Disclosure of Commercial Interests

I have no commercial interests.

1

SUCCESSFUL DISCHARGE TO THE COMMUNITY

ACHCA

November 2017

2

QUALITY MEASURES

3

Successful discharge defined as those for which the beneficiary was not hospitalized, was not readmitted to a nursing home, and did not die in the 30 days after discharge.

Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community

4

Measure Description

- The percent of short-stay residents admitted to the nursing home from a hospital who were discharged to the community within 100 calendar days of the start of the episode, and who remained in the community for 30 consecutive days following discharge to the community.

5

Numerator and Denominator Window

- The numerator and denominator include stays that started over a 12-month period. The data are updated every six months (in April and October of each year), with a lag time of nine months (i.e., the data posted in April will include stays that started 9-21 months ago).

6

Numerator

- Met the inclusion and exclusion criteria for the denominator; **AND**
- Had a discharge assessment indicating discharge to the 'community' (A2100 = [01]) within 100 calendar days of the start of the episode; **AND**
- Was not admitted to a nursing home within 30 days of the community discharge, as determined from Medicare claims; **AND**

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Numerator

- Did not have an unplanned inpatient hospital stay within 30 days of the community discharge, as determined from the principal diagnosis and procedure codes on Medicare claims; **AND**
- Did not die within 30 days of the community discharge, as determined from the Medicare Enrollment Data Base.

8

Denominator

- Entered the nursing home within 1 day of discharge from an inpatient hospitalization (Note that inpatient rehabilitation facility and long-term care hospitalizations are not included). These hospitalizations are identified using Medicare Part A claims; **AND**
- Entered the nursing home within the target 12-month period

9

Denominator Exclusions

- The resident did not have Fee-for-Service Parts A and B Medicare enrollment for the entire risk period (measured as the month of the index hospitalization and the month after the month of discharge from the nursing home); **OR**
- The resident was ever enrolled in hospice care during their nursing home episode; **OR**
- The resident was comatose (B0100 =[01]) or missing data on comatose on the first MDS assessment after the start of the episode; **OR**

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Denominator Exclusions

- Data were missing for any of the claims or MDS items used to construct the numerator or denominator; **OR**
- The resident did not have an initial MDS assessment to use in constructing covariates for risk-adjustment.

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SNF QRP CLAIMS BASED MEASURE

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SNF QRP Claims-Based Measures

- 2% withhold to Part A payments that can be partially earned back based on re-hospitalization rate and level of improvement
- Passed in 2014, rates not impacted until FY 2019 (October 1, 2018); details to be developed by CMS rulemaking

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Two Measures

- Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program;
- Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program;

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Discharge to Community- Post Acute Care

15

Discharge to Community Measure Description

- Reports a SNF's risk-standardized rate of Medicare FFS residents who are discharged to the community following a SNF stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the **31** days following discharge to community, and who remain alive during the **31** days following discharge to community. Community, for this measure, is defined as home/self-care, with or without home health services, based on **Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim**

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Key Difference from 5 Star

- Re-admission to nursing home is ***not*** included.
- Bring them back directly to you to avoid recovery of revenue

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Numerator

- No simple form for numerator and denominator
  - Risk adjustment method does not make the *observed* number of community discharges the numerator, and a *predicted* number the denominator.
  - Numerator is the *risk-adjusted estimate* of the number of patients/residents who are
    - Discharged to the community,
    - Do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window,
    - And who remain alive during the post-discharge observation window.

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Numerator

- Uses a model estimated on full national data specific to the post-acute setting;
  - Applied to the facility's patient/resident stays included in the measure, and
  - Includes the estimated effect of that facility.

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Numerator

- The prediction equation is based on a logistic statistical model with a two-level hierarchical structure.
  - The patient/resident stays in the model have an indicator of the facility they are discharged from; the effect of the facility is measured as a positive or negative shift in the intercept term of the equation.
  - The facility effects are modeled as belonging to a normal (Gaussian) distribution centered at 0, and are estimated along with the effects of patient/resident characteristics in the model

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Discharge Status Codes to Determine Discharge to Community

- 01 Discharged to home/self-care (routine discharge)
- 06 Discharged/transferred to home under care of organized home health service organization
- 81 Discharged to home or self-care with a planned acute care hospital readmission
- 86 Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission

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Denominator

- Risk-adjusted expected number of discharges to community.
  - Includes risk adjustment for patient/resident characteristics with the facility effect removed.
  - The "expected" number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients/residents were treated at the average facility appropriate to the measure

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Target Population & Exclusions

- Medicare Fee-For-Service Residents except
  - < 18 years old
  - No short-term acute stay in preceding 30 days
  - Discharged to psychiatric hospital
  - AMA
  - Discharges to disaster sites or federal hospitals
  - Discharges to law enforcement
  - Discharges to Hospice

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Target Population & Exclusions

- Medicare Fee-For-Service Residents except
  - Not continually enrolled in Part A FFS in 12 months prior and 31 days post
  - Short term acute stay was for non-surgical treatment of cancer
  - Transfer to same level of care
  - Claims data is problematic
  - Planned discharges

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Target Population & Exclusions

- Medicare Fee-For-Service Residents except
  - Part A exhausted
  - Facility outside US, Puerto Rico, or US territory
  - Swings Beds Stays in Critical Access Hospitals

25

Requirements of Participation

26

Admission, Transfer, and Discharge Rights (§ 483.15)

- Documented in the medical record and
- that specific information be exchanged with the receiving provider or facility when a resident is transferred.

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Admission, Transfer, and Discharge Rights (§ 483.15)

- Increase ability of residents who want to go home to be discharged
- Provide information to facilitate care coordination during transitions
- Treat all discharges the same regardless of resident's Payor status

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Admission, Transfer, and Discharge Rights (§ 483.15)

- Decrease inappropriate transfers or discharges
- Provide information to residents & their representative about
- Post-discharge plans and follow-up
- Their rights to remain or return to the center
- Due process for discharges and transfers

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Transfer and Discharge Requirements F622

- **"Facility-Initiated"** – A transfer or discharge which the resident objects to, did not originate through the resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.
- **Resident-Initiated** – Resident or representative has provided verbal or written notice of the intent to leave the facility.
- **Transfer** - Movement from bed in 1 certified facility to another certified facility when resident expects to return to original facility.
- **Discharge** – Return to original facility not expected.

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Facility-Initiated Discharge

- NO significant changes in permitted reasons for Discharge
  - The resident's welfare and the resident's needs cannot be met in the facility;
  - The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
  - The safety of other individuals in the facility is endangered due to the clinical or behavioral status of the resident.

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Facility-Initiated Discharge

- NO significant changes in permitted reasons for Discharge
  - The health of other individuals in the facility would otherwise be endangered.
  - The resident has failed, after reasonable and appropriate notice, to pay or have Medicare or Medicaid pay for a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after a third part, including Medicare or Medicaid denies the claim and the resident refuses to pay.
  - The facility is ceasing to operate.

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Documentation to be Provided to Receiving Provider

- Required for all transfers and discharges when going to another provider
- At a minimum, must include:
  - Contact information for practitioner in charge
  - Contact information for Resident representative
  - Advance Directive Information
  - All instructions for ongoing care, as appropriate
  - Comprehensive Care Plan goals
  - All other "necessary information", including the discharge summary, and documentation necessary for a safe discharge

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Notice Before Transfer /Discharge F623

- **Facility must now send a *copy* of the notice to Ombudsman**
  - Discharge – At same time given to resident
  - Transfers – List can be provided monthly
- **Changes to Notice**
  - If information changes prior to effecting the transfer, must update the notice
  - If change is "significant" (e.g., new location) – new 30 day clock
- **Timing of Notice**
  - No change in 30 day or less than 30 day notice requirements
  - Emergency hospital transfers – provide to resident and representative "as soon as practicable"

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Discharge Planning Process – 483.21(c)(1)

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Intent & Purpose

Partner with the resident to maximize the likelihood that they may be able to return to the community, if they want to, without complications.

36

Discharge Planning Process F660

- 483.21(c)(1) – New rule focuses on "*implementation of discharge planning process that focuses on the resident's discharge goals, preparation of residents to be active partners and effectively transition them to post-discharge care*."
- Applies to all discharges (facility-initiated, resident-initiated, AMA)

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Discharge Planning Process F660

MAJOR required steps

1. Create an INVOLVED interdisciplinary team which includes the resident
2. Evaluate the resident's discharge potential, goals, and needs
3. Document results of evaluation in discharge plan
4. Create a discharge plan (see below for required content)
5. Update discharge plan
6. Share discharge plan with the resident

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Discharge Planning Process

7. Prepare resident & their representative for discharge
8. Notify Ombudsman of all facility-initiated discharges and transfers
9. Document reason for discharge or transfer Provide required information to receiving provider [Complete a discharge summary]

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Discharge to SNF/NF, HHA, IRF. LTCH

- Give available public data
  - Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites,
  - Resource use data, which may include, number of residents/patients who are discharged to the community, and rates of potentially preventable hospital readmissions.

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Discharge &/or Destination Unsafe?

- Treat this situation similarly to refusal of care, and must:
- Discuss with the resident and document the implications and/or risks of going to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;
- Document that other, more suitable, options of locations equipped to meet his/her needs were presented and discussed;
- Document that despite being offered other options, the resident refused those other more appropriate settings;

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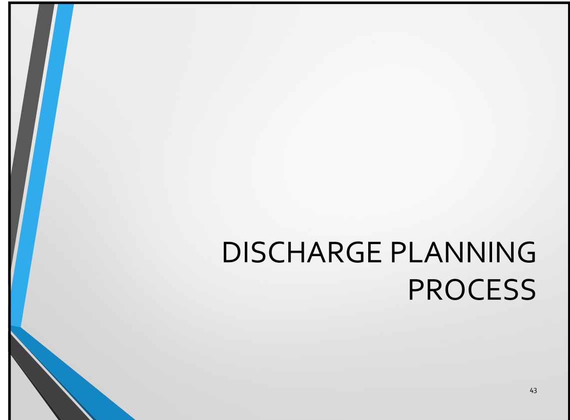
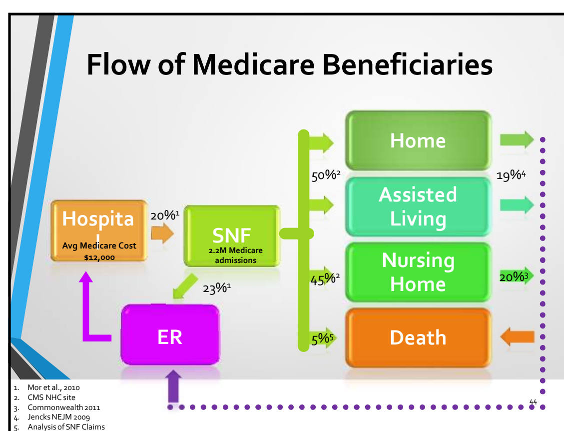
Discharge &/or Destination Unsafe?

- Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.
- As appropriate, facilities should follow their policies, or state law as related to discharges which are Against Medical Advice (AMA).

42





Discharge Planning Process

- Practice person-centered care by:
  - Establishing goals of care and discharge goals early on (part of comprehensive care plan)
    - Incorporate those goals into discharge planning starting at admission – what resources are available and what resources need to be in place to make discharge goals feasible?
  - Involving the IDT, including the resident and their representative(s)
  - Re-evaluate goals and options regularly/as changes arise
  - Providing information to resident and future caregivers to facilitate a smooth transition of care

45

Discharge Planning Process

MAJOR required steps

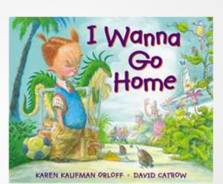
1. Create an INVOLVED interdisciplinary team which includes the resident
2. Evaluate the resident's discharge potential, goals, and needs
3. Document results of evaluation in discharge plan
4. Create a discharge plan (see below for required content)
5. Update discharge plan
6. Share discharge plan with the resident

46

Discharge Planning Process

7. Prepare resident & their representative for discharge
8. Notify Ombudsman of all discharges and transfers
9. Document reason for discharge or transfer Provide required information to receiving provider [Complete a discharge summary]

47



Discharge Plan of Care

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Intent & Purpose

Provide the healthcare team and resident with a plan and goals to help get the resident back to the community.

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Post Discharge Plan of Care

- Must be developed with participation of IDT and resident and with the resident representative with the resident's consent
- Must detail the arrangements the facility has made to address all needs at discharge and any instructions given to the resident and representative, if applicable.
- Medical record should contain documentation of written discharge instructions given to resident and representative

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Post Discharge Plan of Care

- Should show what arrangements have been made for the following:
  - Where resident will live
  - Follow-up care from other providers and provider contact information
  - Needed medical and non-medical (e.g., meals on wheels) services and equipment
  - Community care and support services, if needed
  - When and how to contact continuing care provider

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Discharge Plan Template

- Resident Goals
- Resident preference for discharge
- Referrals to local agencies made
- Services needed after discharge
- Capacity of resident & caregiver to provide services
- Discharge feasible or not

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Services After Discharge

- Make the follow-up appointment with primary care physician for within 7 days of discharge and transportation arrangements
- Schedule lab and other diagnostic testing – gather paperwork – and transportation arrangements
- Home care – what agency, date and time of first visit, contact info
- Homemaker - – what agency, date and time of first visit, contact info

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Services After Discharge

- Local pharmacy – contact info, medications ordered and when to pick up, when next refills are due
- Outpatient Therapy – schedule evaluation and transportation; contact info and address
- Emergency Contacts – Name and Phone
  - Physician
  - Nursing Home
  - Hospital
  - Family / Friends

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Services After Discharge

- Medical Equipment Ordered
  - List
  - Contact Person and Number
  - Verify delivery prior to discharge

oh! oxygen

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Capacity of Resident & Caregiver To Provide Services

1. IDT along with the resident and primary caregiver determine what the resident must be able to do to return home – and what support will be needed.
2. The IDT evaluates the capacity of the caregiver and educates the care giver on how to perform
3. Consider a competency checklist of skills that either the resident or caregiver must demonstrate

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More Discharge Plan Template

- Resident education & orientation to discharge
- Resident and representative involvement in plan
- Interdisciplinary team members
- involvement in plan
- Date last updated
- Date comprehensive assessment completed
- Date shared with resident and/or representative

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Resident Education & Orientation

- Therapy and home safety
- Disease processes and warning signs – what to do when warning signs emerge
- When to call 911
- Medication Usage – return demo, home medication check, refills, etc.
- **RECONCILIATION OF PRE-ADMISSION MEDICATIONS WITH DISCHARGE ORDERS**
- Treatments
- ADL Assistance

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Final Review and Checklist

- Contact information of the practitioner responsible for the care of the resident upon transfer/discharge
- Resident representative information including contact information
- Advance Directive information
- All special instructions or precautions for ongoing care
- Copy of the most recent Comprehensive care plan including goals and discharge plan

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Internal Checklist

- Lists criteria for transfer or discharge that resident meets
- Physician note and order in chart
- Document discharge summary complete (see next section)
- Resident & representative notified
- Resident oriented to discharge follow-up
- Status of any appeal

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Discharge Order Template

- Use a template discharge/transfer order to be signed by the physician that states
  - ➢ Why the person needs to be transferred or discharged
  - ➢ Why the center can't meet the needs of the resident
  - ➢ What services the resident needs following discharge

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Discharge Dated Documentation Checklist

- Who was the involved IDT
- How resident involved and if not, why not practicable?
- How and response when resident was asked about receiving information regarding return to the community.
- The evaluation results of the resident's discharge needs and discharge plan.
- The evaluation results were discussed with the resident or resident's representative.

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Discharge Dated Documentation Checklist

- Informed the resident and resident representative of the final plan.
- Update the Discharge Plan
  - Document and date the discharge plan when updated.
  - Was the discharge plan updated based on information received from referrals to local contact agencies or other appropriate entities?

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Discharge Dated Documentation Checklist

- Was resident (and/or representative) provided orientation about their discharge?
- Was the resident informed of their rights prior to discharge/transfer (e.g. bed-hold policy, appeals, discharge/transfer arrangements)?
- Was information on the quality of home health agency provided to the resident?
- Was rationale for discharge documented in the medical record and signed by the physician?

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Discharge Summary F661

- When facility *anticipates* discharge, must have a discharge summary.
  - "Anticipates" means it is a planned discharge and not one due to death or an emergency
- Must furnish at time when resident leaves the facility – Don't start drafting on the morning of discharge.
- Copy must be in the medical record

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Discharge Summary Requirements

1) Recapitulation of resident's stay, includes but not limited to:
   - Diagnoses
   - Course of illness/treatment
   - Pertinent labs, radiology and consultation results
2) Final summary of resident's status, to include items in a comprehensive assessment
3) Reconciliation of all pre-discharge and post-discharge medications
4) Post discharge plan of care
5) Resident consent to share information

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Discharge Summary Template

- Resident's Name & DOB
- Admission and Discharge Dates
- Diagnoses
- Course of illness/treatments/Therapy during nursing center stay
- Discharge medications (including over-the-counter)
- Reconciliation of all pre-discharge medications and post-discharge medications
- Where the individual plans to reside
- Any arrangements for follow up care

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Discharge Summary Template

- Any post-discharge medical and non-medical services
- Laboratory tests and results (most recent)
- Radiology or other tests and results (most recent)
- Consultations along with findings and recommendations
- A copy of the MDS
- A copy of the discharge plan from the comprehensive care plan
- Consent of the resident or resident's representative to share discharge summary
- Date completed

68

So What Happens After Discharge?

69

Develop Transition of Care Program

- Home visit soon after SNF admission not a few days before
- Establish goals of SNF admission*
- Provide information to receiving provider*
- Provide orientation to resident & representative on discharge instructions*

* Required as part of New SNF requirements of Participation

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Develop Transition of Care Program

- Arrange follow-up and communicate with primary care MD* -
  - Call the day of discharge and inform resident home and confirm next appointment
  - Send discharge summary and plan to primary care

* Required as part of New SNF requirements of Participation

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Develop Transition of Care Program

- Confirm with home health agency that resident discharging that day and the time of home care first visit
  - Send discharge instructions and summary to the home health agency (required)

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Develop Transition of Care Program

- Do follow-up calls to discharges to community within 24 hours and 3-5 days later
  - Call and remind of appointment with primary care
  - Well-being check
- Do follow up home visits after discharge
- Encourage resident to call you if struggling at home

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Speakers

- Vickie Burlew, RN
  vburlew@rolfconsulting.com

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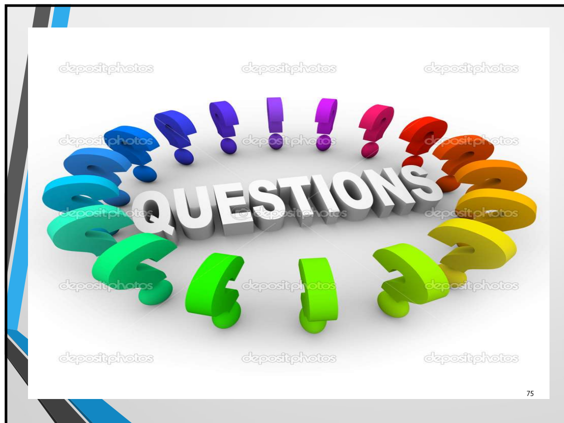

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