Transitional Planning Under Current & Proposed CMS Rules

RELIAS LEARNING

02/15/2017

Speakers

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Founding partner of Case Management Concepts, LLC. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of Case Management. Dr. Cesta also writes a monthly column called *Case Management Insider* in AHC Media's *Hospital Case Management* newsletter. She has been active in the research and development of Case Management for over 20 years.

- **Beverly Cunningham**, MS, RN, ACM

Founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board. Bev is also the former Vice President of Resource Management at Medical City Dallas Hospital.

OBJECTIVES

- Identify the best ways to transition patients across the continuum of care.
- Explain how the new CMS changes relate to transitional and discharge planning.
- Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC, DNV and the federal government.

DEFINITION OF DISCHARGE PLANNING

"A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care."

Centers for Medicare and Medicaid Services, glossary definition (2006)
www.cms.gov

RELIAS LEARNING 4

Acute Care Discharge Planning

- Determining the appropriate post-hospital discharge destination for a patient
- Identifying what the patient requires for a smooth and safe transition from the acute care hospital/post-acute care facility to his or her discharge destination
- Beginning the process of meeting the patient's identified pre- and post-discharge needs
- Implementing a complete, timely, and accurate discharge planning evaluation process, including identification of high risk criteria
- Maintaining a complete and accurate file of appropriate community-based services, supports, and facilities where the patient can be transferred or referred
  - These services, supports, and facilities include Nursing Facility (NF) or Skilled Nursing Facility (SNF) care, long-term acute care, rehabilitation services, Home Health care, Hospice, or other appropriate care (such as home-based supports)
- Coordinating the discharge planning evaluation among various disciplines responsible for patient care

CMS Discharge Planning Education, 2014

RELIAS LEARNING 5

TRANSITIONAL PLANNING PROCESS: New York State Health Department

- Patient-centered, interdisciplinary process that begins with initial assessment of patient's potential needs at time of admission and continues throughout patient's stay

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- Initial discharge screen questions should allow discharge planner to determine whether patient is likely to need a more comprehensive assessment

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- High risk screening criteria

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- Comprehensive assessment

Attachment 1

RELIAS LEARNING 6

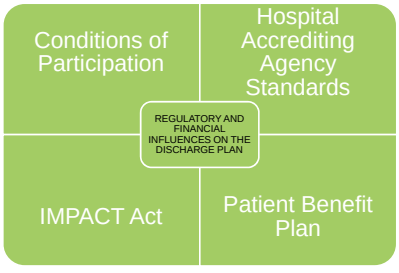
FOUNDATION OF EFFECTIVE TRANSITIONAL PLANNING

- Interdisciplinary team involvement
- Least restrictive environment identified that can meet patient's needs
- Patient and/or family included in discharge planning process in a timely manner
- Patient and family educated about community resources that can help maintain maximum potential and independence
- Safe discharge plan established
- Patient's benefit plan drives discharge plan, along with choice (for home health and skilled nursing facilities)
- Preparation for future rules and regulations

RELIAS LEARNING 7

THE CURRENT RULES, REGULATIONS, AND STANDARDS FOR TRANSITIONAL PLANNING

RELIAS LEARNING 8



RELIAS LEARNING 9

FEDERAL REGULATIONS – SOCIAL SECURITY ACT § 1861 (ee)

Discharge Planning Process:

"The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care."

https://www.ssa.gov/OP_Home/ssact/title18/1861.htm

RELIAS LEARNING 10

SOCIAL SECURITY ACT: DISCHARGE PLANNING REGULATIONS BECAME FOUNDATION FOR THE CMS CONDITIONS OF PARTICIPATION

RELIAS LEARNING 11

CMS CONDITIONS OF PARTICIPATION

- Published in 1983
- CMS called them "health and safety standards"
- Identified as the foundation for improving quality and protecting the health and safety of Medicare and Medicaid beneficiaries
- Few changes since 1983 despite changes in the healthcare industry
- 2013 Interpretive Guidelines and Blue Advisory Boxes added to CoPs
- Screening organizations are to meet or exceed these standards
- Proposed changes to discharge planning section in 2015

RELIAS LEARNING 12

CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING

ATTACHMENT 2

RELIAS LEARNING 13

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

(a) Standard: Hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning

(b) Standard: Discharge planning evaluation

(1) Must provide discharge planning evaluation to patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician

(2) Registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise development of evaluation

http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr482.43.pdf

RELIAS LEARNING 14

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

(3) Discharge planning evaluation must include evaluation of likelihood of patient needing post-hospital services and availability of the services

(4) Evaluation must include evaluation of likelihood of patient's capacity for self-care or possibility of patient being cared for in environment from which he or she entered hospital

(5) Evaluation must be completed timely so appropriate arrangements for post-hospital care are made before discharge to avoid unnecessary delays in discharge

(6) Include evaluation in medical record for use in establishing appropriate discharge plan and must discuss results of evaluation with patient or individual acting on his or her behalf

RELIAS LEARNING 15

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

Discharge plan:

(1) Registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise development of discharge plan if the discharge planning evaluation indicates need for discharge plan

(2) In the absence of finding that a patient needs discharge plan, patient's physician may request discharge plan; in such a case, hospital must develop discharge plan for patient

(3) Must arrange for initial implementation of discharge plan

(4) Must reassess discharge plan if factors may effect continuing care needs or appropriateness of plan

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care

CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

- The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care.
- The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

CONDITIONS OF PARTICIPATION PATIENT CHOICE

- Must include in discharge plan a list of HHAs or SNFs available to patient, that participate in the Medicare program, and serve the geographic area (as defined by the HHA) in which patient resides, or in the case of a SNF, in geographic area requested by patient; HHAs must request to be listed by the hospital
  - List must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation
  - For patients enrolled in managed care organizations, hospital must indicate availability of home health and post-hospital extended care services through individuals and entities that have contract with the managed care organizations
  - Must document in medical record that list was presented the patient or the individual acting on patient's behalf

CONDITIONS OF PARTICIPATION PATIENT CHOICE

- Hospital must inform patient or patient's family of freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when expressed
- Hospital must not specify or otherwise limit qualified providers available to patient
- Must identify any HHA or SNF to which the patient is referred in which hospital has disclosable financial interest

RELIAS LEARNING 19

HOSPITAL ACCREDITATION AGENCIES DISCHARGE PLANNING AND TRANSITIONS OF CARE

RELIAS LEARNING 20

THE JOINT COMMISSION STANDARDS

Focus: Transitions of Care

https://www.jointcommission.org/toc.aspx

RELIAS LEARNING 21

HOSPITAL ACCREDITATION AGENCY STANDARDS: DNV

DC.1 WRITTEN POLICIES

- SR.1 Written policies shall be in place to establish a system for discharge planning that applies to all patients
- SR.2 At an early stage of hospitalization, all patients who are at risk for negative outcomes without adequate discharge planning shall be identified and a plan developed to account for the patient's needs
- SR.3 A registered nurse, social worker, or other appropriately qualified personnel shall develop, or supervise the development of, a discharge planning evaluation for or upon the request of:
  - SR.3a the patients identified in the above paragraph
  - SR.3b any patients upon their request
  - SR.3c a person acting on the patient's behalf
  - SR.3d the patient's physician

HOSPITAL ACCREDITATION AGENCY STANDARDS: DNV

DC.2 DISCHARGE PLANNING EVALUATION

- SR.1 The discharge planning evaluation shall include
  - SR.1a An evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services
  - SR.1b An evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the organization
  - SR.1c A means to inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services, and must, when possible, respect patient and family preferences when they are expressed

HOSPITAL ACCREDITATION AGENCY STANDARDS: DNV

DC.2 DISCHARGE PLANNING EVALUATION

- SR.2 The discharge planning evaluation shall be completed on a timely basis so that appropriate arrangements are made before discharge, and unnecessary delays in discharge are avoided
- SR.3 The discharge planning evaluation shall be a part of the patient's medical record and be used when forming the discharge plan with the patient or individual acting on his or her behalf
- SR.4 If the results of the discharge evaluation so indicate, or at the request of the patient's physician, a registered nurse, social worker, or other appropriately qualified personnel shall develop, or supervise the development of, a discharge plan and associated educational materials

HOSPITAL ACCREDITATION AGENCY STANDARDS: DNV

DC.3 PLAN IMPLEMENTATION

- SR.1 The initial implementation of the patient's discharge plan shall be performed by the organization
- SR.2 Patients shall be transferred or referred with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed
- SR.3 When the discharge planning evaluation determines a referral is medically appropriate, the organization shall give the patient a list of Medicare-participating providers (including those qualified to receive the patient from the patient's managed care organization where applicable) that are available and serve the geographical area where the patient resides. The organization shall document in the medical record that the patient (or authorized representative) received a copy of the list and was advised of his/her freedom of choice.

RELIAS LEARNING 25

HOSPITAL ACCREDITATION AGENCY STANDARDS: DNV

DC.3 PLAN IMPLEMENTATION

- SR.3a The organization must respect the choice of the patient or authorized representative except in unusual circumstances. The organization may not lead, direct, specify or otherwise limit the selection of qualified Medicare-participating providers
- SR.3b The organization must identify in writing any Medicare-participating providers to which the patient is referred in which the organization has a disclosable financial interest and any Medicare-participating providers that has a disclosable financial interest in the organization. Disclosable financial interests are defined by 42 CFR §420, Subpart C.
- SR.4 When the organization must transfer or refer patients, the necessary medical information and other supporting documentation must be provided to appropriate facilities, agencies or outpatient services as needed, for follow-up or ancillary care

RELIAS LEARNING 26

HOSPITAL ACCREDITATION AGENCY STANDARDS: DNV

DC.4 EVALUATION

- SR.1 The discharge plan shall be periodically reevaluated on an on-going basis to provide for changes in the patient's condition or circumstances. The reassessment must include a review of the discharge plans to ensure that they are responsive to discharge needs
- SR.2 As needed, the patient and family members or interested persons shall be educated to prepare them for post hospital care

RELIAS LEARNING 27

THE IMPROVING MEDICARE POST-ACUTE TRANSFORMATION (IMPACT) ACT:

The Foundation for the Proposed Discharge Planning Rule Changes to the Conditions of Participation

RELIAS LEARNING 28

IMPACT ACT

- Passed by Congress in 2014
- Mandates common patient assessment data and quality measure reporting for post-acute providers
- New requirements first took affect October 2016
- Requires general acute-care, critical access hospitals and post-acute care providers to meet the intent of facilitating the flow of patient information
- Sets post-acute care payments rates based on clinical characteristics of patient, rather than on setting of care

RELIAS LEARNING 29

IMPACT ACT

- Incorporate standardized assessment, including components of the CARE tool, into existing assessment tools across post acute care providers: SNF, LTCH, LTC (acute rehab), and HH
  - Measures pressure ulcers, functional status, cognitive status and special services
  - Data collected on admission and discharge
  - Implement October 2018
- Development and public reporting of quality measures across settings
  - Measures as above, medication reconciliation, incidence of major falls, patient preferences and average total Medicare cost per beneficiary
  - All measures approved by National Quality Forum or through notice and comment rulemaking

RELIAS LEARNING 30

IMPACT ACT

- Quality measures provided to consumers when transitioning to a post acute care provider (hospitals and post acute care providers)
  - Conditions of Participation to be modified to incorporate quality measures into the discharge planning process
  - Market basket penalty of 2% for failure to effectively collect and report data
- HHS and MedPAC required to conduct studies and reports to link payment to quality
- Additional $11M in funding for CMS to use payroll data to measure staffing in SNF setting

TRANSFER AGREEMENT REGULATIONS

- A hospital and a skilled nursing facility shall have a written agreement between them for reasonable assurance that:
  - "Transfer of patients will be affected between the hospital and SNF whenever such transfer is medically appropriate as determined by the attending physician"
  - "There will be interchange of medical and other information necessary or useful in the care and treatment of transferred patients between institutions or to help determine if patients can be adequately cared for in either institutions"

- Social Security Act § 1861 (l)

POST HOSPITAL EXTENDED CARE SERVICES 3-DAY STAY RULE

A 3-day inpatient stay is mandatory for Medicare patients that require placement in a Skilled Nursing Facility (SNF) after their hospitalization

Counted by # of days the patient is an ***inpatient status*** in his/her inpatient bed at midnight

Observation days do not count as part of the 3 days

POST HOSPITAL EXTENDED CARE SERVICES 3-DAY STAY RULE

- This rule only applies to traditional Medicare and typically not Medicare replacement policies
- There is an additional 30-day window post acute care discharge for qualification if not discharged directly to a SNF
- A 3-day stay is not needed if the patient is discharged to an Acute Care Rehab or Long Term Care Hospital

Section 1861 of the Social Security Act Federal Regulations 10116, 10118-19 (updated clarification Medicare Benefit Policy Manual, Chapter 8, 2013)

FUTURE OF THE 3-DAY STAY RULE

- Medicare could waive the three-day hospital visit for skilled-nursing care with some Accountable Care Organizations
- The waver would require patients to go to nursing homes with at least three stars on Medicare's five star quality scale
- Could exclude about one-third of the nation's nursing homes that have cared for 39% of nursing residents
- Bundled payment option

Modern Healthcare June 17, 2015

WAIVING THE THREE-DAY RULE: ADMISSIONS AND LENGTH-OF-STAY AT HOSPITALS AND SKILLED NURSING FACILITIES DID NOT INCREASE

- Studied Medicare Advantage plans not requiring 3 day inpatient stay 2006-2010
- 528 plans and 257,415 patients
- Those not requiring 3 day stay: Hospital stay decreased 0.2 days
- Those subject to requirement: Hospital stay increased 0.5 days
- SNF LOS
  - < 20 day LOS at SNF, those not requiring 3 day hospital stay had 5% increase in stay
  - ≤100 days LOS increased 0.8 days
  - Neither of these were statistically significant

Manuscript by Grebla, Keohane, Lee, Lipstiat, Rayman, Trivedl August 2015

POST ACUTE CARE TRANSFER DRG REGULATION

A transfer DRG plays an important role in payment when a patient with a qualified DRG is transferred to a post acute provider earlier than the geometric mean LOS

If a patient is admitted with a transfer DRG and is discharged before the geometric mean LOS, the hospital is paid using a transfer formula which decreases the overall payment to the hospital

Balanced Budget Act of 1997

RELIAS LEARNING 37

PREADMISSION SCREENING AND RESIDENTIAL REVIEW (PASRR) REGULATION

Assessment used to ensure persons with severe mental illness and/or mental disability are identified and placed in the most appropriate settings to meet their needs

PASRR screening is needed on all patients discharging to a Medicaid certified nursing facility regardless of payer

Omnibus Reconciliation Act of 1987 (OBRA) Federal Regulation – 42CFR 483.100 – 483.138

RELIAS LEARNING 38

NOTIFICATION OF DISCHARGE APPEAL RIGHTS REGULATION

Notice – Important Message from Medicare (IM)

- Explains discharge appeal rights for all Medicare beneficiaries—both traditional Medicare and Medicare Advantage plans
- Hospitals must issue and explain IM within 2 calendar days of admission, and obtain the signature of beneficiary or representative
- Hospitals must provide 2nd IM within 2 calendar days of the day of discharge but not routinely on the day of discharge

Section 1154 of the Social Security Act CMS-4105-F

RELIAS LEARNING 39

NOTIFICATION OF DISCHARGE APPEAL RIGHTS REGULATION (Cont'd)

- Hospital delivers Detailed Notice of Discharge and HINN 12
- Hospital will provide all necessary information to the QIO including medical record, IM, and Detailed Notice
- QIO has one calendar day to make a decision after all information is received if request is timely; two calendar days if request is untimely

Section 1154 of the Social Security Act CMS-4105-F

RELIAS LEARNING 40

NOTIFICATION OF DISCHARGE APPEAL RIGHTS REGULATION Cont'd

After QIO review:

- QIO agrees with hospital: Beneficiary is responsible for continued stay charges beginning at noon of the day **after** QIO notification to the beneficiary
- QIO agrees with beneficiary: No liability to beneficiary except for coinsurance and deductibles. Will need new 2nd notice and discharge order from physician

Section 1154 of the Social Security Act CMS-4105-F

RELIAS LEARNING 41

PREPARING FOR A CMS SURVEY WITH THE CURRENT CoPs

- CMS finalized an updated discharge planning survey guidance for surveyors May 2013
- A CMS survey can be
  - Validation survey after a hospital accreditation survey (with deemed status for the Conditions of Participation—deemed status is determined by the hospital)
  - Result of a complaint or severe error
  - Random survey
- Surveyors are now surveying for the following
  - Conditions of Participation requirements and interpretive guidelines
  - Advisory boxes: "blue boxes" to promote better patient outcomes
    - "Blue boxes" not required for hospital compliance
    - Resource information for process improvements
    - Surveyors are to survey advisory boxes, but not issue citations based on these

RELIAS LEARNING 42

CMS SURVEYOR WORKSHEET ATTACHMENT 3

RELIAS|LEARNING 43

CONDITIONS OF PARTICIPATION DISCHARGE PLANNING

Interpretive Guidelines and Advisory Blue Boxes

ATTACHMENT 4

RELIAS|LEARNING 44

HIGHLIGHTS FROM 2013 UPDATE FOR SURVEY GUIDANCE

- New guidance to surveyors, providing additional detail about role and functions of hospitals in transitioning patients to other care settings, including the home
- Effective discharge planning is to be a key element of successful post-hospital care
- CMS acknowledged new terminology, such as transition planning, community care transitions, and care coordination
- "A poor discharge planning process may be slow or complicate the patient's recovery, which may lead to readmission to a hospital, or even result in the patient's death". CMS

RELIAS|LEARNING 45

HIGHLIGHTS FROM 2013 UPDATE FOR SURVEY GUIDANCE

- Suggested that hospitals might consider, on a voluntary basis, using an abbreviated discharge planning process for certain categories of outpatients, including those in outpatient observation
- Acknowledged that these outpatients may have complex medical needs requiring the important discharge planning process
- Increased emphasis on hospitals knowing the capabilities and capacities of facilities to which they refer patients for post-hospital care
- Focus on the importance of engaging patient and family, or patient representative
- Increased emphasis on team approach to discharge planning

TRANSITIONING FROM THE ADVISORY BLUE BOXES TO THE CMS PROPOSED DISCHARGE PLANNING RULES

ATTACHMENT 5

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- November 3, 2015
- Comments were accepted until January 3, 2016
- Estimated final rule was expected in February 2016
- Continue to wait on final rule

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Expanded patient population requiring a discharge plan before leaving the hospital
  - Patients discharged from critical access hospitals, long-term acute care hospitals, inpatient rehab hospitals
  - Observation service patients, ED patients, day surgery patients, patients receiving procedures and require anesthesia or sedation
- Plan must be started within 24 hours of admission
- Collaboration with community service providers is stressed as a need

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Quality measures of post-acute care providers should be provided to patients and caregivers
  - CMS recommends use of Nursing Home Compare and Home Health Compare
  - These are to be used until quality measures in the IMPACT Act are available
- Patient information should be shared with next level of care providers
- Practitioner responsible for patient's care must be involved in discharge planning and participate in documentation of the plan

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Patients who are discharged home should have a copy of their discharge summary sent within 48 hours to the physician responsible for follow up care
- Pending lab results are to be sent to this same physician within 24 hours
- Critical access hospitals and home health agencies will have a new set of Conditions of Participation
- Discharge planning process must be written and approved by the hospital board (both initially and routinely)

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Patient or patient caregiver capability and availability must be considered
- Availability and access to non-healthcare services must be considered—includes home and physical environment modifications, including assistive technologies, transportation services, meal services or household services (or both), including housing for homeless patients
- Discharge plan must address patient's goals of care and treatment preferences with documentation of such

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Discharge planning process must be assessed on a regular basis
  - Ongoing review or representative sample of discharge plans
  - Include patients readmitted within 30 days of discharge to ensure responsiveness to discharge needs
- Medication reconciliation required
- Patient to be made aware that they should ensure a post-acute care provider is in their network

CMS CONDITIONS OF PARTICIPATION PROPOSED DISCHARGE PLANNING RULES

- Appropriate staff must coordinate discharge plan
- Ongoing evaluation must identify any changes in discharge plan
- Hospital administration must be aware of the discharge planning process and provide support to ensure it is effective

COMMENTS PROVIDED TO CMS: AMERICAN HOSPITAL ASSOCIATION

- Lessen the rule: increased staff required, especially during weekend and after-hours; additional training for staff; increased administrative workflow and procedures; EHR altered to align with proposed standards
- Range of patients too extensive
- Timing of 24 hour time frame too stringent
- Patient's caregiver or support person should be involved as must as possible—with the patient's consent
- Add flexibility in providing discharge summary within 48 hours for patients discharged to home
- Cost estimated to be $22,000 annually, without the cost of implementation
- Hospitals who are poorly staffed in case management will have additional cost

COMMENTS PROVIDED TO CMS: AMERICAN CASE MANAGEMENT ASSOCIATION

- Flexible timing of discharge plan for patients whose plan is not clear on admission
- Develop expectation of post acute care provider to accept patients timely (within 12-24 hours of notification)
- Improve frequency of updating of Compare website (currently once/year)
- Align Meaningful Use requirements with these proposed rules

YOUR DEPARTMENT'S OPERATIONS AND THE PROPOSED RULES FOR THE CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING

PROACTIVE DISCHARGE PLANNING

Discharge planning starts on admission

- Evaluate and coordinate discharge planning early in process to ensure timely discharge
- Assessment must be done on day of admission

RELIAS LEARNING 58

PROACTIVE DISCHARGE PLANNING ON DAY OF ADMISSION

- Promotes:
  - Customer satisfaction
    - -Patient & Family
    - -Physician
    - -Nursing
    - -Community partners
  - Improved outcomes
  - Improved patient flow
  - Reductions in LOS, delays, & denials
  - Increased ability to comply to the Conditions of Participation for discharge planning and standards from hospital accrediting agencies

RELIAS LEARNING 59

PROACTIVE CASE MANAGEMENT

Critical Part of the Multidisciplinary Discharge Planning Team

RELIAS LEARNING 60

IDENTIFY NEEDS

Identify all patients who are likely to suffer adverse health consequences upon discharge if there is not adequate discharge planning

Federal Regulations - Sec 482.43 Conditions of Participation

IDENTIFY NEEDS

- All patients identified in the proposed rules must have a discharge plan
- Upon admission, case managers should screen all patients for high risk factors; risk factors should be based on your patient population
- Daily walking rounds provide the opportunity to further identify patients for evaluation and barriers to discharge
  - Attendees should include physician, nursing, case management, and other disciplines as needed
  - Patient is an active part of walking (bedside) rounds

DISCHARGE PLANNING EVALUATION

Case managers must complete an evaluation on all patients identified as needing discharge planning either through screening or request; Evaluation needs to include a comprehensive assessment

- Need for post-hospital services including the most appropriate level of care, i.e., home, home care, placement options
- Patient's capacity for self-care and whether he/she can return to their previous setting
- Evaluate the prior and current level of functioning
- Decision-making capacity
- Mental Status
- Home environment
- Family support system
- Barriers
- Availability of services
- Requires an additional assessment of resources available to the patient

DISCHARGE PLANNING EVALUATION (Cont'd)

Evaluations must be timely so that appropriate arrangements can be made

Case managers must work with the team: physicians, nursing, and key stakeholders in ancillary departments

Discuss evaluation results with the patient and/or representative

- In the event patient and/or representative disagrees with the evaluation/recommendations or is slow in making a decision regarding the recommendations, utilize patient/family conferences to assist in goal setting with expected outcomes
- Case management or nursing should arrange for conference including date, time, location, participants, and documentation of action
- Conference should include patient (if able), family, physician, nursing, case management, social work, and other disciplines as needed, i.e., respiratory care, therapy, etc

DISCHARGE PLANNING EVALUATION (Cont'd)

- Communicate estimated date of discharge on white board in room; update anticipated date of discharge during walking rounds
- Document evaluation in the patient's medical record for use in establishing an appropriate discharge plan
- Monitor ongoing documentation of status changes and disposition

DISCHARGE PLANNING EVALUATION RESOURCE ASSESSMENT

Once the evaluation of needs is complete, the case manager must identify resources available to the patient

Includes:

- Human resources: Availability of a caregiver, i.e., family and friends
- Community-based resources
- Financial resources

DISCHARGE PLANNING EVALUATION COMMUNITY–BASED RESOURCES

- Home Health Care
- Private Duty
- Hospice Care
- Durable Medical Equipment
- Acute Care Hospital Transfer
- Acute Rehabilitation Hospital
- Long Term Acute Care Hospitals
- Skilled Nursing Facilities
- Extended care placement
- Assisted living Facilities
- Outpatients services (Ex: Rehab, IV therapy, dialysis)
- Other Community resources
- Transportation

DISCHARGE PLAN

RN, SW or other qualified professional must develop or supervise the development of a discharge plan if the evaluation indicates a need for such plan

BUT…**every** patient should have a discharge plan

DISCHARGE PLAN (Cont'd)

The RN Case Manager and/or Social Worker Must:

- Arrange for the initial implementation of the plan
- Reassess if conditions change (for example: unexpected transfer to ICU or unexpected surgical procedure)
- As needed, counsel the patient and/or representative to prepare them for discharge
- Document all interventions and the patient's consent to the plan in the medical record

CHALLENGES OF THE PROPOSED RULES

- Discharge planning for short stay and same day surgery/procedure patients
- Plan to be in place within 24 hours
- Discharge planning over the weekend
- Staffing, especially for departments that already have high patient ratios
- Audits
- Changing the focus to include the patient's goals and preferences
- Reducing factors that lead to preventable readmissions
- Collaborating with post-acute level of care providers
- Sharing data with patients from post acute care providers

RELIAS LEARNING 70

CHALLENGES OF THE PROPOSED RULES

- Including the caregiver/support person with the patient in development of the discharge plan
- Discharge summary to the practitioner responsible for follow up care within 48 hours
- Pending tests results to practitioner within 24 hours of availability
- Standard data set of patient's medical information set to facility at time of transfer
- Discharge planning policy
  - Written
  - Reviewed at regular intervals
  - Approved by hospital board

RELIAS LEARNING 71

YOUR NEXT STEPS IN PREPARATION FOR THE FINAL RULES

- Review your policy and understand any possible required changes
- Audit a sample of records
  - Is current policy being followed?
  - What are your gaps with current policy?
  - What are your potential gaps with proposed rules?
- Consider the collaboration that will need to occur should these rules become final
- Review your hospital's readmission strategy, its completeness and its effectiveness

RELIAS LEARNING 72

YOUR NEXT STEPS IN PREPARATION FOR THE FINAL RULES

- Share proposed rules with
  - Your executive leader
  - Nursing and other appropriate disciplines
  - Your Case Management Steering Team
- Determine the impact of the proposed rules to your department
  - Number of additional patients requiring discharge plans
  - Number of patients who are now being discharged without a plan
  - Staffing required for 24 hour discharge plan requirement, weekend and after hours impact
  - Required audits

RELIAS LEARNING 73

YOUR EVALUATION TOOL

ATTACHMENT 6

RELIAS LEARNING 74

THE PROPOSED CHANGES TO THE CONDITIONS OF PARTICIPATION ARE NOT ONLY FOR YOUR CASE MANAGEMENT DEPARTMENT TO IMPLEMENT

THIS IS A COLLABORATIVE PROCESS

RELIAS LEARNING 75

BARRIERS TO DISCHARGE PLANNING

Sometimes, it's like pulling a rabbit out of a hat!

Comorbidities that complicate discharge planning:

- Presenting diagnosis(diagnoses)
- Preadmission activities of daily living
- Patient's home location (home, SNF, etc); closeness to family
- Readmission risk
- Psychosocial history
- Social support
- Benefit status
- Finances
- Patient treatment goals and preferences

RELIAS LEARNING 76

COMMON BARRIERS

- Acuity
- Age
- Bariatric Issues
- Bed Availability
- Behavior/Restraints
- Finances
- Patient/Family
- Physicians
- Lack of Resources
- Advanced Directives/DNR paperwork
- Abuse and Neglect
- Homeless
- Legal
- Transportation
- Undocumented Immigrants
- Incompetency Issues - Guardianship

RELIAS LEARNING 77

WHAT HAPPENS WHEN DISCHARGE PLANING IS NOT EFFECTIVE?

READMISSIONS, RESULTING IN QUALITY AND COST IMPACT

- 11.6% of Medicare beneficiaries are rehospitalized within 30 days of discharge
  - Results in $15 billion in spending
  - Of those readmitted within 30 days, 64% receive no post-acute care between discharge and readmission MEDPAC 2007
- 19% are readmitted within 30 days NEW ENGLAND JOURNAL OF MEDICINE 2009
  - Only 50% saw physician before their readmission
  - As many as 90% of rehospitalizations within 30 days appear to be unplanned
  - Cost estimated to be $17 billion per year HRET 2011
- 12.3% readmitted with potentially preventable readmissions MEDPAC 2011
- 41% of inpatients leave the hospital with pending test results
  - 66% of physicians are unaware of the results
  - 37% of the results are actionable
  - 13% of the results are urgent ANNALS OF INTERNAL MEDICINE 2005
- 20% of patients experience adverse events after discharge; 75% of those could be prevented AHRQ

RELIAS LEARNING 78

READMISSIONS (FROM MEDICARE.GOV--HOSPITAL COMPARE) January 2017

15.6% of Medicare beneficiaries rehospitalized within 30 days of discharge

Out of 4746 hospitals in the United States	214 were better than the national rate	4074 were no different than the national rate	283 hospitals were worse than the national rate

BUSINESS CASE FOR READMISSIONS

- LOS for rehospitalized patients is 0.6 day longer than the stay for patients with same DRG who were not hospitalized in previous 6 months
- Penalty for excess readmissions: 3% of all Medicare payments
- Value-based penalty of up to 2%, especially impacted by Medicare Spending Per Beneficiary
- CMS continues to propose more conditions for readmission penalties (watch for the IPPS proposed rules in May 2017)

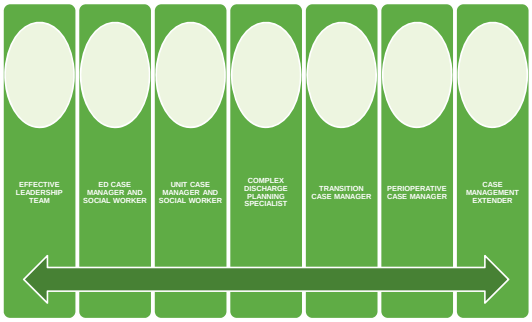
HEALTH RESEARCH & EDUCATIONAL TRUST (HRET) 2011

IDEAL DISCHARGE PLANNING

- **I**nclude the patient and family as full partners
- **D**iscuss with the patient and family key areas to prevent problems at home
- **E**ducate the patient and family throughout the hospital stay
- **A**ssess how well doctors and nurses explain the diagnosis, condition, and next steps in their care and use teach back
- **L**isten to and honor the patient and family's goals, preferences, observations, and concerns

Agency for Healthcare Research and Quality (AHRQ)

KEY CASE MANAGEMENT POSITIONS FOR EFFECTIVE DISCHARGE PLANNING



DISCHARGE PLANNING DASHBOARD METRICS

- % of patients with timely discharge plan
- % patients with discharge plan re-evaluated, as appropriate
- % of patients going home with home health
- % of patients discharged to home health with choice documented in medical record
- % of patients discharged to a skilled nursing facility with choice documented in medical record
- % of patients with required PASRR
- % of patients with second Important Message
- % of patients with timely second Important Message
- % of patients transferred to SNF without 3-day qualifying stay (as inpatient)
- % of patients discharged with complaints about their discharge planning
- # and trends of avoidable days

RESOURCES

- Balanced Budget Act of 1997
- Centers for Medicare and Medicaid Services (CMS)
  - www.cms.gov
  - Glossary
  - CMS – 4105F
- Federal Regulations
  - Sec 482.43, Hospital Conditions of Participation
  - Sec 10116, 10118-19
  - 42 CFR 483.100- 483.138
  - 42 CFR 411,424
  - 42 CRR 417.23 (b)2
- Social Security Act – Section 1861
  - http://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- The Omnibus Reconciliation Act of 1987 (OBRA)

RESOURCES

- Social Security Act – section 1802 Freedom of Choice
  - http://www.ssa.gov/OP_Home/ssact/title18/1802.htm
- Hospital Regulations for 3 day inpatient to qualify for SNF
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R161BP.pdf
- PASARR Screening
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html
- Important Message from Medicare: Discharge Appeal Rights
  - http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html
- Center for Medicare Advocacy: Discharge Planning
  - www.medicareadvocacy.com
- CMS Discharge Planning Education
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Discharge-Planning-Booklet-ICN908184.pdf

RESOURCES

- Discharge planning introduced to patients
  - Care Conversations when discussing transition from the hospital to assisted living care http://careconversations.org/transitioning-hospital-assisted-living?utm_source
  - Robert Wood Johnson's Care about Your Care on transitioning from hospital http://www.rwjf.org/en/library/research/2013/01/care-about-your-care-discharge-checklist---care-transition-plan.html
- Care Transitions from Hospital to Home; Agency for Healthcare Research and Quality
  - http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html
- 90 Day Care Transitions; National Association for Home Care and Hospice http://www.nahc.org/news/90-day-transition-plans-a-safer-journey-to-living-safely-at-home
- Gaps in Hospital Discharge Planning and Transitional Care; The Commonwealth Fund http://www.commonwealthfund.org/interactives-and-data/chart-cart/survey/2008-international-health-policy-survey----in-chronic-condition--experiences-of-patients-with-comple/g/gaps-in-hospital-discharge-planning-and-transitional-care
- Joint Commission Transitions of Care Portal http://www.jointcommission.org/toc.aspx
- DNV Discharge Planning Standards https://www.dnvgl.es/.../standard-interpretive-guidelines-and-surveyor-guidance-for-h...

RESOURCES

- American Hospital Association
  - Private-Sector Hospital Discharge Tools (Sample hospital discharge tools that strive to improve transitions to post-acute care and reduce admissions) January 2015
- CMS Revision to State Operations Manual Appendix A – Interpretive Guidelines for 42 CFR 482.43, Discharge Planning May 17, 2013
- Medicare Learning Network: Discharge Planning
- CMS: Your Discharge Planning Checklist (For patients and caregivers preparing to leave a hospital, nursing home or other care setting) www.medicare.gov
- Caregiver Action Network www.caregiveraction.org
- Family care givers www.caregiving.com
- Care Conversations http://careconversations.org/understand-care-needs

RESOURCES

- Robert Wood Johnson Care About Your Care http://www.rwjf.org/en/library/research/2013/01/care-about-your-care-discharge-checklist---care-transition-plan.html
- Case Management Concepts www.casemanagementconcepts.com
- Medicare Benefit Policy Manual (Publication 100-02) http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html
- IDEAL Discharge Planning AHRQ https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf

Thanks for attending!! Questions??

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THANK YOU