The Successful Plan: From Admission through Discharge
Wisconsin Health Care Association
The Successful Plan: From Admission through Discharge

Summary

A successful plan from admission to discharge is the first step in preventing re-hospitalization. The all cause 30-day readmission measure may pose a problem to resident's known as the “frequent flyer.” As health care professionals in the post-acute care arena we must establish best practice protocols to ensure a successful discharge into the community. This session will review the concepts to a successful process from the time of admission through discharge to prevent unnecessary re-admission.

Objectives:

On completion of this session the participant will:

1. Examine the current claim based quality measure on hospital readmission.
2. Identify the key steps in developing a plan of care integrating admission and discharge elements.
3. Understand the importance of integrating the interdisciplinary team to promote resident choice.
4. Review the potential F-tags associated with the care planning and discharge process.

Audience: Admission Nurse, Discharge Planner, DNS, Nurse Manager, Social Service, Dietary
ABOUT THE PRESENTER
Patricia J. Boyer
Director

Current Position and Responsibilities
Pat Boyer brings more than 30 years of experience to Wipfli LLP’s senior living health care practice. Her clients appreciate her deep knowledge and understanding of the challenges they face and her assistance with achieving performance improvement and process development as well as meeting and exceeding state and federal compliance standards. Pat is dedicated to providing exceptional client service to help long-term care and senior living providers attain their strategic goals.

Specializations
- Resource Utilization Group (RUGs)-based Medicare/Medicaid reimbursement
- Performance improvement and process development
- State and federal compliance programs
- Long-term care and subacute operations
- Assisted living operations

Past Experience
- Founder and president of Boyer & Associates, LLC (merged with Wipfli LLP in February 2014)
- Operations consultant for BDO Healthcare Group, LLC
- Director of nursing services and administrator, quality improvement specialist, and director of regulatory compliance for a national nursing home company
- Conducted RUGs-based Medicare and Medicaid operational assessments in nursing facilities
- Conducted numerous workshops at the national, state, and local levels

Professional Memberships and Activities
- Authors the monthly Ask the Payment Expert column in McKnight’s Long-Term Care News
- LeadingAge Wisconsin - Program Committee member

Education
St. Petersburg College
- Nursing
Cardinal Stritch University
- Master of science degree in management
Objectives

1. Examine the current claims-based quality measure on hospital readmission.
2. Identify the key steps in developing a plan of care integrating admission and discharge elements.
3. Understand the importance of integrating the interdisciplinary team to promote resident choice.
4. Review the potential F-tags associated with the care planning and discharge process.
Overview of Claims-Based Measures

- Measures use Medicare claims, although the MDS is used in building stays and for some risk-adjustment variables.
- Measures only include Medicare fee-for-service beneficiaries. Eventually, encounter data may allow us to include Medicare Advantage enrollees.
- All are short-stay measures that only include those who were admitted to the nursing home following an inpatient hospitalization.
- Measures are risk-adjusted, using items from claims, the enrollment database and the MDS.

Percentage of Short-Stay Residents Who Were Rehospitalized After a Nursing Home Admission

- Development of readmission measures is a high priority for CMS.
- The Protecting Access to Medicare Act calls for public reporting of readmission measures on Nursing Home Compare.
- SNF Value-Based Purchasing (VBP) will use a claims-based readmission measure.
- Includes hospitalizations that occur after nursing home discharge but within 30 days of stay start date. Includes observation stays.
- Excludes planned readmissions and hospice patients.
- A “stay-based” measure that includes both those who were previously in a nursing home and those who are new admits.

Claims-Based Measures

<table>
<thead>
<tr>
<th></th>
<th>30-Day All-Cause Readmissions</th>
<th>100-Day Community Discharge Without Readmission</th>
<th>30-Day Outpatient ED Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source</td>
<td>Part A claims to identify inpatient readmissions and Part B claims for observation stays. Claims and MDS are used for risk adjustment.</td>
<td>MDS to identify community discharges, claims to identify successful community discharges, Claims and MDS for risk adjustment.</td>
<td>Part B Claims to identify outpatient ED visits. Claims and MDS for risk-adjustment.</td>
</tr>
<tr>
<td>Numerator Window</td>
<td>30 days after admission to a SNF following an inpatient hospitalization.</td>
<td>100 days after admission to a SNF following an inpatient hospitalization and 30 days following discharge.</td>
<td>30 days after admission to a SNF following an inpatient hospitalization.</td>
</tr>
<tr>
<td>Denominator Window</td>
<td>Patients must have been admitted to the nursing home following an inpatient hospitalization within 1 day of discharge.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Claims-Based Measures (Continued)

<table>
<thead>
<tr>
<th>Measurement Period</th>
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<th>30-Day Outpatient ED Visits</th>
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<td><strong>Numerator</strong></td>
<td>The number of SNF stays where there was a discharge to an acute care hospital within 30 days of SNF admission. Planned readmissions are excluded.</td>
<td>The number of SNF stays where there was a discharge to the community (identified using the discharge status information on the MDS) within 100 days of admission who are not admitted to a hospital (inpatient or observation stay), a nursing home, or who die within 30 days of discharge.</td>
<td>The number of SNF stays where there was an outpatient ED visit not resulting in an inpatient stay or observation stay within 30 days of SNF admission.</td>
</tr>
<tr>
<td><strong>Numerator Exclusions</strong></td>
<td>Planned readmissions</td>
<td></td>
<td></td>
</tr>
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**Denominator**

The denominator is the number of SNF stays that began within 1 day of discharge from a prior hospitalization at an acute care, CAH, or psychiatric hospital. Prior hospitalizations are identified using claims data.

**Denominator Exclusions**

- Medicare Advantage enrollees.
- Those who were in a nursing home prior to the start of the stay.
- Those who enroll in hospice during the observation period.

**Risk Adjusted**

Logistic regression based on claims (primary diagnosis and length of stay) and MDS items found to be associated with readmission rates. Note that there are some differences in the MDS items across the three measures. The risk-adjusted rate is calculated as the (actual rate/expected rate) x national average.

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Short-Stay Residents Made Improvements in Function

- Measures the percentage of short-stay residents who made functional improvements during their complete episode of care, based on self-performance in three mid-loss activities in daily living (ADLs): transfer, locomotion on unit, walk in corridor
- Calculated as the percent of short-stay residents with improved mid-loss ADL functioning from the 5-day assessment to the discharge assessment
- Based on discharge assessment at which return to the nursing home is not anticipated
- Excludes residents receiving hospice care or who have a life expectancy of less than six months

Percentage of Long-Stay Residents Whose Ability to Move Worsened.

- Measures the percentage of long-stay nursing residents who experienced a decline in their ability to move around their room and in adjacent corridors over time. Defined based on “locomotion on unit: self-performance” item.
- Includes the ability to move about independently, whether a person’s typical mode of movement is by walking or by using a wheelchair
- Risk adjustment based on ADLs from prior assessment
- Decline is measured by an increase of one or more points between the target assessment and prior assessment
Percentage of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit

- Better preventative care and access to physicians and nurse practitioners in an emergency may reduce rates of emergency department (ED) visits.
- Outpatient ED visit measure has same 30-day time frame as the rehospitalization measure and considers all outpatient ED visits except those that lead to an inpatient admission (which are captured by the rehospitalization measure).

Measure Specifications: MDS-Based Measures

<table>
<thead>
<tr>
<th>Description</th>
<th>Functional Improvement</th>
<th>Mobility Decline</th>
<th>Presence of Antianxiety Hypnotic Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>The percent of short-stay residents who have functional improvements on mid-loss ADLs during their complete episode of care</td>
<td>The percent of long-stay residents who have a decline in their ability to move about their room and adjacent corridors since their prior assessment</td>
<td>Percent of long-stay residents who receive antianxiety or hypnotic medications</td>
</tr>
<tr>
<td>Data Source</td>
<td>MDS</td>
<td>MDS</td>
<td>MDS</td>
</tr>
<tr>
<td>Numerator Window</td>
<td>Based on change in status between the 5-day assessment and discharge assessment</td>
<td>Based on change in status between prior and target assessments</td>
<td>Based on the target assessment</td>
</tr>
</tbody>
</table>

MDS-Based Measures

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<tr>
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</thead>
<tbody>
<tr>
<td>Residents must have a valid discharge (return not anticipated) assessment and a valid preceding 5-day assessment</td>
<td>Long-stay residents must have a decline in locomotion since their prior assessment</td>
<td>Percent of long-stay residents who receive antianxiety or hypnotic medications</td>
<td></td>
</tr>
<tr>
<td>Measurement Period</td>
<td>Updated quarterly</td>
<td>Updated quarterly</td>
<td>Updated quarterly</td>
</tr>
<tr>
<td>Numerator</td>
<td>The number of short-stay residents who have a mid-loss ADL change in their 5-day assessment</td>
<td>The number of long-stay residents who have a decline in locomotion since their prior assessment</td>
<td>The number of long-stay residents who received any number of antianxiety medications or hypnotic medications</td>
</tr>
<tr>
<td>Numerator Exclusions</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
MDS-Based Measures (Continued)

| Denominator | Functional Improvement | Memory Decline | Antidepressant Medication
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>All short-stay residents who have a valid discharge assessment and a valid preceding 5-day assessment</td>
<td>All long-stay residents who have a qualifying MDS target assessment (e.g., annual, quarterly, significant change, correction, 14, 30, 60, or 90-day assessment, or a discharge assessment with or without return anticipated by a provider or staffing)</td>
<td>All long-stay residents with a selected target assessment</td>
<td></td>
</tr>
</tbody>
</table>

| Denominator | Evidence | Functional Improvement | Memory Decline | Antidepressant Medication
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Comatose on the 5-day assessment</td>
<td>Comatose on the 5-day assessment</td>
<td>Comatose or missing data or condition on prior assessment</td>
<td>Missing data on number of antianxiety hypnotic meds</td>
<td></td>
</tr>
<tr>
<td>Missing data on comatose at prior assessment</td>
<td>Missing data on number of antianxiety hypnotic meds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>Prognosis of &lt;6 months on the 5-day assessment</td>
<td>Resident totally dependent during locomotion on prior assessment</td>
<td>Hospice care on the 5-day assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing data on locomotion</td>
<td></td>
<td></td>
<td></td>
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<tbody>
<tr>
<td>No MLADL impairment (MLADL=0) on the 5-day assessment</td>
<td>Risk discharge assessment with or without return anticipated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing data on locomotion</td>
<td></td>
<td></td>
<td></td>
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</table>

Risk Adjustment

| Risk-adjusted based on diagnosis | Risk-adjusted based on ADLs |

Regulatory Changes

Transitions of Care (483.15)

- CMS proposes to redesignate current § 483.12 "Admission, transfer, and discharge rights" as new § 483.15 and revise the general title to "Transitions of care" in order to reflect current terminology that applies to all instances where care of a resident is transitioned between care settings. Extensive literature speaks to quality of care concerns related to the transitions.
Proposed Changes to Discharge Plan

- In proposed new paragraph (a), we would begin with requirements for admissions policies, which would be moved to the beginning of the section to reflect chronological order.
- CMS proposes a new paragraph (a)(1) to require that the facility establish an admissions policy.
- First, they propose to clarify that the transfer or discharge would be documented in the resident's clinical record and that appropriate information would be communicated to the receiving setting. While this type of documentation is presently required for hospitals with which the facility has a transfer agreement, such communication is important regardless of the setting to which the resident is being transferred or discharged.

Changes to the Survey Process

1. Surveyors should be mindful of the elevated risk of psychosocial harm associated with the regulation that may lead to noncompliance and consider this during their investigation.
2. Once the team has completed their investigation, analyzed the data, reviewed the regulatory requirements, and identified any deficient practice(s) that demonstrate that noncompliance with the regulation as it exists, the team must determine the scope and severity of each deficiency, based on the resultant harm or potential for harm to the resident.
3. The survey team must consider the potential for both physical and psychosocial harm when determining the scope and severity of deficiencies related to sufficient staffing. See also the Psychosocial Outcome Severity Guide and Investigative Protocol in Appendix P, Part IV, Section E for additional information on evaluating the severity of psychosocial outcomes.

F-Tag Changes

- F-222: Restraints
- F-241: Dignity
- F-242: Self-determination
- F-246: Accomodations of needs
- F-248: Activity
- F-250: Social services
- F-310: Activities of daily living
- F-320: Psychosocial
- F-329: Unnecessary Drug
- F-353: Nursing service
Prior to Admission Screen

1. Risk screen upon admission for high-risk rehospitalization; consider clinical and social factors
2. Use teach back during discharge
3. Schedule follow-up physician appointment
4. Telephone follow-up within 48 to 72 hours

Transitions of Care

- The term “transitions of care” connotes the scenario of a patient leaving one care setting (i.e., hospital, nursing home, assisted living facility, SNF, primary care physician, home health, or specialist) and moving to another.
- The care transition frequently involves multiple persons.
- An optimal transition should be well planned and adequately timed.
- However, communication between settings fails to provide all of the information needed for optimum quality of care.
Poor Transitions

- Compromise patient safety and quality of care
- Place a significant burden on patients and their families and caregivers through inefficiencies
- Increase costs to patients, providers, payers

Key Points for Improving Transitions

1. Improve communications during transitions between providers, patients, and caregivers.
2. Implement electronic medical records that include standardized medication reconciliation elements or have a manual medication reconciliation process.
3. Establish points of accountability for sending and receiving care, particularly for hospitalists and nursing home providers.
4. Increase the use of case management and professional care coordination.
5. Expand the role of the pharmacist in transitions of care.
6. Implement payment systems that align incentives and include performance measures to encourage better transitions of care

Case Study

Case study: In a nursing home to hospital bi-directional transfer, you may consider that there are six exchanges:
Exchange 1: Preparation in nursing home to transfer patient to hospital (nursing home handover)
Exchange 2: EMS/Ambulance transport
Exchange 3: Hospital receipt of patient
Exchange 4: Preparation in hospital to transfer patient back to nursing home (hospital handover)
Exchange 5: EMS/ambulance transport
Exchange 6: Nursing home receipt of patient
Medication Reconciliation: Collect Data

- Collect a complete list of current medications (including dose and frequency) for each patient on admission.
- Validate the preadmission medication list with the patient (whenever possible).
- Assign primary responsibility for collecting the preadmission list to someone with sufficient expertise, within a context of shared accountability (the ordering prescriber, nurse, and pharmacist must work together to achieve accuracy).

Write Accurate Admission Orders

- Use the preadmission medication list when writing orders.
- Place the reconciling form in a consistent, highly visible location within the patient chart (easily accessible by clinicians writing orders).
- Reconcile patient medications within specified time frames.
- Adopt a standardized form to use for collecting the preadmission medication list and reconciling the variances (includes both electronic and paper-based forms).
- Develop clear policies and procedures for each step in the reconciling process.

Preparation From ED to Nursing Home

- Provide access to drug information and pharmacist advice at each step in the reconciling process.
- Improve access to complete medication lists at admission.
- Provide orientation and ongoing education on procedures for reconciling medications to all health care providers.
- Provide feedback and ongoing monitoring (within context of non-punitive learning from mistakes/near misses).
Preparation From ED to Nursing Home (Continued)

- Physician writes discharge orders and dictates discharge summary (stat order)
- Medication reconciliation performed
- Case manager/discharge planner contacts NF to coordinate patient's return
- Patient/family counseled on physician orders, medication changes (My Medicine List), pending tests/results, appointments scheduled, and medical condition "red flags"
- Paperwork is gathered to send with patient back to NF; appropriate information sent to specialist's/PCP office
- Ambulance arrives to transport patient

Key Members of the Transition Team

- Patient
- Family members/caregivers
- Primary care physician
- Specialist physician
- Hospitalist
- Nurses
- Case manager
- Pharmacist
- Therapists
- Discharge planner
- Nursing home staff
- Home health providers
- Others
Key to Identifying Change

- Learn to notice a change early.
- Not reporting a change can lead to other things going wrong.
- The sooner something is done, the better.

How to Follow Up on the First Sign of Changes

Shift-to-shift comparisons.
Are there any changes that should be watched for or reported?

Early Warning tool:
- Form that nursing assistants can use to write down what they have noticed about a resident's condition. (Interact - Stop and Watch)
- Use the tool any time a resident has had a change.

SBAR tool:
- An abbreviation that helps you to remember how to communicate change.
- SBAR stands for Situation, Background, Assessment, Recommendation.

Document-Document-Document

Need for Consistent Assignment

1. Nursing center leadership educates staff on the benefits of consistent assignment.
2. All members of the team participate in meetings about consistent assignment.
3. There is a process to ensure that nursing assistants have input when assignments are given, with the goal of having everyone feel that their assignment is fair.
4. Care team members meet regularly to discuss how the consistent assignment is working, including reviewing assignments to ensure that relationships with the residents are going well.
5. Leadership invites suggestions from team members about improvements.
### Key Factors in Detecting Change

1. Spend as much time as possible with each new resident.
2. Meet with the family as soon as possible.
3. Stay in touch with the family every day.
4. Closely observe the functional ability of each resident.

COMMUNICATE-COMMUNICATE-COMMUNICATE

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### Nursing Assistants Can Use the SBAR

- Be sure to have the residents' situation in your mind before you start. If your NOTES are a nursing assistant talking to a licensed nurse, this is usually what you have noticed about the resident.

- Example:
  - Ms. C fell asleep in her clothes this evening and cursed at me. She is the 85-year-old from room C6; she is usually pretty friendly and does her own ADLs. She seems OK physically, but I'm worried. I'd feel better if you would take a look at her and make an assessment.

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### Concerned, Uncomfortable, Safety: Nursing Assistant

1. I am **Concerned** about my resident's condition.
2. I am **Uncomfortable** with my resident's condition.
3. I believe the **Safety** of the resident is at risk.
Detecting Change

1. Know the resident's normal (baseline) condition.
2. Note the resident's ability to move around.
3. Know how the resident does with activities of daily living.
4. Know the resident's preferences for activities, eating, and dressing.
5. Changes from the resident's normal condition can signal a medical change.

Key Steps for a Successful Discharge

1. Medication reconciliation
2. Reconcile discharge plan with national guidelines
3. Follow-up appointments
4. Outstanding tests
5. Post-discharge services
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone reinforcement

Recognizing Change

1. Do a shift-to-shift comparison.
2. Make sure the needed equipment is available.
3. See if a change occurred in any other resident's vital signs.
4. Check the resident's records of urination and bowel movements.
Registered Nurse’s Assessment

1. Ask the resident how he or she feels even if the resident is confused or seems to be "out of it.”
2. Ask the resident how the symptoms began and when.
3. Take the resident’s vital signs again.
4. Perform a general exam and assessment of the resident’s level of consciousness or cognitive function and physical function, following the usual methods for resident assessment.
5. When the assessment is completed, the registered nurse will organize this information to report the change to the resident’s nurse practitioner or doctor, if this is necessary.

Changes That Matter

Physical Changes
- Walking
- Urination and bowel patterns
- Skin
- Level of weakness
- Falls
- Vital signs

Non-Physical Changes
- Demeanor
- Appetite
- Sleeping
- Speech
- Confusion or agitation
- Resident complaints of pain

Physical Changes

Walking—If the resident needs assistance, watch how much assistance he or she needs with walking. You can watch to see if the resident changes mode of transportation (walking to wheelchair). You can watch the resident when they walk down the hall to see if he/she uses the guard rails more than usual.

Urination and bowel problems—Be sure to notice if the resident is incontinent of urine or stool, or if urination is more frequent, urine smells different, or if bowel movements are rare or change to diarrhea.

Skin—While bathing and dressing the resident, look to see if the resident’s skin is discolored or puffy.
Physical Changes (Continued)

- **Level of weakness**—Watch when the resident raises his or her arms while eating, during activities, or while performing personal hygiene to see if the resident has more difficulty than usual.
- **Falls**—Watch the resident when doing things that could result in a fall (e.g., reaching for objects when in a wheelchair).
- **Vital signs**—Record the resident’s blood pressure and heart rate and look for any changes in breathing and temperature.

Creating a Safe Environment

1. Reporting changes helps keep residents as safe as possible.
2. Learning and experience help providers to keep residents safe.
3. Open communication among team members helps to keep residents safe.
4. Team members must move beyond blaming someone.
5. Those who care will speak up.

Observing and Reporting

- Who is responsible?
- Front-line providers are the eyes and ears of the team.
- Part of helping the team perform best is sharing information.
- Receptionists, occupational therapists, chaplains, volunteers, housekeeping staff, other staff members, and visitors are important observers.
Post-Discharge Plan

1. Health status
2. Medicines
3. Appointments
4. Home services
5. Plan for what to do if a problem arises. Name and phone number of person to call.

Questions?

Thank you!