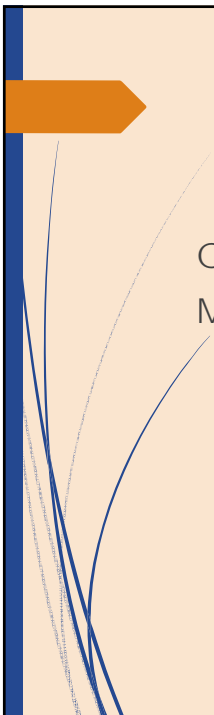


Discharge Planning Process

Fall Provider Meeting 2018

Department of Health and Senior Services
Section for Long Term Care Regulation

Angela Duvall, RN FAN III, State Training Coordinator
Angela Verslues, RN FAN III, State Training Coordinator



Discharge Planning Process

CMS - F660, F661, and F849

MO CSR - 19 CSR 30-85.042 (58) SNF
- 19 CSR 30-86.047 (44) ALF
- 19 CSR 30-86.047 (56)(C) ALF
- 19 CSR 30-86.043 (55) RCF II
- 19 CSR 30-86.042 (49) RCF I
- 19 CSR 30-88.010 (15) All

Friday Night Discharge

- ▶ Resident Harriet was discharged to home late Friday afternoon. Her discharge orders included:
 - ▶ Discharge to home with Home Health services
 - ▶ Diagnoses: Bladder Ca with associated chronic pain
 - ▶ Home Health services for narcotic pain management, routine medication set up, indwelling catheter care, follow up appointment with PCP next week

Friday Night Discharge (cont.)

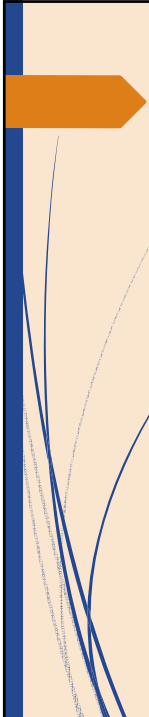
- ▶ Saturday afternoon Home Health admission assessment
 - ▶ Resident Harriet home alone with ID adult child
 - ▶ No pain medications at home and last dose was given in the SNF
 - ▶ Initial assessment showed Harriet rated her pain 7 out of 10 (Home Health requirements-any pain rating four or greater requires intervention)
 - ▶ Three day bubble-pack cards of routine meds with medical jargon instructions (take i-ii tab BID, TID etc.)

Friday Night Discharge (cont.)

- ▶ Incontinent with perineal redness
- ▶ Call to SNF MD shows would not provide orders for resident due to discharge
- ▶ Resident said she did not have a PCP
- ▶ Call to hospital shows no on-call physician available
- ▶ Returned call to the facility showed facility failed to dispense the resident's pain meds on discharge
- ▶ Resident sent to ER via ambulance for mgmt. of uncontrolled pain

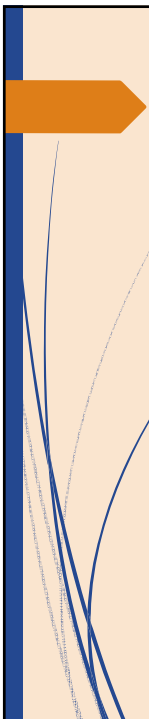
Discharge Requirements - F660 **§483.21(c)(1)**

- ▶ Discharge planning includes creating an individualized plan for discharge as part of the residents comprehensive care plan



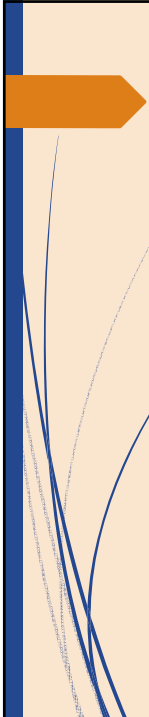
Discharge Requirements - F660 **§483.21(c)(1)**

- Discharge Planning
 - Involves the ID team
 - Begins at admission
 - Must focus on discharge goals
 - Must prepare resident to effectively transition
 - Must reduce factors that lead to **preventable** readmissions
- Intent
 - Ensure facility has a plan that addresses
 - Resident's goals
 - Any necessary support** (caregiver, referral to local contact agencies, etc.)
 - Provides education regarding post discharge care



Discharge Requirements - F660 **§483.21(c)(1)**

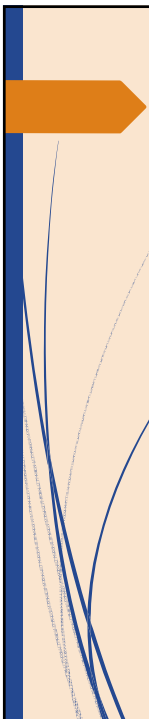
- **What will the resident need at home?**
 - The plan must include the identified needs and written plan to address them
- **Who will assist/support the resident once home?**
 - Consider caregiver/support person availability and capacity to provide required care



Discharge Requirements - F660 **§483.21(c)(1)**

- ▶ Who will coordinate services
 - ▶ Pharmacy services
 - ▶ Laboratory Services
 - ▶ Home Health Service
 - ▶ Discharge instructions/resident teaching

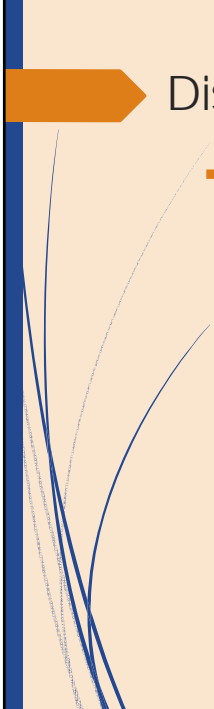
*The plan should include staff responsible for coordination of any planned services after discharge



What If?

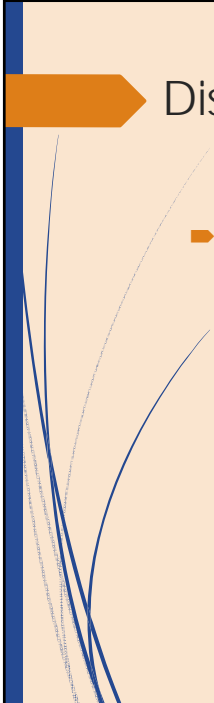
- ▶ Often Surveyors are Asked:
- ▶ If a resident wishes to return to their own home, and facility staff believe that would not be a safe environment for the resident, and the family wants the resident to return home as well.....

What Are We Supposed To Do?



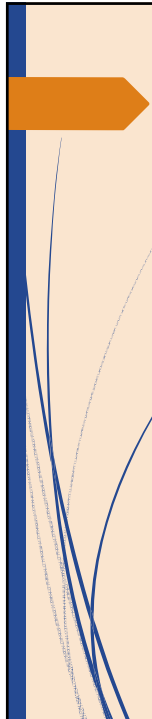
Discharge Requirements - F660

- ▶ Discharge to the Community
 - ▶ Discharge planning must identify the destination and ensure it meets the resident's health and safety needs
 - ▶ If a resident wishes to be discharged to a setting that does not appear to meet his/her post-discharge needs, or appears to be unsafe, the facility must treat this situation as similar to refusal of care and must:
 - ▶ Discuss with the resident and/or representative and document the risks and implications
 - ▶ Document that other more suitable location options equipped to meet the resident's needs were discussed
 - ▶ Document the resident's refusal
 - ▶ **Determine if a referral to Adult Protective Services is necessary**



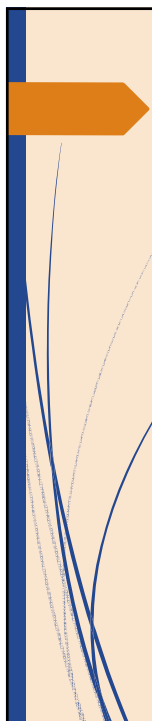
Discharge Requirements - F660

- ▶ Discharge to the Community
 - ▶ Must include:
 - ▶ Documentation of referrals to local agencies- (Ombudsman, local AAA)
 - ▶ Documentation of the response to referrals
 - ▶ If returning to the community is determined not feasible, record must include who made the decision and the supporting rationale



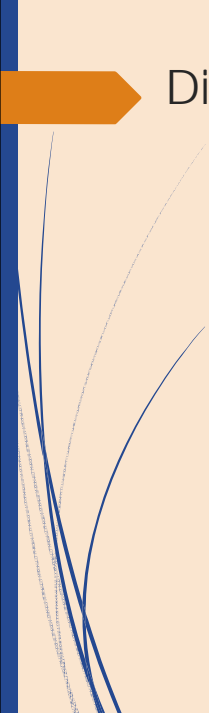
Discharge Requirements - F660

- ▶ Discharge to another SNF, HHA, IRF or LTCH
 - ▶ The facility must assist the resident in choosing an appropriate post-acute care provider that will meet the resident's needs
 - ▶ The facility must assist by presenting information about the potential receiving provider and must include:
 - ▶ Publicly available standardized quality information such as Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Compare and Long-Term Hospital Compare websites
 - ▶ Resource information on the number of residents discharged to the community and rates of potentially preventable hospital readmissions



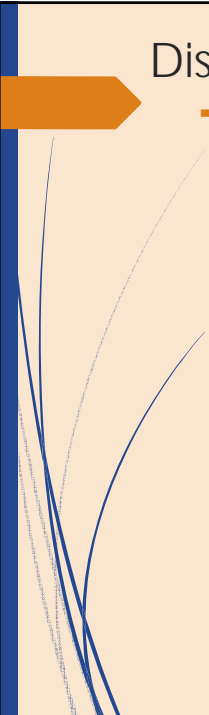
Discharge Requirements - F661 *§483.21(c)(2)*

- ▶ **When the facility anticipates discharge, a resident must have a discharge summary that includes the following:**
 - ▶ A recapitulation of the resident's stay
 - ▶ A final summary of the resident's status
 - ▶ A reconciliation of pre-discharge meds with post-discharge meds (prescribed and OTC)
 - ▶ A post-discharge plan of care



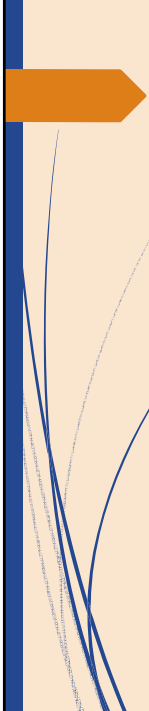
Discharge Requirements - F661

- ▶ Recapitulation of Resident's Stay
 - ▶ Describes the course of treatment while residing in the facility
 - ▶ Recapitulation includes diagnosis, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including pending lab results



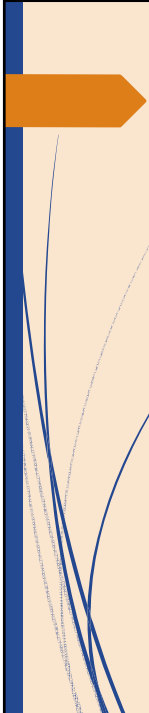
Discharge Requirements – F661

- ▶ Final Summary of Resident Status (Includes the following items from the most recent comprehensive assessment):
 - ▶ Identification and demographic information
 - ▶ Customary routine
 - ▶ Cognitive patterns
 - ▶ Communication
 - ▶ Vision
 - ▶ Mood and Behavior Patterns
 - ▶ Psychosocial well-being
 - ▶ Physical functioning and structural problems
 - ▶ Continence
 - ▶ Disease diagnosis and health conditions
 - ▶ Skin conditions
 - ▶ Activity pursuit
 - ▶ Medications
 - ▶ Special treatment and procedures
 - ▶ Discharge planning as evidenced by most recent DC plan
 - ▶ Documentation of summary information
 - ▶ Documentation of participation in assessment



Discharge Requirements - F661

- In addition, the facility must provide the following information to the receiving provider:
 - Contact information of the practitioner for the care of the resident
 - Resident representative information, if applicable, including contact information
 - Advance Directive information
 - All special instructions or precautions for ongoing care, as appropriate
 - Comprehensive care plan goals
 - All other necessary information, including a copy of the resident's discharge summary, and any other information for a smooth transition of care



Discharge Requirements - F661

- Discharge Summary
 - Contains necessary information the facility must furnish **at the time the resident leaves the facility**
 - Can be in hard copy or sent electronically
 - The medical record must contain the discharge summary information and identify the recipient of the summary

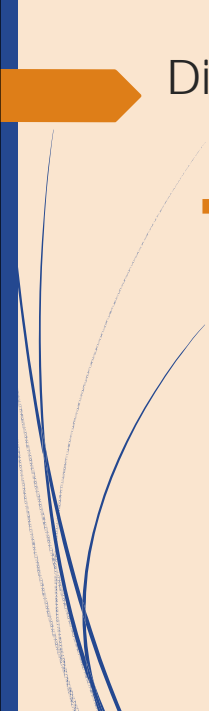
Discharge Requirements - F661

- ▶ The summary must also include the following information for the receiving provider:
 - ▶ Contact information of the practitioner for the care of the resident
 - ▶ Resident representative information, if applicable, including contact information
 - ▶ Advance Directive information
 - ▶ All special instructions or precautions for ongoing care, as appropriate
 - ▶ Comprehensive care plan goals
 - ▶ All other necessary information, including a copy of the resident's discharge summary, and any other information for a smooth transition of care

Discharge Requirements - F661

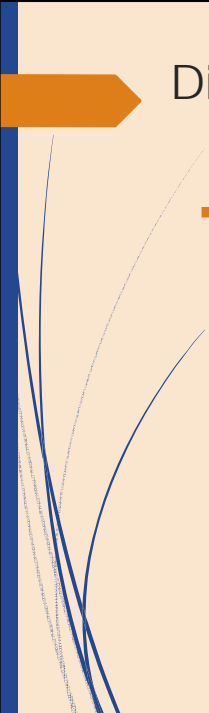
Note:

- ▶ In the situation when a resident is discharged with no continuing care provider (no primary care physician in the community), the facility is expected to document in the medical record efforts to assist the resident in locating a continuing care provider



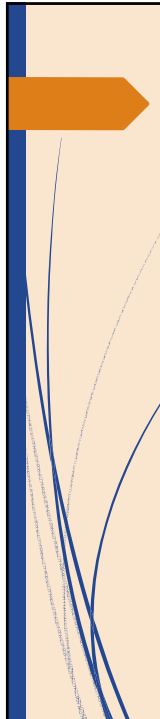
Discharge Requirements - F661

- ▶ Reconciliation of Medications
 - ▶ A resident's discharge medications may differ from the medications he/she took in the facility
 - ▶ If a discrepancy is found then the facility must assess and resolve
 - ▶ **Discharge instructions and accompanying prescriptions provided to the resident and if applicable, the representative, must accurately reflect the reconciled medication list in the discharge summary**



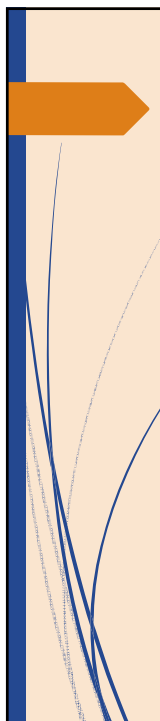
Discharge Requirements - F661

- ▶ Post-Discharge Plan of Care
 - ▶ Must detail the arrangements facility staff have made to address the resident's needs after discharge and include instructions given to the resident and/or representative
 - ▶ Developed by the ID team and the resident and/or representative with resident's consent



Discharge Requirements - F661

- ▶ Post-Discharge Plan of Care (cont.)
 - ▶ Post Discharge Plan of Care should include:
 - ▶ Where the resident will live
 - ▶ Follow-up care the resident will receive
 - ▶ Needed medical and non-medical services
 - ▶ Community care and support services
 - ▶ When and how to contact the continuing care provider



Discharge Requirements - F661

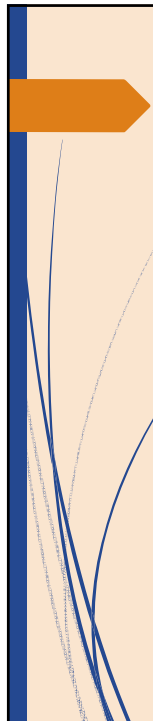
- ▶ Instructions for Residents Discharged to home
 - ▶ The medical record must include documentation that the resident and/or representative received the discharge instructions.
 - ▶ The discharge instructions must be conveyed in a manner that the resident and/or representative can understand.

Discharge Requirements - F661

- Key Elements of Compliance
 - Prepare a Discharge Summary with all of the components;
 - Recapitulation of the resident's stay
 - A reconciliation of pre and post discharge meds
 - A final summary of the resident's status
 - A discharge plan of care containing all required components
 - Reconcile the resident's pre and post discharge meds
 - Convey the discharge summary to the continuing provider

What could go wrong?

- Resident discharged to home from SNF via ambulance. Resident lives in a mobile home in a rural area. She is non-ambulatory. Access inside the resident's home is via a deck which is 20 steps off the ground. The deck and stairs are surrounded by a wood railing. The ambulance gurney is wider than the railing. The back door to the mobile home does not have a landing and therefore is not accessible.



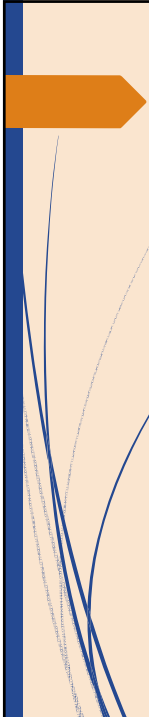
Hospice Service Requirements – F849 **§483.70(o)(1)**

- ▶ Long Term Care can do either of the following:
 - ▶ Arrange for hospice services through an agreement with one or more Medicare-certified hospices.
 - ▶ Not arrange for the provision of hospice services at the facility and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.



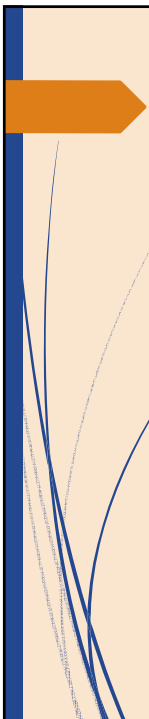
Hospice Service Requirements – F849 **§483.70(o)(1)**

- ▶ If hospice services are provided through an agreement as specified, the facility must meet the following requirements:
 - ▶ Ensure that the hospice services provided meet professional standards of practice;
 - ▶ Have a written agreement that addresses:
 - ▶ The services provided by hospice
 - ▶ The services provided by the facility
 - ▶ Process for communicating between hospice and the facility



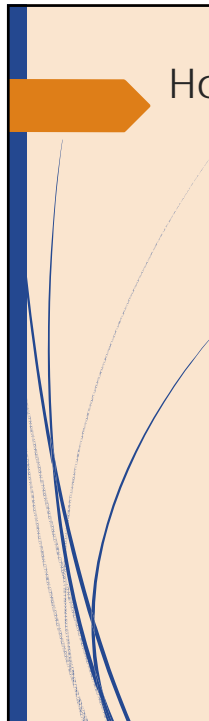
Hospice Service Requirements – F849 ***§483.70(o)(1)***

- ▶ A provision that the LTC facility immediately notifies the hospice about the following:
 - ▶ (1) A significant change in the resident’s physical, mental, social, or emotional status.
 - ▶ (2) Clinical complications that suggest a need to alter the plan of care.
 - ▶ (3) A need to transfer the resident from the facility for any condition.
 - ▶ (4) The resident’s death.



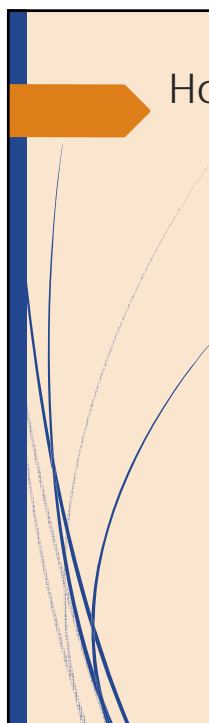
Hospice Service Requirements – F849 ***§483.70(o)(1)***

- ▶ LTC facility must designate a member of the ID team responsible for working with hospice representatives to coordinate care for the resident.
- ▶ The designated ID team member must have a clinical background and be able to assess the resident or have access to someone that has the skills.



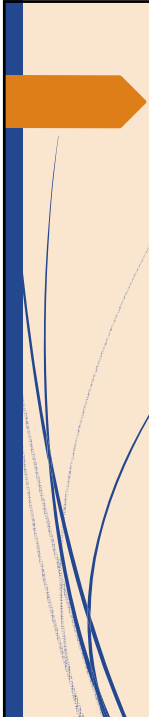
Hospice Service Requirements – F849 **§483.70(o)(1)**

- Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.



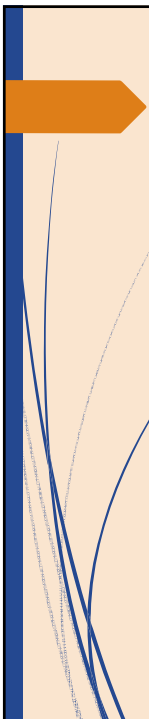
Hospice Service Requirements – F849 **§483.70(o)(1)**

- Coordinated Plan of Care
 - Is to be established by the nursing home and hospice, through collaboration
 - The care plan may specifically assign the care tasks to clearly show what cares need to be completed by hospice and which cares will be the facility's responsibility
 - The care plan must include how this plan will be coordinated between the hospice and the facility



Hospice Service Requirements – F849 **§483.70(o)(1)**

- Based on the communication between the hospice and the nursing home, the coordinated plan of care should reflect the identification of:
 - Diagnoses;
 - Common Problem List;
 - Palliative interventions;
 - Palliative goals/objectives;
 - Responsible disciplines;
 - Responsible providers;
 - Resident/designated representatives choices regarding care and goals.



Hospice Service Requirements – F849 **§483.70(o)(1)**

- Surveying for compliance
 - Number of residents during sample selection
 - Prompted by the program if not selected
 - Requested during Entrance Conference
 - (residents receiving hospice services in the facility)
 - (policy and procedure addressing written agreements between facility and Medicare certified Hospice provider)

