Care Planning and Discharge Planning for Phase 2

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Objectives
Participants will:
1. Discuss the new regulatory requirements for care plan development.
2. Review new discharge planning regulations
3. Identify methods for including required members of the interdisciplinary team in the care plan development process
4. Determine steps to implement system changes to meet regulations and promote successful discharges.

Definitions
Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.
Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
"Return" instead of "Readmit" require facilities, at the time they determine a resident cannot return to the facility, to comply with the requirements as they pertain to discharges.

Notification of Changes
• A facility must immediately inform the resident; consult with the resident’s physician; and notify, consistent with his or her authority, the resident representative(s), when there is—
  ▶ A decision to transfer or discharge the resident from the facility
§483.10 Resident Rights

Discharge Documentation
Transfers or discharges under any circumstances,
• Document in the resident’s medical record
  ▶ Basis for the transfer
  ▶ Specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
  ▶ Appropriate information communicated to the receiving health care institution or provider.
  ▶ Must be made by
    ▶ The resident’s physician when transfer or discharge is necessary for resident’s welfare—needs cannot be met and
    ▶ A physician when transfer or discharge is necessary—safety of individuals is endangered due to clinical or behavioral status of the resident.
Discharge Documentation

Information provided to the receiving provider must include:
- Contact information of the practitioner responsible for the resident
- Resident representative information with contact information.
- Special instructions or precautions for ongoing care
- Comprehensive care plan goals
- All other necessary information, a copy of the discharge summary and any other documentation to ensure safe and effective transition of care.

Orientation for transfer or discharge.
- Provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.
- Provided in a form and manner that the resident can understand

Not Returning From Hospital

Resident transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the discharge notice regulations.
- At the time a facility determines that a resident cannot be readmitted to the facility, the resident is effectively discharged from the facility.

Baseline Care Plans

The facility must develop and implement a baseline care plan for each resident
- Instructions needed to provide effective and person-centered care
- Meets professional standards of quality care
- Baseline care plan must—
  - Be developed within 48 hours of a resident's admission.

Baseline Care Plans

- Minimum healthcare information to properly care for a resident including, but not limited to:
  - Initial goals based on admission orders.
  - Physician orders.
  - Dietary orders.
  - Therapy services.
  - Social services.
  - PASARR recommendation, if applicable

Strategies for 48 Hr. Care Plan

Use software to trigger care plan from assessments
- Care plan templates
  - Develop trigger grid from assessments
  - Interdisciplinary (if possible)
  - Make available to direct care staff
    - Review with resident/representative and offer a copy
Focus Areas

- Safety
- Skin Risk
- Medical conditions
- Potential adverse effects of meds (by drug class)
- Diet/Nutrition
- Mobility/therapy
- Psychosocial
- Cognitive
- Mental health/ID

<table>
<thead>
<tr>
<th>Goals</th>
<th>Interventions</th>
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<tr>
<td>Long term goal: what the resident/rep wants to accomplish from admission (discharge preferences)</td>
<td>Assess, Monitor, Provide care, Educate resident/Rep</td>
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Short term goals: Improve, Maintain

Comprehensive Care Plans

Develop and implement a comprehensive person-centered care plan
- consistent with the resident rights
- measurable objectives and timeframes to meet medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment.
- Within 7 days after completion of the comprehensive assessment.

Comprehensive Care Plans

- Must describe:
  - Services to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being and
  - Services that would be required but are not provided due to the resident’s exercise of rights, including the right to refuse treatment
  - Specialized services or specialized rehabilitative services as a result of PASARR recommendations.
    - If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

Comprehensive Care Plans

In consultation with the resident and the resident’s representative(s)
- Resident’s goals for admission and desired outcomes
- Resident’s preference and potential for future discharge.
  - Document whether the resident’s desire to return to the community was assessed and any referrals made for this purpose
  - Discharge plans in the comprehensive care plan, as appropriate

RAI Manual Q0300

Resident’s Overall Expectation
Steps for Assessment
1. Ask the resident about his or her overall expectations.
2. Ask the resident to consider current health status, expectations regarding improvement or worsening, social supports and opportunities to obtain services/supports in the community.
3. Ask the resident directly about expectation regarding the outcome of this admission and expectations about returning to the community.
4. The resident’s stated goals should be recorded here.
5. If the resident is unable to communicate verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual.

Code 1, Expects to be discharged to the community: home, assisted living, another community setting.
Code 2, Expects to remain in this facility: remains in the nursing home.
Code 3, Expects to be discharged to another facility/institution: discharged to another nursing home, rehabilitation facility, or another institution.
Code 9, Unknown or uncertain: resident is uncertain/not able to participate and family, significant other, or guardian or legally authorized representative do not exist or are not available.

Comprehensive Care Plans

To the extent practicable, the participation of the resident and the resident’s representative(s).
- Explanation in the medical record if participation of the resident AND resident representative is practicable for the development of the care plan.
RAI manual Q0100

RESIDENT’S PARTICIPATION IN ASSESSMENT

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Engage the resident during assessment determine expectations and perspective during assessment.

Steps for Assessment

1. Review the medical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process.
2. Ask the resident, the family member or significant other (when applicable), and the guardian or legally authorized representative (when applicable) if he or she actively participated in the assessment process.
3. Ask staff members who completed the assessment whether or not the resident, family or significant other, or guardian or legally authorized representative participated in the assessment process.

Comprehensive Care Plan

Prepared by interdisciplinary team

- The attending physician.
- A registered nurse with responsibility for the resident.
- A nurse aide with responsibility for the resident.
- A member of food and nutrition services staff.

Strategies to Include IDT Members

Revise assessments (nursing, social work, nutrition) to include an area for nurse aide input

Use a standard worksheet for information collection

Copy Baseline care plan and review at shift report for input prior to sharing with resident.

- Invite nurse aide to care conference for limited time
  - Prep them with a standard list of items to talk about

Discharge Planning

Develop and implement an effective discharge planning process

- Focus on the resident’s discharge goals,
- Prepare resident to be active partner
- Prepare resident to effectively transition to post-discharge care
  - Reduce factors leading to preventable readmissions.

Discharge Planning

Discharge planning process consistent with discharge rights —

- Identifies discharge needs of each resident
- Results in a discharge plan for each resident
- Includes regular re-evaluation of progress toward discharge
  - Updates the discharge plan to reflect changes.

Discharge Planning

Involves the interdisciplinary team to develop the discharge plan

Considers caregiver/support person availability

Considers resident’s or caregiver’s/support person(s) capacity and capability to perform required care

Involves the resident and resident representative development of the discharge plan

- Informs the resident and resident representative of the final plan.
- Addresses goals of care and treatment preferences
Discharge Planning

Document that the resident has been asked about receiving information about returning to the community.
- If interested, document referrals to local contact agencies or other entities.
- Update comprehensive care plan and discharge plan, with information from referrals.
  - If discharge is determined to not be feasible, document who made the determination and why.

RAI Manual Q0500B: Return to Community

Discharge Planning

Residents transferred to another SNF or discharged to a HHA, IRF, or LTCH.
- Assist residents and their resident representatives in selecting a post-acute care provider by using data.
  - Standardized patient assessment data,
  - Data on quality measures, and
  - Data on resource use to the extent the data is available.
- Ensure that post-acute care data is relevant and applicable to the resident's goals of care and treatment preferences.

www.medicare.gov/nursinghomecompare

Discharge Planning

Document on a timely basis based on the resident's needs.
- Evaluation of the resident's discharge needs and discharge plan.
- Results of the evaluation discussed with the resident/resident's representative.
- Relevant resident information incorporated into the discharge plan to avoid unnecessary delays in the resident's discharge or transfer.

Discharge Summary

Anticipated discharges must have a discharge summary.
- Recapitulation of the resident's stay that includes,
  - Diagnoses,
  - Course of illness/treatment or therapy, and
  - Pertinent lab, radiology, and consultation results.
- Final summary of resident's status including items in RAI, at the time of the discharge.
- Release to authorized persons and agencies, with the consent of the resident or resident's representative.

Discharge Summary checklist

- Recapitulation of the resident's stay that includes, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
- Final summary of resident's status including items in RAI, at the time of the discharge.
- Reconciliation of medications (pre-discharge to post-discharge).
- Where the individual plans to reside.
- Arrangements that have been made for the resident's follow up care.
- Post-discharge medical and non-medical services.
RESOURCES


Enhancing Care Coordination Program for Cognitively Impaired Older Adults and Their Family Caregivers Resource Nurse Care Training Modules; University of Pennsylvania School of Nursing 1. Dementia and Delirium Education Modules © 2006 http://www.transitionalcare.info/sites/default/files/Dementia%20and%20Delirium%20Training%20Modules%202006-2008%20For%20UPLOAD_kbh.pdf

IDEAL Discharge Planning Overview, Process, and Checklist Include Discuss Educate Assess Listen www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html


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