**Discharge Planning Process**

**Fall Provider Meeting 2018**

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Section for Long Term Care Regulation

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**Discharge Planning**

- **What is discharge planning?**
  - A process of identifying each resident’s discharge goals and needs, and then developing and implementing interventions to ensure those goals and needs are met.

- **When does discharge planning start?**
  - Upon Admission

- **Why is discharge planning important?**
  - Ensure we know the resident goals related to discharge.
  - Identify any necessary support (caregiver, referral to local contact agencies, etc.) to meet those goals.
  - To provide education regarding post discharge care to prevent readmission and ensures resident safe transition home or to another care setting.
Meet Harriet

- Admitted from an acute care hospital
- History of falls at home
- Post hip fracture requiring surgical repair
- Diagnosis of bladder cancer with chronic pain
- Receives narcotic pain medication
- Indwelling catheter
- Physical Therapy discharging resident on Friday
- Upon discharge, plans to resume living with her daughter, who has an intellectual disability

Discharge Planning

- Who should be included in the discharge planning process?
  - Resident
  - Resident’s representative
  - Physician
  - Nursing staff
  - Direct Care Staff
  - Dietician or nutrition staff
  - Anyone else determined by resident’s needs (Home Care, Hospice, Ombudsman) or requested by the resident (primary caregiver, family)
Discharge Planning to Community

**Identify the destination and ensure it meets the resident’s health and safety needs**
- What if the setting is unsafe but the resident is insistent that they are discharged:
  - Discuss risks and implications
  - Discuss and document more suitable location options
  - Document the resident’s wishes
  - Determine if a referral to Home and Community is necessary (A/N hotline)

Discharge Planning to Community

**Determine:**

- **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 Planning to Community

Determine:

- 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.

Plan ahead to prevent “Friday Night Discharge” pitfalls!

Discharge Planning to New Care Provider

- Assist the resident in choosing an appropriate care provider, by helping them find information to make an educated decision, such as:
  - Show Me Home Care and Rehab
  - Nursing Home Compare
  - Home Health Compare
  - Show Me Long Term Care
Discharge Planning

DOCUMENT!
DOCUMENT!
DOCUMENT!

Individualized Service Plan (ISP)
Minimum Data Set
Resident Record

Preparing a Discharge Summary

At the time of discharge, all certified SNFs must complete a discharge summary, which includes:

- A recap of the resident’s stay
  - Describes the course of treatment while residing in the facility
  - Diagnosis, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including pending lab results
Preparing a Discharge Summary

- A final summary of the resident’s status, which includes information from the most recent comprehensive assessment, including:
  - 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

Preparing a Discharge Summary

- A reconciliation of medications

  - A resident’s discharge medications may differ from the medications he/she took in the facility
  - If a discrepancy is found, assess and resolve
  - Ensure discharge instructions and accompanying prescriptions accurately reflect the reconciled medication list in the discharge summary
Preparing a Discharge Summary

- **Create a post-discharge plan of care**
  - Developed by the resident and/or representative, and the ID team
  - Include arrangements facility has made to address the resident’s needs after discharge
  - Include instructions given to the resident and/or representative, in a manner they are able to understand

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Preparing a Discharge Summary

- **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 (document if efforts to assist the resident in locating a continuing care provider are unsuccessful)
Preparing a Discharge Summary

- 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

What Can Go Wrong?

- Harriet: Discharged home without pain medication and no continuing care provider. Admitted to hospital to obtain necessary medication.
- Discharged to another facility without current orders for Coumadin and PT/INR monitoring.
- Resident discharged home with a manual lift and her primary caregiver was 9 months pregnant and not able to operate the lift.
- Resident discharged home and primary caregiver had dementia and unable to care for the resident.
- Resident discharged home in wheelchair and home had 12 steps to get inside.
- Resident discharged home with no support system in place to provide basic care, outside what home health is able to provide.
Discharge Planning Regulations

CMS - F660 and F661
MO CSR - 19 CSR 30-85.042 (16) SNF
- 19 CSR 30-85.042 (58) SNF
- 19 CSR 30-86.047 (12) ALF
- 19 CSR 30-86.047 (31) ALF
- 19 CSR 30-86.047 (44) ALF
- 19 CSR 30-86.047 (56) (C) ALF
- 19 CSR 30-86.043 (49) RCF
- Knowing Act or Omission of Duty

Discharge Planning and Summary Wrap-Up

Questions?
Hospice Service Requirements

- A long term care facility can either:
  - Arrange for hospice services through an agreement with one or more hospices, or
  - Not. If not, the facility must assist the resident in transferring to a facility that will arrange for hospice services.

Hospice Service Requirements

If hospice services are provided, the facility must:

- 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
  - A provision that the LTC facility immediately notifies the hospice about the following:
    - A significant change in the status.
    - A need to alter the plan of care.
    - A need to transfer the resident from the facility.
    - The resident’s death.
Hospice Service Requirements

- Facility must designate a person to work with hospice representatives to coordinate care for the resident.
  - The designee must have a clinical background and be able to assess the resident or have access to someone that has the skills.
- Facility must ensure that each resident’s written plan of care includes the most recent hospice plan of care, and a description of the services furnished by the facility.

Hospice Service Requirements

- Coordinated Plan of Care
  - Created by the facility and hospice, through collaboration
  - Clearly shows what care needs to be completed by hospice and what care will be the facility’s responsibility
  - Include how the plan will be coordinated between the hospice and the facility
Hospice Service Requirements

- The coordinated plan of care should reflect:
  - Diagnoses;
  - Common Problem List;
  - Palliative interventions;
  - Palliative goals/objectives;
  - Responsible disciplines;
  - Responsible providers;
  - Resident choices regarding care and goals.

Hospice Service Requirements

- Surveying for compliance
  - Requested during Entrance Conference
  - Identification of residents receiving hospice services
  - Facility policy and procedures
  - Written agreements between facility and Hospice provider(s)
  - Residents receiving hospice services will be selected as part of the sample
Hospice Service Requirements

CMS - F849- Hospice Services

SNF - Contract with outside resources - 19 CSR 30-85.042 (6) and (7)

RCF and ALF- Promptly referred to outside resources or discharged
  - 19 CSR 30-86.042 (30) RCF
  - 19 CSR 30-86.043 (27) RCF**
  - 19 CSR 30-86.047 (10) ALF

Hospice services
  - 19 CSR 30-86.047 (30) ALF

Questions?
Situations?
Experiences?