GOING HOME:
Effective Discharge Planning
Tuesday, May 15, 2012
3:30 – 5:00 p.m.

HOOSIER HOME CARE & HOSPICE
2012 Annual Conference

Your Speaker
Bonny Kohr, RN, CHCE, HCS-D
Manager Clinical Services
FR&R Healthcare Consulting, Inc.
Frost, Ruttenber & Rothblatt, P.C.
111 S. Pfingsten Road, Suite 300
Deerfield, IL  60015
Main: (847) 236-1111 or (888) 377-8120
Direct: (847) 282-6511
bkohr@frrcpas.com

Impact of Effective Discharge Planning
• Improve regulatory compliance
• Improve resource utilization
• Improve outcomes
• Improve patient satisfaction
Regulatory Compliance

- Patients are accepted when the agency can reasonably expect to meet the patient’s medical, nursing, and social needs adequately
- The plan of care includes instructions for “timely” discharge or referral
- The comprehensive assessment must identify the patient’s discharge planning needs
- PAC must establish and review admission and discharge policies

Effective Discharges Begin With

APPROPRIATE ADMISSIONS

Admission Policies

- Define the circumstances in which your agency will accept a patient for care
  - Safety issues
    - Patient safety
    - Staff safety
  - Eligibility issues
  - Payer issues
  - High risk areas
  - Types of care/services
  - Patient responsibilities
Admission Policies

• Include the action to take when
  – Patient does not meet the admission criteria or cannot be cared for by the agency
  – Patient refuses OASIS assessment
  – Patient refuses comprehensive assessment
• Enforce the policy consistently

Discharge Policies

• Define the circumstances when a patient would be discharged
• Standard reasons
  – Patient no longer in need of home care
  – Patient chooses to be discharged or transferred
  – Physician discontinues the order for care
  – Patient expires
  – Patient moves out of service area
Selective Discharge Reasons

- Non-compliance
  - This does not mean a difficult patient
  - This means non-compliance with
    - Third-party payer guidelines
      - Failure to obtain a face-to-face within 30 days
      - Eligibility issues
    - Pattern of non-compliance with agency guidelines
    - Pattern of non-compliance with Medicare Conditions of Participation
    - Safety issues

Discharge Policies

- Include the action to take when
  - Patient is discharged from agency due to eligibility issues
  - Patient no longer meets the admission criteria or cannot be cared for by the agency
  - Patient is non-compliant, etc.
- Enforce the policy consistently

DISCHARGES FOR NON-COMPLIANCE
Discharge for Non-Compliance

- Documentation must support consistent non-compliance with no attempt to change the behavior
  - Refusal of supervisory visits
  - Refusal to stop smoking with oxygen
  - Refusal to lock all guns or remove them from the home
  - Refusal to comply with ordered services
  - Refusal to secure pets behind closed doors
  - Abuse or threat

Decision to Discharge due to Non-Compliance

- RN supervisor should conduct a home visit
- Review the goals
  - Discuss with the patient/caregiver the goals met
  - Discuss with the patient/caregiver the unmet goals
- Review medication reconciliation
- Review any instructions provided to patient/caregiver
- Provide community referrals

Decision to Discharge due to Non-Compliance

- Provide a Home Health Advanced Beneficiary Notice (HHABN)
  - Choose option box 2 for termination
  - Describe the reason for termination
    - Home health administrative decision
      - Patient continues to smoke with oxygen while home health staff present, which poses safety issues for staff
      - Patient failed to keep appointment with physician to obtain a face-to-face encounter, which is required for Medicare coverage
Discharge Planning

• Begin the discharge plan at admission
  – Establish under which circumstances your agency will discharge
  – Establish the estimated time until discharge
  – Establish what care may still be needed
  – Establish who will be responsible for patient care

Patient Centered Care

• Patient-centered care
  – Active involvement of patients and their families in the design of their care and decision-making about treatment options
  – Basic principle of home health care
• Patients living with chronic illnesses are expected to self-manage their condition
• When done effectively, it will empower the patient/caregiver and improve the discharge process
Patient Communication

• Effective communication is the key to effective, patient-centered care
• The quantity and quality of clinical training in patient communication is lacking
  – Provide additional training to improve clinicians’ patient communication skills
• Many patients/caregivers hesitate to tell the clinician that they do not fully understand what they are being told
• Assess the patient’s/caregiver’s feeling about discharge

Circumstances

• Start with the concept that you have two months or less
• Focus should be on how to make the patient/caregiver independent in the care
• Clearly describe what it will take to safely discharge the patient
• Document effectively
  – Check box next to “discharge planning” does not support the patient’s knowledge of the discharge plan

What Care Will Be Needed after Discharge?

• Dressing changes to wound
• Daily/weekly weights
• Insulin injections
• Medication set up/reminders/changes
• Nutritional support
• Bathing assist
• Etc.
Who Will Be Responsible?

- Patient
- Private caregivers
- Family
- Friends
- All of the above
  - The commitment needs to be made at the beginning

Resources after Discharge

- Where will the patient/caregiver obtain needed supplies?
- When and who should they call with changes?
- Who do they call with questions?
- When do they need their next blood draw?
  - Where will it be done?
  - How will they get there?
- When is their next doctor appointment?
- Availability of other community resources

Caregiver Limitations

- Caregiver’s health and safety
  - High risk for injury and/or adverse events
    - Caregivers on average are 47 years old and working part-time
    - One-third of these caregivers are in fair to poor health themselves
    - Research has shown that caregivers are at risk for lower immune functioning, altered response to flu shots, slower wound healing, increased insulin levels and blood pressure levels, altered lipid profiles, and higher risk for cardiovascular disease

Source: *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Agency for Healthcare Research and Quality (US); April 2008. Publication No.: 08‐0043
Caregiver Limitations

• Caregiver’s health and safety
  – High risk for burnout
    • On average, informal caregivers devote 4.3 years to providing support
    • 4 out of 10 caregivers spend 5 or more years
    • 2 out of 10 have spent 10 years or more providing support


Caregiver Limitations

• Determine what resources are available to improve the current situation, or what resources are available to prevent deterioration after discharge
• Even providing care on a short-term basis can cause a strain on a caregiver

Caregiver Assessment

• Patient/Caregiver’s ability to provide the care at discharge
  – Provision of care must be assessed, not assumed
  – Assess competence and safety
  – Assess access to resources
Discharge Plans

- What does your discharge plan really say?
  - Discharge when goals are met
  - Discharge when progress plateaus

Post Discharge

- Does your agency have a post discharge plan?
  - Do you call the patient/caregiver after discharge
    - When and how often?
    - Is there a script?
  - Do you call the physician’s office?
  - Do you call the out of town caregivers?

Discharge Planning Impact On

HHCAHPS
HHCAHPS Quality Reporting

- HHCAHPS public reporting
  - Three composite items
    - Patient care – Q9, Q16, Q19, Q24
    - Communication between provider and patient – Q2, Q15, Q17, Q18, Q22, Q23
    - Specific care issues regarding safety, medications, and pain – Q3, Q4, Q5, Q10, Q12, Q13, Q14
  - Two global measures
    - Patient’s overall rating of care
    - Patient’s willingness to recommend the agency to friends and family

Discharge Planning Effects on HHCAHPS

- Care of Patients
  - In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?
    - Is nursing surprised when therapy discharges the patient or vice versa?
    - Did the patient tell the aide that she plans to move in with her son and daughter-in-law and forget to tell anyone else?

HHCAHPS Quality Reporting

- Communications Between Providers and Patients
  - When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?
    - Does the patient feel as if they do not know who is coming or what they are supposed to be doing when they come?
    - Did the patient understand that they would be responsible for the care at discharge?
HHCAHPS Quality Reporting

• Communications Between Providers and Patients...continued
  – In the last 2 months of care, how often did home health providers from this agency listen carefully to you?
  • Are your discharge plans based on the nurses’, the therapists’, the caregivers’ goals or are they based on the patient’s?

HHCAHPS Quality Reporting

• Specific Care Issues
  – When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?
  • Discharge planning needs to include the equipment needs and/or home modifications that will be necessary to remain safely at home

HHCAHPS Quality Reporting

• Patient’s overall rating
  – What number would you use to rate your care from this agency’s home health providers?
  • How would a patient/family feel if they were surprised to find out that your agency will not be staying in the home until the patient is completely recovered?
  • How would a patient/family feel if they were given one week to plan for being independent when they could have had two months?
HHCAHPS Quality Reporting

• Patient’s overall rating
  – Would you recommend this agency to your family or friends if they needed home health?
  • Doubtful if they feel ignored
  • Doubtful if the family feels that their concerns were not addressed
  • Doubtful if they feel abandoned

Discharge Planning Effects on OBQM/OBQI

OASIS OUTCOMES

Impact on Outcome Results

• Percentage of patients who got better
  – Bathing
  – Dressing
  – Medication management
  – Etc.
Impact on Outcome Results

• Include all appropriate improvements in the discharge plan
  – If a deficit is identified in bathing, ensure that the discharge plan includes what the expected improvement in bathing will be
  – If a deficit is identified in management of oral medications, ensure that the discharge plan includes what the expected improvement will be

Impact on Outcome Results

• Acute care hospitalization
  – Top diagnoses: AMI, CHF, pneumonia
  • However, is it really an exacerbation of the condition?
    – Up to 45% of readmissions among the elderly can be attributed to medication mismanagement
    – It may be higher – this number only represents the readmissions that can be directly related to medication mismanagement

Impact on Outcome Results

• Discharged to the community percentage
  – Did the discharge plan include a discharge to the community and when?
    • Did the caregiver have enough time to make arrangements or were they told two days before the certification was over?
Impact on Outcome Results

• *Emergency Department use*
  – Did the discharge plan include a phase out approach?
    • Example: Cardiac patient on oxygen when he first came home
    • Cardiac condition improves and physician discontinues oxygen

Impact on Outcome Results

• Cardiac condition improves and physician discontinues oxygen....continued
  – Patient is discharged from home health
  – Patient continues to feel short of breath at nighttime; he’s scared and goes to ER
  – Versus decreasing visits to 1xmonth, instructing patient to call home health with any problems, questions, etc.
  – Home visit made – oxygen saturation level obtained in the evening (or telehealth unit installed) and patient reassured

Are They?

**POTENTIALY AVOIDABLE EVENTS**
Potentially Avoidable Events

- Emergent care
- Discharged with new, worsening, or unresolved health problems
- Discharged with unmet needs

Emergent Care

- Injury caused by fall
- Wound infection or deterioration
- Improper medication administration or side effects
- Hypo/hyperglycemia

Emergent Care for Injury Caused by Fall

- If a fall risk is assessed at admission, does discharge planning address the risks unique to the patient
  - Multiple medications
  - Confusion
  - Vision
  - Gait/balance
  - Blood pressure
  - Etc.
Falls

• The focus is on injuries caused by fall
  – If there is a history of falls, does the assessment include the reason for the falls followed by a discharge plan related to the reason?
    • Simplify medication regime
    • Modify medications causing dizziness or drowsiness
    • Vision; pair of single vision distance lenses for some activities such as walking outside
    • Removing items that cause tripping, etc.
    • Adding grab bars, stair railings, and lighting
    • Exercises that focus on increasing and improving balance

New, Worsening, or Unresolved Health Problem

• Patient develops a UTI
• Increase in number of pressure ulcers
• Substantial decline in three or more ADLS
• Substantial decline in management of oral medications
• Discharged to community with unhealed Stage 2 pressure ulcer

New, Worsening, or Unresolved Health Problem

• Your discharge plan should include what the patient/caregiver will need to do regarding:
  – Treating and preventing UTI
  – Care or prevention of pressure ulcers
  – Who is responsible for the ADLs
  – Who is responsible for the medications
  – Ongoing care of the Stage 2 pressure ulcers
## Discharged With Unmet Needs

- Discharged to Community Needing Wound Care or Medication Assistance
- Discharged to Community Needing Toileting Assistance
- Discharged to Community with Behavioral Problems

---

## Discharged to Community....

- Includes types and sources of assistance (M2100) and Discharge Disposition (M2420)
- Definition for all three includes the following:
  - ..."Patient was discharged, with no assistance available, needing" ....

---

### Title Description OASIS items used

<table>
<thead>
<tr>
<th>Discharged to the Community Needing Wound Care or Medication Assistance</th>
<th>Percentage of home health episodes of care at the end of which the patient was discharged, with no assistance available, needing wound care or medication assistance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to the Community Needing Toileting Assistance</td>
<td>Percentage of home health episodes of care at the end of which the patient was discharged, with no assistance available, needing toileting assistance.</td>
</tr>
<tr>
<td>Discharged to the Community with Behavioral Problems</td>
<td>Percentage of home health episodes of care at the end of which the patient was discharged, with no assistance available, demonstrating behavioral problems.</td>
</tr>
</tbody>
</table>
Potential Avoidable Events

• Discharged to Community Needing Wound Care or Medication Assistance
• What does it really mean?
  – Patient remained in the home, they have no competent assistance available, they are confused and had a pressure ulcer Stage 3 or 4, non-healing surgical wound, or non-healing stasis ulcer, or they do not have competent assistance and are totally dependent in medication administration

Did the Assessment Really Describe This?

• M2420 = 01 (Patient remained in the community (without formal assistive services) and
  • M2100 C Medication Administration = 2,3,4,5 (Caregiver needs training, not likely to provide assistance, unclear if caregiver will provide assistance, or assistance needed, but not available) or

Did the Assessment Really Describe This?

• M2100 D Medical Procedures/Treatments = 2,3,4,5 (Caregiver needs training, not likely to provide assistance, unclear if caregiver will provide assistance, or assistance needed, but not available) and
  • M1710 When confused = NA or >2 (pt is non-responsive or is confused during the day or evening or constantly) or
Did the Assessment Really Describe This?

- M1324 = 03 or 04 (patient has a pressure ulcer of Stage 3 or 4) and M1710 = confused or
- M1334 = 03 (patient has a non-healing stasis ulcer) and M1710 = confused or
- M1342 = 03 (patient has a non-healing surgical wound) and M1710 = confused or
- M2020 = 03 (unable to take medication unless administered by another person)

Discharged to Community Needing Wound Care or Medication Assistance

- On admission if the patient is identified with one of the problems indicated above, the discharge plan should include resolution of the problem or
- The plan should include who will provide the care at discharge

Discharged with Unmet Needs

- **Discharged to Community Needing Toileting Assistance**
  - M2420 = 01 (discharged no formal assistance) and
  - M2100a ADL Assist = >02 (nobody providing assistance) and
  - M1840 = 04 (totally dependent in toileting) or
  - M1845 = 03 (totally dependent in toilet hygiene)
Discharged Needing Toileting Assistance

• Is this patient appropriate for admission?
  – Totally dependent on toileting/toileting hygiene and they have nobody to provide the assistance
  • Maybe (if the caregiver is available, but needs further education and/or resources to provide the care)
  • If this is the situation, then the discharge planning should include that the caregiver will become independent in providing the care or
  • That the patient’s condition will improve and no longer require this level of assistance

Discharged With Unmet Needs

• Discharged to Community with Behavioral Problems
  – M2420 = 01 (discharged no formal assistance) and
  – M2100f Supervision > 02 (nobody providing assistance) and
  – M1740 = 1,2,3,4,5,6 (any type of behaviors demonstrated at least once a week)

Discharged to Community with Behavioral Problems

• This happens more than we like with our psychiatric patients, but our discharge plan should be based on what our goals are to be
• If we identify that they exhibit behavioral problems at least weekly
  – The discharge plan needs to include that these behaviors will diminish or
  – Caregivers will be found to remind, supervise, or provide care