

• **High-risk Medications**
  - Diabetic Medications
    - Insulins
    - Oral Hypoglycemic
  - Seizure medications
  - Cardiac Medications
    - Antihypertensive
    - Anticoagulants
  - Antibiotics
  - Psychotropic
Clinical Concerns Affecting a Safe Discharge

- Multiple Co-Morbidities
  - High-risk medical conditions to manage for Discharge to Community planning
Other Clinical Concerns Affecting Discharge to Community and Reducing Readmissions
Discharge Planning includes:

- Assessing the resident’s continuing care needs, including:
  - Consideration of the resident’s and family/caregiver’s preferences for care
  - How services will be accessed
  - How care should be coordinated among multiple caregivers
- Developing a plan designed to ensure that the resident’s needs will be met after discharge from the facility, including resident/patient and family/caregiver education needs
- Ensuring support in the community with a Primary Care Physician
  - Work with the patient/resident and/or caregiver to schedule the appointment
  - Is there a transportation need?
- Determine Community Pharmacy used by the patient/resident for required prescriptions
  - Can the patient/resident make the co-pay for prescriptions?
Discharge Planning cont.:

- Initiating and maintaining collaboration between the SNF and the local contact agency to support the resident’s transition to the community living
  - Transportation
  - Meal delivery/Grocery delivery
  - Food Pantry/Farmer markets
- Assisting the resident/patient and family/caregiver in locating and coordinating post-discharge services
### Discharge Criteria

**Low Risk Discharge**
- Independent in ADLs
- Caregivers in the home and available to assist
- Lives alone with community support
- Independent with management of chronic diseases/meds
- Adherent to treatment plan
- Able to direct medical care
- Consistently followed by MD/Practitioner

**Moderate Risk Discharge**
- Lives alone with limited community support
- Requires assistance with medications
- Issues of health literacy
- History of mental illness
- Polypharmacy (greater than 7 meds)
- Requires temporary assistance with ADLs and ADLs
- Requires assistance in:
  - Ambulating
  - Wound Care
  - Management of oxygen and/or nebulizer

*If ≥ 2 then refer to home health agency*

**Refer to Home Care Services For:**
- Patient received services from home care prior to hospitalization?
  - Yes
  - No
  - If Yes, name of agency:

**Discharge to Community**
Refer to home care services (including patients who reside in Adult Home or Assisted Living Facility)

- Skilled Nursing
  - Observation and assessment
  - Teaching and training
  - Performance of skilled treatment or procedure
  - Management and evaluation of a client care plan
  - ADJ/DOR
  - Physical, occupational and/or speech therapy
  - Medical social work
  - Home health aide service for personal care and/or therapeutic exercises
  - Telehealth Care Management

**High Risk Discharge**
- Lives alone with no community support
- Lives with family that is not actively involved in care
- Clinically complex
  - (multiple co-morbidities, repeat hospitalizations or ED visits, needs considerable assistance to manage or is unable to manage medical needs independently)
- History of falls
- Acute/chronic wound or pressure ulcer
- Incontinent
- Cognitive impairment
- History of mental illness
- CHF and/or COPD and/or diabetes and/or HIV/AIDS
- End stage condition
- Requires considerable assistance in:
  - Transferring
  - Ambulating
  - Medication management (greater than 7 meds)
  - Management of oxygen and/or nebulizer

*If ≥ 4 then refer to home health agency upon patient admission to hospital*

**This Patient is High Risk For Rehospitalization Refer to Home Care Services Immediately**

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*This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.*

**IPRO**
Experts in Defining and Improving the Quality of Health Care
# NEW YORK STATE DISCHARGE PLANNING AT A GLANCE

**Patient is going home and requires home care services (skilled/non-skilled)**

If patient has commercial insurance, call to see if CHHA or LHCSA requirement.

<table>
<thead>
<tr>
<th>SKILLED SERVICES</th>
<th>SKILLED OR NON-SKILLED SERVICES</th>
<th>NON-SKILLED SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Services</td>
<td>Certified Home Health Agency (CHHA)</td>
<td>Medicaid Waiver AND Long Term Care Services</td>
</tr>
<tr>
<td>Certified Home Health Agency (CHHA)</td>
<td>Medicaid or Private Pay</td>
<td>Medicaid or Private Pay</td>
</tr>
<tr>
<td>Medicare (Homebound requirement)</td>
<td>No skilled care required</td>
<td>No skilled care required</td>
</tr>
<tr>
<td>Medicaid</td>
<td>(assist with personal care and activities of daily living (ADLS))</td>
<td>(assist with personal care and activities of daily living (ADLS))</td>
</tr>
<tr>
<td>Commercial insurance</td>
<td>Requires skilled care (Nursing, PT, OT, ST, MSW, RT, RD, personal care aids)</td>
<td>Requires skilled care (Nursing, PT, OT, ST, MSW, RT, RD, personal care aids)</td>
</tr>
</tbody>
</table>

To locate services within a specific NYS County: access [www.nyconnects.org](http://www.nyconnects.org) or county-based point of entry (Central Assessment Unit in County Department of Social Services).

### What to consider when assessing for referral to home care services:

- Patient's pre-hospitalization functional ability
- Informal supports—able, willing, available caregiver
- Cognition
- Patient's current functional ability
- Prior home care services
- Multiple hospitalizations—high risk
- Chronic illness(es)
- Special needs—durable medical equipment
- Traumatic brain injury (TBI)
- Services through the Office of Mental Health & Office of Mental Retardation and Developmental Disability

Other services provided at home: Access [www.nyconnects.org](http://www.nyconnects.org)

### Types of Programs

- Long Term Home Health Care Program
- Home Attendant/Personal Care Program
- ESSEF (Expanded In-Home Services for Elderly Program)
- Nursing Home Transition and Diversion Program
- Managed Long-Term Care Program
- PACF (Program for All Inclusive Care for the Elderly)
- Consumer-directed Program

For Children (0-18 years)

- Care At-Home Program

Case management, supervision, environmental modification, home-making, assistance with personal care and ADLs: housekeeping, shopping, errands

This information is provided as guidance and should not be considered to be an all-inclusive list of discharge planning options. Providers need to select and/or develop protocols that apply to their specific patient population and region.
Adult Day Services
in the Capital Region

Albany County
Rensselaer County
Saratoga County
Schenectady County

INCLUDES LISTINGS AND DEFINITIONS FOR:
Adult Day Health Care Programs
Social Adult Day Services Programs

PRODUCED BY
ALBANY GUARDIAN SOCIETY | ALBANY, NEW YORK
2014 - 2015
What the Discharge Planner Needs to Know in Order to Effect a Safe and Efficient Transition

- Baseline information about the individual\(^1\) such as: current medical, psychological and mental health status, family and community support systems, payer source, financial status, decision making capacity (pros/cons, Do Not Resuscitate, Power of Attorney, Guardianship), religious preference, legal issues, Adult Protective Services involvement, environmental limitations, etc.
- Does the individual have a community medical provider?
- Would they like assistance in finding one?
- What are the medical team’s expectations regarding length of stay?
- What are the individual’s expectations/goals in terms of their long term plan and short term or immediate plan?
- What are the expectations/goals of the informal supports assisting the individual?
- What services did the patient have prior to admission/will same level of service be sufficient or is an increase in hours needed? Is provider willing to reinstate services? If not, why?
- Are there any reimbursement restrictions or limitations of service providers involved with delivering services to the individual?
- Who will be the medical provider responsible at home and what is the means of communication between providers from the hospital to the home setting? (In certain situations a medical provider other than a physician will be responsible. Please note that the rules vary regarding whether a non-physician such as a nurse practitioner who is able to sign orders for clinical purposes may do so for payment purposes).
- Who or what entity has overall responsibility for checking the facts?
- Are there any parameters or limitations affecting the patient’s right to choose?
- What constitutes “non-compliance” by the individual living at home, and how is that communicated to the home care provider (which may be a home care agency or a community services provider)?
- Can the non-compliance be addressed?
  1. Can it be fixed?
  2. Is there history of behavior that affects the individual’s health and puts them at risk of imminent danger?
  3. Does patient have capacity?
  4. How serious is the risk?
  5. Are staff at risk/created?
  6. Is care giver non-compliance/abandonment a factor?
  7. Is the back up plan realistic?
  8. Is there adequate care being provided?
  9. Is compliance linked to reimbursement?

\(^1\) We have chosen to use the term “individual” to refer to the user of healthcare services. This includes the individual in the community, the patient in the hospital or the resident in a skilled nursing facility.
Discharge Summary

A LTC Facility Discharge Summary must include:

• A recapitulation of the resident’s/patient’s stay
• A final summary of the resident’s/patient’s status at discharge
• A post-discharge plan of care, developed with the resident’s/patient’s and family’s/caregiver’s participation
Discharge Planning Reassessment

Quality Assessment and Performance Improvement (QAPI):

- Include a mechanism for ongoing reassessment of the discharge planning process
  - Review of discharge plans in closed clinical records
- Review whether the discharge planning process was responsive to the patient’s post-discharge needs