DISCHARGE PLANNING
ADVISOR

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IN THIS ISSUE

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Scorecard of red flags helps improve the discharge process

Tracking data can stem persistent problems

Successful discharge planning is a much more complex process than simply moving patients safely out the door, so it follows that evaluating your discharge planning process also might be a complex proposition. But some experts suggest that keeping an eye on small, easily tracked data can prompt you to red flags before they become persistent problems.

"I think the most important way to know if your discharge planning process is working well is to have some sort of scorecard for it," says **Beverly Cunningham**, RN, MS, vice president of Clinical Performance Improvement for Medical City Dallas Hospital.

That scorecard can be as simple or as far-reaching as your situation demands, but some obvious and easily tracked statistics can give you a good snapshot of changes to keep an eye on. [**See Table for sample discharge planning scorecard, p. 3.**]

While patient satisfaction is a big factor in determining whether any aspect of care is successful, measurable data and benchmarking can help spot where processes could be improved and patient discharge and movement through the hospital made smoother.

Those include factors such as length of stay, days in intensive care (ICU) and telemetry, number of bed holds in the emergency department (ED), rate of Medicare appeals upheld by the quality improvement organization (QIO) that reviews them, and number of patients who leave the hospital with no services.

"There are five things I track myself, but it could be any number – it dovetails with the discharge planning model you use," explains **Toni G. Cesta**, PhD, RN, vice president, patient flow optimization, corporate quality management at North Shore-Long Island Jewish Health System in Great Neck, NY.

Check data, review criteria

Cesta says one of the indicators she tracks is the number of discharges who are seen by a case manager or social worker. If the percentage of patients seen by a CM or SW is 32% to 56%, for example, that means half

to two-thirds of patients who come into the hospital aren't seen by case management.

"That would be a red flag to me," says Cesta.

A red flag might mean your facility's handling of the discharge process is malfunctioning; or, it might be that the process itself is the problem.

In the case of a high percentage of patients being discharged without seeing a CM or SW, Cesta suggests, "go back and look at your processes."

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"Maybe you're using high-risk criteria, and maybe the criteria are too restrictive," she says. "Maybe the type of patients has changed, and maybe you need to look at how, under your model, patients are assessed. If every patient is assessed [under your hospital's model], and you're only hitting 56%, then the problem is something else."

Another factor Cesta measures is the time from admission until the patient is seen.

"The national benchmark is 24 hours, while in some organizations it's 72 hours on a weekend, or even universally 72 hours," she points out. "Obviously, you can track that and see how you do. In some of our facilities, we have 30% of patients taking longer to be seen, and that affects their length of stay and the discharge planning process."

Cunningham monitors the number of patients who meet the "medical necessity" criteria for their stay. If a significant or growing number of patients remain in the hospital even when they aren't meeting the criteria for continued stay, it can be a red flag calling for evaluation.

Wearing out their welcome?

Besides looking at how long patients are staying, Cunningham suggests looking at *where* they're staying.

"Look at your length of stay for telemetry and ICU days, and train [staff] to benchmark that," she says. "There are not good benchmarks for that, but you can look for a longer length of stay in those units when they're not meeting the criteria."

Cesta says some hospitals might consider a "long" length of stay to be 14 days; in years not too long past, 30 days was considered a long stay.

"The average might be to say '10 days or greater' to define a long length of stay," Cesta suggests. "Then, categorize those patients; how many are acute and appropriately in the hospital? We found that 70% of our patients in the hospital 14 days or longer were acute."

The remaining 30%, non-acute patients, fell into other categories, with discharge issues that could include:

- Patient/family issues, such as the patient or family waiting to select a continuing care facility, or when the family is wrestling over whether to move the patient to a nursing facility or try to care for the patient at home;
- Facility-specific delay, as when a facility is

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selected but has no bed available;

•Payer issues, as when transfer is delayed pending approval, or awaiting Medicaid application or managed care/continuing care service approval;

•Psychiatric issues, when the patient needs a psychiatric bed but one is unavailable;

•Legal issues, including guardianship questions, or individuals with questionable or no documentation.

"And then there are patients you can't discharge today because you're waiting on the physician to do a consult, or to write discharge orders or a prescription, or waiting for labs, or an MRI or CT, or a stress test, echocardiogram, or for nuclear medicine," Cesta adds. "And family issues as simple as the family member works and can't get by to pick up the patient until late in the day. Or the patient can't leave without a walker, and you're having to wait for the DME [durable medical equipment] delivery."

While each of these might seem specific to each patient, Cesta and Cunningham advise tracking them nonetheless; an inordinate number of one delay or another might suggest re-thinking things such as discharge time (morning vs. afternoon), supplier requests, and communication with family.

"Look at your avoidable days, and ask what they're due to," says Cunningham. "There are four functions of case management: discharge planning, care coordination, utilization management, and resource management. If you're not doing good care coordination, you can't do good discharge planning."

Unfunded patients who are staying longer than medical necessity criteria dictate, she says, are a clear red flag that some discharge planning procedures aren't being applied appropriately.

Discharge with no services: Too little planning?

Cesta says she tracks how many discharges leave the hospital with no services at all. This is a benchmark that's variable based on the hospital, "but it shouldn't be greater than 60% to 70%," she says, meaning that at most, if more than 60%-70% of patients go home with no services, "you might be missing patients."

Of patients leaving with services, it helps to know what services they are going into – home care, sub-acute care, etc.

"It helps with your discharge planning acuity," Cesta points out.

Care coordination is a big factor in good discharge planning, Cunningham says. So if you're hearing complaints from case management staff

Table. Sample discharge planning 'scorecard'

Category	Target	Month
# patients seen by SW/CM		
Time from admission to first seen		
# patients and discharges with LOS >10 days		
LOS for telemetry and ICU		
# continued stay denials		
% patients discharged home w/ no services		
% occupancy		
# bed holds in ED (sign of overcapacity)		
# patients who stay when medical necessity not met		
% of Medicare IM message appeals substantiated by QIO		

Key: SW/CM = social worker or case manager; LOS = length of stay; ED = emergency department; IM =important message; ICU = intensive care unit; QIO = quality improvement organization

about consultants, for example, your care coordination is bound to suffer.

Cunningham and Cesta both strongly suggest paying attention to QIO findings in Medicare appeals.

"If you have appeals regarding the second IM [the notification to patients that they're about to be discharged and that they can appeal], and those appeals are being substantiated by the QIO, that would be something you'd need to think about," Cunningham says. "And even if you have appeals that are not substantiated by the QIO, you have to ask yourself, 'How did we get to this point? Did the patient just want to stay longer, or did this happen because we weren't managing it?'"

Finally, Cunningham says, give weight to patient complaints and satisfaction.

Focus groups including patients or families who've had recent hospital stays, including parents of pediatric patients and patients who have had more than one admission, can be tremendous resources for information on how the discharge planning aspect of their case management worked.

"We use a Gallup survey, and we ask them about the discharge planning process and whether they have aftercare services. I think if patients aren't happy with their experience with being discharged, then I think that, too, is a red flag that the process isn't working well." ■

Mercy Health to put med reconciliation online

Patients transferred with clear med orders

The Joint Commission in 2006 initiated a new standard that demands "accurate and complete reconciliation of medications across the continuum of care," but nurses and case managers at Mercy Health Center in Oklahoma City were way ahead of them. Long troubled by discrepancies in patients' in-hospital and at-home medications, they already had a solution in the works.

An interdisciplinary team — including nursing, physical therapy, speech therapy, occupational therapy, clinical dieticians, pharmacy, pastoral services, medical records, radiology, case management, and a physician representative — created a computer-generated discharge home medication order (now an order) that already has reduced duplication and adverse medication events, and is poised to do more.

SOURCE

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Eventually, with the addition of a new computer system expected in about two years, the discharge home medication order will generate a medication history that will follow patients through subsequent discharges and admissions, giving clinicians an immediate account of what medications the patient has been prescribed in the hospital and at home.

"When we first put it out [in 2004], medication reconciliation wasn't a safety standard," according to **Donna Poole**, BSN, RN, nurse manager, who served as nursing informatics coordinator for the project. "We were just doing it because our nurses were asking for help, so we created a tool to help."

The medication reconciliation 'battle'

Medication reconciliation can be one of the more dreaded aspects of care coordination, and a holdup in the discharge planning process.

"We're still battling it," even with the automated order, Poole says.

Patients come into the hospital on medications that their hospitalist might decide to continue, temporarily suspend, end altogether, increase, or pair with other medications; when the patient is ready to return home, it's not uncommon for the patient and family to be confused about what medications to resume, continue, or quit once they leave the hospital.

The discharge home medication order is a computer-based form in three versions — drugs brought in at admission, to be continued or changed; medications the patient is prescribed in the hospital, to go with him or be changed at transfer; and medications that the patient is to take at home after discharge. It is populated with hospital formularies as well as home medi-

Continued on p. 30

RUN DATE: 07/20/07 Mercy Hlth Ctr Care Documentation *LIVE*
RUN TIME: 1431
RUN USER: NUR DLP

DISCHARGE HOME MEDICATION RECONCILIATION ORDERS

MQ3A M313-1

Please Check to Continue Medications at Home

Check to Continue	Bold = Hospital Med Hospital & Home Meds	Hosp Med	Home Med	Dose	Route	Frequency	Comments
	PROCRIT (EPOETIN ALFA)	**X**		**20000 UNITS**	**IV**	**UD**	
	ROXICODONE (OXYCODONE)	**X**		**5-10MG**	**PO**	**Q6HPRN**	
	ROXICODONE		X	5-10MG		EVERY 6 HOURS AS NEEDED	
	SENSIPAR (CINACALCET HCL)	**X**		**30MG**	**PO**	**DAILY@1800**	
	SENSIPAR		X	90MG		QPM	
	SINEMET CR		X	1 TAB		HOUR OF SLEEP	
	XANAX		X	0.25MG		EVERY 8 HOURS AS NEEDED	

Additional Prescriptions given to Patient

Medication	Dose	Route	Frequency	Comments/ Reason for Medication

Med Allergies: PROCARDIA, BENADRYL
Weight: 268 lbs 5oz 121.7kg
Date Weight Taken: 07/16/07

Physician Signature: _____

Date: _____

Time: _____

Source: Mercy Health Center.

Continued from p. 28

cations — so that providers have a clear list – eventually it will cross-match formularies and home meds — of what the patient is taking at each step of the way. At admission, during hospitalization, and at discharge, the physician can access the form; change, add, or take away medicines; change doses, and make substitutions, leaving behind an up-to-date, clearly understandable record of the patient's medications and physician's orders. [**See Figure 1, pg. 29 for sample discharge order**].

Because the current computer system doesn't allow the tool to function at what Poole envisions its full capacity to be, there is a good deal of free-text entering that has to be done; eventually, the form will self-populate quickly, and medications will be sorted with like medications and formularies automatically, rather than alphabetically as they do now.

For the time being, nurses have to call physicians who haven't yet adopted the task of filling in the forms themselves, and go down the list to fill out the forms – [which is] time-consuming, Poole admits, but worth it.

"I had a good example recently," says Poole, who does floor duty on occasion. "I had a patient, and suddenly they're going home. The doctor has written orders for the patient to go home, and hadn't printed a [discharge medication] form, so I told the patient it would be about 45 minutes before they could leave, so I could call the doctor to get the [list of] home meds.

"The patient said that I didn't need to do that, that the doctor had told him just to keep taking the medications he was on at home and an additional script he had handed them. So I got out the list of the medications he'd been taking in the hospital; there were two meds that he had been taking in the hospital that he was not taking at home. The family was not sure about those; neither was I as the nurse. I called the physician, and he clarified that indeed, he did want the patient to continue those, but made a change in the frequency. It would have been very easy for them to leave without knowing what the doctor intended for them to take."

Progress isn't held up by wait for computers

As she waits for the computer system that will take the process to near its full capability, Poole says a challenge in the meantime is getting the hospital's 800 physicians to sign on to the process.

"Our nurses are online, but the physicians aren't yet, so we have half paper outputs, half online," she explains. "We still have to generate paper forms to get compliance. But in two years, we'll be totally computerized."

And while inconvenient for now, Poole says the process is still an improvement that is getting better all the time. What started as a worksheet has now become an order sheet, she adds.

"We're working hard on our processes to get us the safest we can be right now — we can't wait two years," she explains.

When the system is fully computerized, when a physician opens a patient profile, he or she will see a populated list of medications the patient is already on, and will indicate that he or she has reviewed the medications and whether any changes should be made. The process is repeated at discharge, so the nurse or social worker planning the discharge will have an accurate order at his or her fingertips for advising the patient about the medications to take at home. (The form itself stays with the patient's record, and doesn't go home with the patient.)

A review of the tool in 2006 found the form reduced discrepancies in frequency and dose and reducing therapeutic drug duplication at the time of discharge. Resolution of discrepancies in frequency improved by 65% with the tool. Resolution of discrepancies in dosages improved by 60%, and therapeutic drug duplication was addressed in 58% more cases.[1]

Transfer form vetted through Six Sigma

Mercy's medication reconciliation phases are being analyzed using Six Sigma, and while the discharge reconciliation form has yet to undergo analysis, the transition form used when patients move from one level of care to another within the hospital has been through the quality evaluation.

"Transition is one area we could catch adverse drug events, and we've perfected that," Poole says. "We have been getting very good compliance on transition."

Compliance at admission will be easier once the process is fully computerized. When patients in the system are admitted to the hospital, the list in their profile will repopulate with their home medications and any medications that were added during their last hospitalization — a "historical meds list," Poole says.

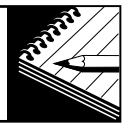
One finding that Poole and her colleagues found interesting after the reconciliation order for discharge was in use is that the number of medica-

tions ordered at discharge didn't decrease — it increased. The 2006 study concluded that the form — at that time, a worksheet rather than an order — prompts the doctor to clearly specify all discharge medications "instead of giving the common order to 'discharge home, and continue home meds.'" [1]

Reference

1. Poole DL, Chainakul JN, Pearson M, et al. Medication reconciliation: A necessity in promoting a safe hospital discharge. *J Healthc Qual* 2006;28:12-19. ■

GUEST COLUMN



Effective discharge planning defined

By **Diane Holliman**, PhD, LCSW
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In this age of evidence-based practice and cost containment in health care, effective discharge planning is increasingly important. But how is effective discharge planning defined and measured?

For this article, the academic nursing database (CINAHL) and the social work database (Social Work Abstracts) were used to find research articles defining and describing effective discharge planning. The articles in these databases are reviewed by authorities in their fields before publication, and reflect the results of qualitative and quantitative studies on discharge planning. These databases may be accessed through university and other public libraries so all those doing discharge planning may have access to them.

The term "discharge planning" did not appear in the academic or professional literature until the 1970s; however, the process of discharge planning in health care, social work, and nursing has a long history that includes urban hospitals clearing their wards of chronic patients and homeless Civil War veterans during the 1890s, child welfare organizations protesting the indiscriminate placement of infants who were abandoned by their mothers during the early 1900s, and the deinstitutionalization movement in mental health of the 1960s.

In the 1970s, with advances in medical treatment, technology, and medications, health care costs began to steadily increase.

In the 1980s, prospective payment plans such as diagnosis-related groups (DRGs) were put into place to contain health care costs. These prospective payment and managed care systems required prompt patient discharges and reduced length of stays for hospitals to maintain their financial viability. Thus, discharge planning emerged as an important function in the hospital setting.

Discharge planning: Many names and purposes

Today there are various definitions of discharge planning and terms that are synonyms for discharge planning. However, there is some agreement that:

- Discharge planning is a complicated, dynamic, multidimensional, and multi-task process;
- Today, many individuals and organizations (patients; caregivers; health and mental health professionals; community organizations; private, for-profit outpatient health care providers; insurance companies; Medicare; and Medicaid) have a stake in discharge planning;
- These individuals and organizations often have competing interests and objectives.

Terms that have been linked to discharge planning or that are closely associated with discharge planning are "care transitions," "relocation management," "transitional care," "continuity of care," "coordination of care," and even "premature termination" and "patient dumping."

Among professional discharge planners, there is a maxim that "discharge planning begins the day of admission." However, today we are seeing that effective discharge planning should start before admission and can be as important in a person's preplanning as a living will or organ donation.

For example, a 74-year-old female with congestive heart failure may come into the hospital with "Plan A" and "Plan B" for discharge. "Plan A" may be to return home with housekeeping assistance if she is continent and able to ambulate after the hospitalization. "Plan B" could be to be discharged to her daughter's home with home health care and home physical therapy if she is incontinent or unable to ambulate.

For this patient, as well as many others, there may be a need for a "Plan C" or "Plan D." There

are often multiple variables that affect individuals' dispositions when they are ready to leave the hospital (financial status, community resources, available caregivers, severity of their medical condition, functional abilities).

Today, discharge planning includes more than just discharge from an inpatient hospital setting. Patients today are commonly discharged from nursing homes and outpatient hospices because of their physical improvements or the increased confidence and education of the patient and caregivers. Discharge planning should be a part of outpatient surgery admission and community mental health. Discharge planning, short — and long-term planning, or even "life planning," as some call it — should be a comprehensive process that involves medical, functional, psychological, social, financial, community, and organizational assessment and referral.

A challenge to measure

Because of the multiple and changing factors that influence discharge planning, effective discharge planning can be challenging to measure. Measures for effective discharge planning have included:

- length of stay;
- patient/caregiver satisfaction;
- readmission or recidivism rates;
- cost of hospitalization or treatment;
- amount of time spent discharge planning by staff;
- documentation of the tasks done by discharge planners

However, none of these factors alone define effective discharge planning.

Effective discharge planning remains a fuzzy concept. The products of effective discharge planning are seamless, invisible, and silent, whereas ineffective discharge planning can lead to extended lengths of stay, patient/caregiver dissatisfaction, readmissions, malpractice, and higher health care costs.

The academic and research literature describes factors that adversely affect discharge outcomes. Patients whose conditions or situations are atypical or non-routine may have less successful discharge outcomes. These atypical or non-routine situations may include:

- severity of illness or disability;
- chronic and persistent mental illness;
- homelessness;
- language barriers;
- substance abuse;
- absent or inconsistent social support;
- patient inability or refusal to follow treatment plans or staff directives;
- financial, housing, and insurance barriers.

Other barriers include institutional and community limitations such as conflicts between the patient's rights and managed care requirements, the temptation to manipulate diagnosis to prolong length of stay, limited community resources, lack of discharge planning by the treatment team, and a lack of awareness of the biopsychosocial factors affecting the patient and his or her caregivers.

Predictors that lead to effective discharge planning are high-risk screening for discharge planning; preadmission planning; biopsychosocial assessment as part of treatment and discharge planning; involvement of patients, caregivers, and community in the planning; development of literature and other educational tools for discharge planning; and scheduling post-discharge phone calls for follow-up.

Discharge planning is a process that takes place throughout the course of a person's treatment and care. Recommendations for successful discharge planning on the individual level are to take a comprehensive biopsychosocial approach to discharge planning, and to involve patients, caregivers, and the community in the process.

On the macro level it is important to look at organizational, community, state, and national policies that affect discharge. Can programs be developed to educate patients and caregivers on discharge treatments and community resources? Are there state and federal policies that may adversely affect patients in your setting? How can you educate your patients and policy-makers?

Collaborating with organizations, contacting your legislators with specific examples of how policies are problematic while insuring patient confidentiality, supporting outcome-based research, and building community networks can lead to effective discharge planning not just for one patient or caregiver, but for patients and caregivers over time. ■

Discharging frail elderly population

Diligence by social worker can make the difference

Preparing to discharge a frail, elderly patient is a task that shouldn't be taken lightly in

any setting, but for **Priscilla F. Cutler,** MSW, LICSW, MFA, ensuring that an elderly patient's safety net is in place can prove challenging in a mountainous, lightly populated area of New Hampshire.

"We work with home health and a visiting nurse service, and they do a good job, but we don't always have enough control over some of the more rural pockets, and sometimes we have trouble getting people in there," says Cutler, a clinical social worker at Monadnock Community Hospital, a 62-bed acute care hospital in Peterborough, NH, with a population of more than 6,000. "It can be quite challenging."

Dealing with a patient with lots of needs takes creativity to get the most out of limited staff and equipment resources.

"Frankly, as a team we have very good relationships and very limited resources," she says. The collaborative team that plans patient discharges at Monadnock Community comprises a physical therapist, occupational therapist, social worker, nurse, and doctor.

"Our average stay is supposed to be about 96 hours, but we have skilled nursing at the hospital, so if we see someone is very deconditioned — either they came in very deconditioned or they became deconditioned while in the hospital — we can switch them to skilled nursing without having to go to rehab or a nursing home, which is very helpful," she explains. "The stumbling block for us is coordination of equipment and service in the home."

But proving that good discharge planning can trump a lack of resources, Cutler says the recidivism rate for frail elderly patients who are discharged from Monadnock Community "is pretty low."

Shoot for Plan A, but have Plan B ready

"We really want to anticipate what problems are going to happen, and to do that we coordinate with the family on the very first day, and then every day — maybe more than once a day — with the family until the patient is discharged," she says. "We want the family to come in and go over [the plan] before the patient is discharged."

She says it's not uncommon for patients to enter the hospital anticipating that they'll be discharged home with no complications, but once the situation is assessed, the family realized they hadn't taken into account the remote location of the patient's home, or the flights of steps that have to be navigated once the person gets there.

"You want to troubleshoot before the discharge," Cutler adds. "You want to pull in that family and friends, and get them in the loop and find out what their time commitments are, what they're willing to do, what shopping or driving they can do.

"Because a lot of times, the family lives across the country, and maybe the person has few resources, or they have no family, so you have to find a friend, a neighbor, someone in that person's personal life, and work it out."

And most important: "What does the patient want?"

"We find out what the patient's 'Plan A' and 'Plan B' are, and we operate with those in mind at all times, but we know we sometimes have to go to Plan C, D, or E," she admits.

That's where being a social worker comes into play.

"The patient might be insisting on going home, and the members of the team see lots of questions about that, that it might not be the best option for that patient, but that's what the social worker brings into it — you look at it, look at the patient, and you want the patient to get what's best for them," she explains. "We certainly raise safety issues, especially when a patient wants to go back and live in a place that others on the team are afraid won't meet his or her needs, but the social worker is left to advocate for what the patient wants."

While staffing doesn't permit Cutler and her colleagues to routinely follow up with patients after discharge, they make it clear to patients and families that they are there if needed.

"Every plan can fail," she points out. "The team may say 'We don't think this plan will work,' but the family or the patient insists, then they get home and realize the next day or within a few hours that they can't do it. And when that happens, we help facilitate the best we can." ■

Underperforming nursing homes named by CMS

Agency hopes exposure will push them to improve

Sometimes the bright light of unwanted attention can spur improvement, and that's the the-

ory behind the Centers for Medicare & Medicaid Services' (CMS) decision to publish the names of underperforming nursing homes.

CMS in November 2007 began publishing the names of "special focus facility" (SFF) nursing homes that had failed to improve significantly after being given the opportunity to do so. (The updated list is available at www.cms.hhs.gov/CertificationandComplianc/Downloads/SFFList.pdf.)

Once a facility is selected as an SFF, state survey agencies are responsible for conducting twice the number of standard surveys and will apply progressive enforcement until the nursing home:

•significantly improves and is no longer identified as an SFF;

•is granted additional time due to promising developments; or

•is terminated from Medicare and/or Medicaid.

"This is the latest in a series of steps we will be taking to improve quality and oversight in nursing homes," according to **Kerry Weems**, CMS acting administrator. "We are issuing more information on special focus facilities to better equip beneficiaries, their families, and caregivers to make informed decisions and stimulate robust improvements in nursing homes having not improved their quality of care."

Between November 2007 and February 2008, CMS worked with states to create an SFF list that the agency says is current and provides consumers with the information needed to make a distinction between nursing homes that are improving and those that are not.

The updated and expanded list identifies facilities by the category they fall within:

•New Additions: Nursing homes added within approximately the past six months;

•Not Improved: Nursing homes that have failed to improve significantly in at least one survey after being named as a SFF nursing home;

•Improving: Nursing homes that have significantly improved on the most recent survey, including no findings of harm to any resident and no systemic potential for harm;

•Recently Graduated: Nursing homes that have sustained significant improvement for about 12 months, indicating an upward trend in quality improvement compared to the nursing home's prior history of care; and those

•No Longer in Medicare and Medicaid: Nursing homes that were either terminated by CMS from participation in Medicare within the past few months or voluntarily chose not to con-

CNE *questions*

9. An increase in the number of Medicare Important Message appeals upheld by a hospital's QIO may signal _____ in the hospital's discharge process?
A. strength
B. weakness

10. In a 2006 study of the effectiveness of its relatively new physician discharge medication order form, Poole et al found the reconciliation order prompts physicians to clearly specify all discharge medications instead of giving the common order to "discharge home, and continue home meds," leading to an increase in the number of medications ordered.
A. True
B. False

11. When Centers for Medicare & Medicaid Services designates a nursing home as a "special focus facility" (SFF):
A. it retains that designation permanently.
B. it must shut its doors.
C. it can have the designation removed by showing significant improvement over time.
D. it receives additional Medicare and Medicaid money as an incentive to improve.

12. According to Holliman's review of the literature, predictors that lead to effective discharge planning include:
A. high-risk screening for discharge planning
B. preadmission planning
C. biopsychosocial assessment as part of treatment and discharge planning
D. involvement of patients, caregivers, and community in the planning
E. All of the above

Answer key: 9. B; 10. A; 11. C; 12. E.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with this issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

tinue participation.

Initiative not new, but publicity is

The SFF initiative was created by CMS in 1998 in response to the number of facilities that were consistently providing poor quality of care. Those facilities were periodically instituting enough improvement so that they would pass one survey, only to fail the next, often for the same problems as before.

CMS investigators found that facilities with this compliance history rarely addressed the underlying systemic problems that were leading to the repeated cycles of serious deficiencies — deficiencies such as failing to give residents their medications in the correct dose at the correct time, failing to take steps to prevent abuse or neglect, inappropriate use of restraints, and failure to prevent or properly treat bed sores.

Nearly 3 million Americans, most of whom are enrolled in Medicare or Medicaid, are in the 16,000 nursing homes in the United States at some point during each year. The nursing homes listed for each state had survey results that were, at the time of their selection as an SFF, among the poorest 5% to 10% in their state.

The attention is working, CMS reports. Data indicate that about 50% of the nursing homes identified as SFFs significantly improve their quality of care within 24–30 months, while about 16% are terminated from Medicare and Medicaid.

Weems says that by summer 2008, nursing homes that have been designated as SFFs will be able to access technical assistance from CMS to help move into compliance with federal quality of care regulations.

More information on the SFF initiative is available by going to www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp and scrolling down to "Special Focus Facility Background Info and List." ■

CMS offers overview on Medicare/Medicaid appeals

The Centers for Medicare and Medicaid Services (CMS) has created a free brochure outlining the five levels of the Medicare Part A and Part B appeals process. The overview describes the process and provides details on where to get more information about Medicare appeals.

"The Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers" is aimed at informing anyone who provides services and supplies to Medicare beneficiaries about the levels of appeals and where to find out more.

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) included provisions aimed at improving the Medicare fee-for-service appeals process. Part of these provisions mandate that all second-level appeals (for both Part A and Part B), also known as reconsiderations, be conducted by qualified independent contractors (QICs).

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Discharge Planning Advisor*, CNE participants should be able to:

- Identify particular clinical issues affecting discharge planning.
- Apply discharge planning regulations to the process of discharge planning.
- Describe how the discharge planning process affects patients and all providers along the continuum of care.
- Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies. ■

COMING IN FUTURE MONTHS

- QIO role changing
- Discharging infants home
- Discharge plans for patients leaving AMA?
- When same patients return again and again
- Hospice vs. home

The reconsiderations that are conducted by the QICs have replaced the hearing officer hearing process for Medicare Part B claims, and established a new, second level of appeal for Medicare Part A claims.

The brochure is available as a free download at www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf. ■

For the Record

New ABN alters voluntary notification

Revised ABN replaces Notice of Exclusion

Medicare providers by now should have begun using the revised advance beneficiary notice (ABN) of coverage to let participants know when Medicare is unlikely to cover their care. Notable among the changes brought about by the revised ABN, CMS-R-131, is that it effectively eliminates most need for the Notice of Exclusion from Medicare Benefits (NEMB) when providing voluntary notification.

In the past, ABNs were only for procedures that Medicare might not cover, but didn't apply to procedures that were statutorily excluded from Medicare benefits. That was where the NEMB could be used for services that Medicare didn't cover, such as cosmetic surgery. The revised ABN form will be used for either purpose, and may be used to provide voluntary notification of financial liability.

CMS-R-131, the revised version, replaces those previously used: ABN (CMS-R-131-G) and lab ABN (CMS-R-131L). Skilled nursing facilities will continue to use ABNG until a revised SNFABN is released sometime later this year.

The new ABN includes a mandatory field for cost estimates of the items and/or services at issue, and a new beneficiary option under which the beneficiary may choose to receive an item or service and pay for it out of pocket rather than submitting a claim for Medicare coverage.

For a patient to be held responsible for non-covered Medicare expenses, providers are required to have a signed and dated ABN in the patient's file prior to any service provided by a physician or heath care professional. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. The beneficiary gets a copy, and the original is retained by the provider.

CMS is observing a six-month transition period from the date of implementation for use of the revised form and instructions (March 1, 2008). Thus, all providers and suppliers must begin using the new ABN no later than Sept. 1, 2008. The form and notice instructions are posted on CMS's beneficiary notice initiative Web page, www.cms.hhs.gov/bni. ■