AHC Media

# CMS Discharge Planning Worksheet 101

Friday,
March 28th, 2014



## Speaker


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- President of Patient Safety and Education Consulting
- Board Member
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- 614 791-1468
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# Learning Objectives

1. Explain the current CMS worksheet on discharge planning.
2. Discuss revisions to the CMS discharge planning worksheet.
3. Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
4. Evaluate compliance requirements and penalties.

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# You Don't Want One of These


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# The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - CoP manual updated February 14, 2014 and 456 pages long
  - Tag numbers are section numbers and go from 0001 to 1164
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **survey procedures** [2]
  - Hospitals should check the CMS Survey and Certification website once a month for changes

[1]www.gpoaccess.gov/fr/index.html [2]www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

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# Location of CMS Hospital CoP Manuals

**Medicare State Operations Manual**

**Appendix**

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop. use the browser "back" button. This is because closing the file usually will also close most browsers

CMS Hospital CoP Manuals new address
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

| App. No. | Description | PDF File |
|---|---|---|
| A | Hospitals | 2,185 KB |
| AA | Psychiatric Hospitals | 606 KB |

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# CMS Hospital CoP Manual

**State Operations Manual**
**Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals**

**Table of Contents**

*(Rev. 103, 02-14-14)*

Transmittals for Appendix A

**Survey Protocol**

**Introduction**

- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering/Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 – Post-Survey Activities

**Psychiatric Hospital Survey Module**

**Psychiatric Unit Survey Module**

**Rehabilitation Hospital Survey Module**

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# CMS Survey and Certification Website


www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Click on Policy & Memos to States and Regions

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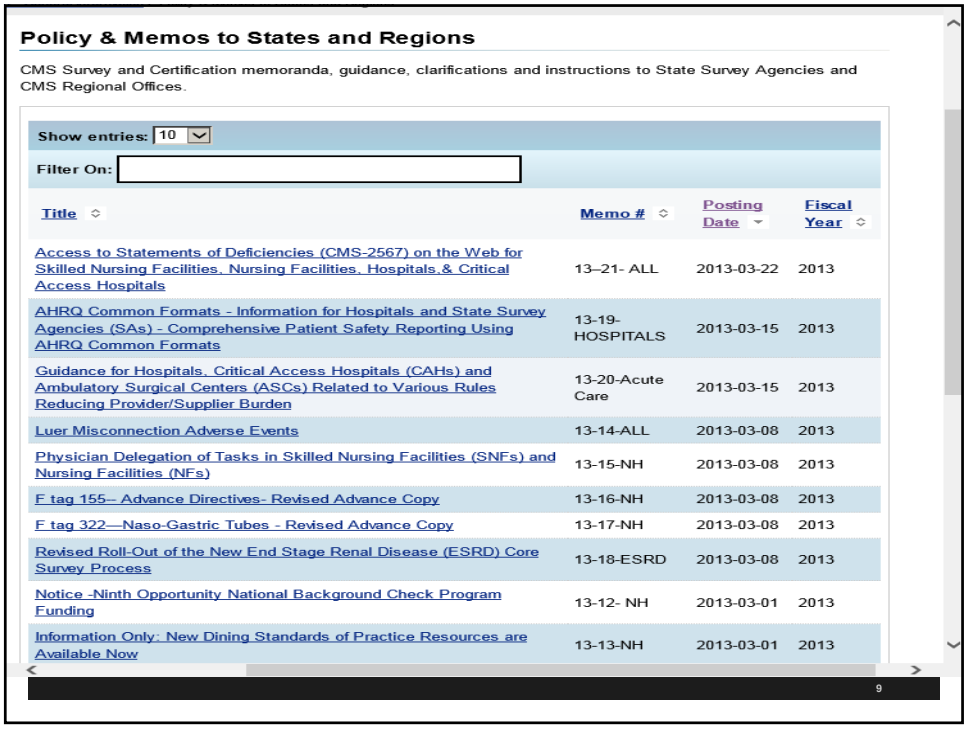

## Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

| Title | Memo # | Posting Date | Fiscal Year |
|---|---|---|---|
| Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals,& Critical Access Hospitals | 13–21- ALL | 2013-03-22 | 2013 |
| AHRQ Common Formats - Information for Hospitals and State Survey Agencies (SAs) - Comprehensive Patient Safety Reporting Using AHRQ Common Formats | 13-19-HOSPITALS | 2013-03-15 | 2013 |
| Guidance for Hospitals, Critical Access Hospitals (CAHs) and Ambulatory Surgical Centers (ASCs) Related to Various Rules Reducing Provider/Supplier Burden | 13-20-Acute Care | 2013-03-15 | 2013 |
| Luer Misconnection Adverse Events | 13-14-ALL | 2013-03-08 | 2013 |
| Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) | 13-15-NH | 2013-03-08 | 2013 |
| F tag 155– Advance Directives- Revised Advance Copy | 13-16-NH | 2013-03-08 | 2013 |
| F tag 322—Naso-Gastric Tubes - Revised Advance Copy | 13-17-NH | 2013-03-08 | 2013 |
| Revised Roll-Out of the New End Stage Renal Disease (ESRD) Core Survey Process | 13-18-ESRD | 2013-03-08 | 2013 |
| Notice -Ninth Opportunity National Background Check Program Funding | 13-12- NH | 2013-03-01 | 2013 |
| Information Only: New Dining Standards of Practice Resources are Available Now | 13-13-NH | 2013-03-01 | 2013 |

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# Transmittals

CMS.gov
Centers for Medicare & Medicaid Services

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Insurance Oversight | Innovation Center | Regulations and Guidance | Research, Statistics, Data and Systems | Outreach and Education

www.cms.gov/Transmittals/01_overview.asp

**Transmittals**

The Centers for Medicare & Medicaid Services uses transmittals to communicate new or changed policies or procedures that we will incorporate into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes. The transmittals for 2000 through 2003 have been archived. The archived transmittals can be accessed using the following URLs:

**2003 Transmittals**

http://wayback.archive-it.org/2744/20111201175645/http://www.cms.gov/Transmittals/2003Trans/list.asp

**2002 Transmittals**

http://wayback.archive-it.org/2744/20111201175723/http://www.cms.gov/Transmittals/2002Trans/list.asp

**2001 Transmittals**

http://wayback.archive-it.org/2744/20111201175802/http://www.cms.gov/Transmittals/2001Trans/list.asp

**2000 Transmittals**

http://wayback.archive-it.org/2744/20111201175840/http://www.cms.gov/Transmittals/2000Trans/list.asp

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## Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Will update quarterly
  - Available under downloads on the hospital website at www.cms.gov

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## Access to Hospital Complaint Data

- There is a list that includes the hospital's name and the different tag numbers that were found to be out of compliance
  - Many on restraints and seclusion, EMTALA, infection control, patient rights including consent, advance directives and grievances
- Two websites by private entities also publish the CMS nursing home survey data and hospitals
- The ProPublica website
- The Association for Health Care Journalist (AHCJ) websites

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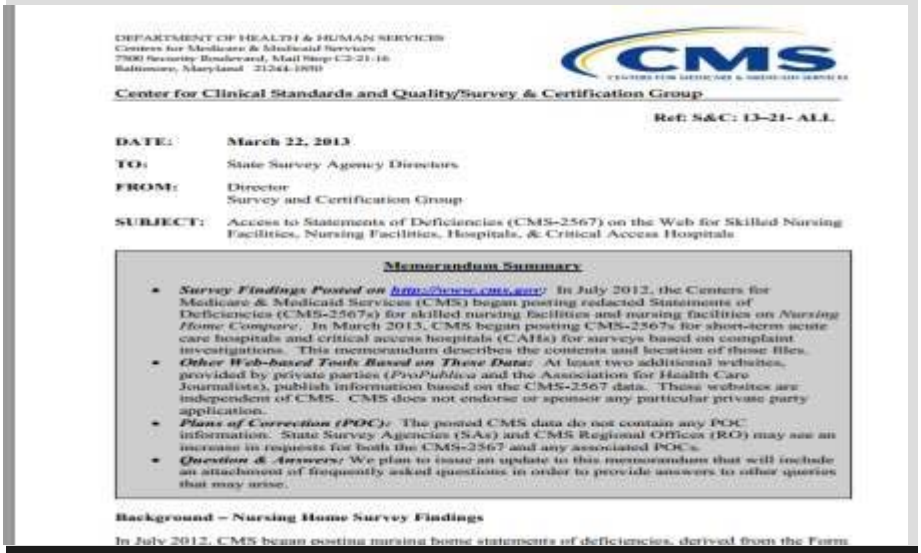
# Access to Hospital Complaint Data



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-21- ALL

DATE: March 22, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

**Memorandum Summary**

- ***Survey Findings Posted on*** *http://www.cms.gov:* In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on *Nursing Home Compare*. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.
- ***Other Web-based Tools Based on These Data:*** At least two additional websites, provided by private parties (*ProPublica* and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- ***Plans of Correction (POC):*** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.
- ***Question & Answers:*** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

**Background – Nursing Home Survey Findings**

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form

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# Deficiency Data Discharge Planning

| Tag Number | Section | Nov 2013 | Jan 2014 |
|---|---|---|---|
| 799 | Discharge Planning (DP) | 20 | 20 |
| 800 | DP Evaluation | 25 | 25 |
| 806 | DP Needs Assessment | 58 | 58 |
| 807 | Qualified DP Staff | 8 | 8 |
| 810 | Timely DP Evaluation | 12 | 12 |

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# Deficiency Data Discharge Planning

| Tag | Section | Nov 2013 | Jan 2014 |
|---|---|---|---|
| 811 | Documentation & Evaluation | 15 | 16 |
| 812 | Discharge Planning | 3 | 3 |
| 817 | Discharge Plan | 26 | 28 |
| 819 | MD Required DP | 3 | 3 |
| 820 | Implementation of DP | 53 | 53 |

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# Deficiency Data Discharge Planning

| Tag | Section | Nov 2013 | Jan 2014 |
|---|---|---|---|
| 821 | Reassess DP | 37 | 49 |
| 823 | List of HH Agencies | 28 | 31 |
| 837 | Transfer or Referral | 37 | 38 |
| 843 | Reassess DP Process | 30<br>Total 355 | 30<br>Total 364 |

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# Discharge Planning Memo

- CMS issues 39 page memo on May 17, 2013 and final transmittal July 19, 2013 and in current manual
- Revises discharge planning standards
- Includes advisory practices to promote better patient outcomes
  - Only suggestions and will not cite hospitals
  - Call blue boxes
- The discharge planning CoPs have been reorganized
- A number of tags were eliminated
  - The prior 24 standards have been consolidated into 13

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# Discharge Planning Revisions

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

**Center for Clinical Standards and Quality/Survey & Certification Group**

**Ref: S&C: 13-32- HOSPITAL**

**DATE:** May 17, 2013

**TO:** State Survey Agency Directors

**FROM:** Director
Survey and Certification Group

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

**SUBJECT:** Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning

**Memorandum Summary**

- ***Discharge Planning Guidance Revised:*** SOM Hospital Appendix A has been revised to update the guidance for the discharge planning Condition of Participation (CoP).
- ***Advisory Boxes:*** Included in the updated interpretive guidelines are "blue boxes," to display advisory practices to promote better patient outcomes. The information found in these advisory boxes is **not** required for hospital compliance but only resurce information or references for process improvement.
- ***Automated Survey Processing Environment (ASPEN) Tags:*** ASPEN Tags for discharge planning CoPs have been reorganized. A number of tags were eliminated. These changes were made in 2012.

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# Discharge Planning Transmittal July 19, 2013

**CMS Manual System**
**Pub. 100-07 State Operations**
**Provider Certification**

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

**Transmittal 87** — **Date: July 19, 2013**

**SUBJECT: Revised Appendix A, Interpretive Guidelines for Hospitals, Condition of Participation: Discharge Planning.**

**I. SUMMARY OF CHANGES: Clarification is provided for the provisions of 42 CFR 482.43, concerning discharge planning. Several "Tags" within this CoP guidance have a been consolidated, but there are no changes to the regulatory text.**

**NOTES:**

**Tag A-0808 is deleted. Content combined with Tag A-0806**
**Tag A-0809 is deleted. Content combined with Tag A-0806**
**Tag A-0817 is deleted. Content combined with Tag A-0818**
**Tag A-0822 is deleted. Content combined with Tag A-0820**
**Tag A-0824 is deleted. Content combined with Tag A-0823**
**Tag A-0825 is deleted. Content combined with Tag A-0823**
**Tag A-0826 is deleted. Content combined with Tag A-0823**
**Tag A-0827 is deleted. Content combined with Tag A-0823**
**Tag A-0828 is deleted. Content combined with Tag A-0823**
**Tag A-0829 is deleted. Content combined with Tag A-0823**
**Tag A-0830 is deleted. Content combined with Tag A-0823**
**Tag A-0831 is deleted. Content combined with Tag A-0823**
**Exhibit XX is deleted, renamed Exhibit 353 and moved with other SOM Exhibits**

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# CMS Worksheet

## Discharge Planning

## CMS Hospital Worksheets Third Revision

- First, October 14, 2011 CMS issues a 137 page memo in the survey and certification section
- Memo discusses surveyor worksheets for hospitals by CMS during a hospital survey
- Addresses discharge planning, infection control, and QAPI
- Second, it was pilot tested in hospitals in 11 states and on May 18, 2012 CMS published a second revised edition
  - Piloted test each of the 3 in every state over summer 2012

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## CMS Hospital Worksheets

- Next, November 9, 2012 CMS issued the third revised worksheet which was 88 pages
- Third pilot was non-punitive and will not require action plans unless immediate jeopardy is found
- CMS assigned a specific number of surveys using all three tools for each state in 2013
- March 2014, CMS comes out with the final revised worksheet for discharge planning
- In the process of revising the infection control and QAPI worksheet also

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# CMS Hospital Worksheets

- Have selected hospitals in each state and will complete all 3 worksheets at each hospital in 2014
- Money in the budget if the state agencies wants to do more than the assigned number
- This is the final evaluation tool and in 2014 will use whenever a CMS survey such as a validation survey is done
- Hospitals should be familiar with the three worksheets

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# Third Revised Worksheets

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

**Center for Clinical Standards and Quality/ Survey & Certification Group**

**REF: S&C: 13-03-Hospital**

**DATE:** November 9, 2012

**TO:** State Survey Agency Directors

**FROM:** Director
Survey & Certification Group

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

**SUBJECT:** Patient Safety Initiative FY 2013 Pilot Phase – Revised Draft Surveyor Worksheets

**Memorandum Summary**

- *Patient Safety Initiative*: The Centers for Medicare & Medicaid Services (CMS) is continuing to test revised surveyor worksheets for assessing compliance with three hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. We are focusing on compliance with these CoPs as a means to reduce hospital-acquired conditions (HACs), including healthcare associated infections (HAIs), and preventable readmissions.
- *Draft Worksheets Made Public:* Via this memorandum we are making the revised draft worksheets publicly available. As was the case previously, there may be additional revisions to the worksheets at the end of FY 2013.

**Patient Safety Initiative Pilot Phase**

The Survey & Certification Group (SCG) Patient Safety Initiative is continuing to pilot test three revised surveyor worksheets designed to help surveyors assess compliance with the hospital CoPs for QAPI, infection control, and discharge planning. In S&C-12-01 released October 14, 2011 and in S&C-12-32 released May 18, 2012, we made available to the public copies of the initial and revised draft surveyor worksheets. These worksheets were used during the pre-test and pilot phases of the SCG initiative, from September 2011 through September 2012.

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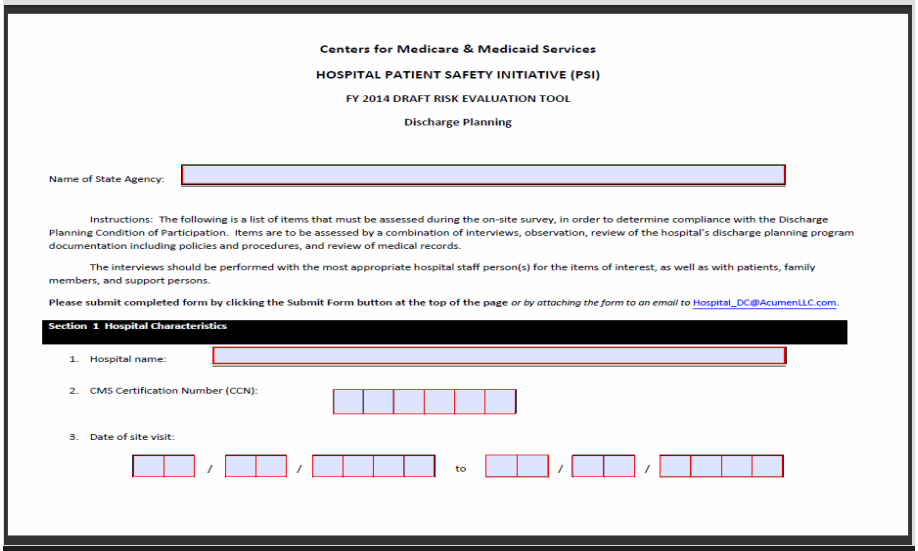
# Final Discharge Planning Evaluation Tool



**Centers for Medicare & Medicaid Services**

**HOSPITAL PATIENT SAFETY INITIATIVE (PSI)**

**FY 2014 DRAFT RISK EVALUATION TOOL**

**Discharge Planning**

Name of State Agency:

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Discharge Planning Condition of Participation. Items are to be assessed by a combination of interviews, observation, review of the hospital's discharge planning program documentation including policies and procedures, and review of medical records.

The interviews should be performed with the most appropriate hospital staff person(s) for the items of interest, as well as with patients, family members, and support persons.

**Please submit completed form by clicking the Submit Form button at the top of the page** *or by attaching the form to an email to* Hospital_DC@AcumenLLC.com.

**Section 1 Hospital Characteristics**

1. Hospital name:
2. CMS Certification Number (CCN):
3. Date of site visit:

/ / to / /

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# CMS Hospital Worksheets Goals

- Goal is to reduce hospital acquired conditions (HACs) including healthcare associated infections
- Goal to prevent unnecessary readmission and currently 1 out of every 5 Medicare patients is readmitted within 30 days
- Many hospitals (66%) financially penalized after October 1, 2012 because they had a higher than average rate of readmissions (forfeited 280 million in 2013 and 217 million in 2014)
- The underlying CoPs on which the worksheet is based did not change

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# CMS Hospital Worksheets

- However, some of the questions asked might not be apparent from a reading of the CoPs
- A worksheet is a good communication device
- It will help clearly communicate to hospitals what is going to be asked in these 3 important areas
- Hospitals might want to consider putting together a team to review the 3 worksheets and complete the form in advance as a self assessment
- Hospitals should consider attaching the documentation and P&P to the worksheet

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# Hospital Patient Safety Initiative PSI

- This would impress the surveyor when they came to the hospital
- The PSI worksheet is used in new hospitals undergoing an initial review and hospitals that are not accredited by TJC, DNV, or AOA who have a CMS survey every three or so years
  - The Joint Commission (TJC), American Osteopathic Association (AOA) Healthcare Facility Accreditation Program, CIHQ, or DNV Healthcare
- It would also be used for hospitals undergoing a validation survey by CMS

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# CMS PSI Hospital Worksheets

- The regulations are the basis for any deficiencies that may be cited and not the worksheet per se
- The worksheets are designed to assist the surveyors and the hospital staff to identify when they are in compliance
- Will not affect critical access hospitals (CAHs) but CAH would want to look over the one on PI and especially infection control
- Questions or concerns should be addressed to Mary Ellen Palowitch at PFP.SCG@cms.hhs.gov

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# CMS Hospital Worksheets

- First part of the risk evaluation tool includes identification information and is 15 pages
  - Called the Hospital Patient Safety Initiative or PSI
- Name of the state survey agency which in most states is the department of health under contract by CMS
  - In Kentucky it is the OIG or Office of Inspector General
- It will ask for the name and address of the hospital, CCN number, and date of the survey

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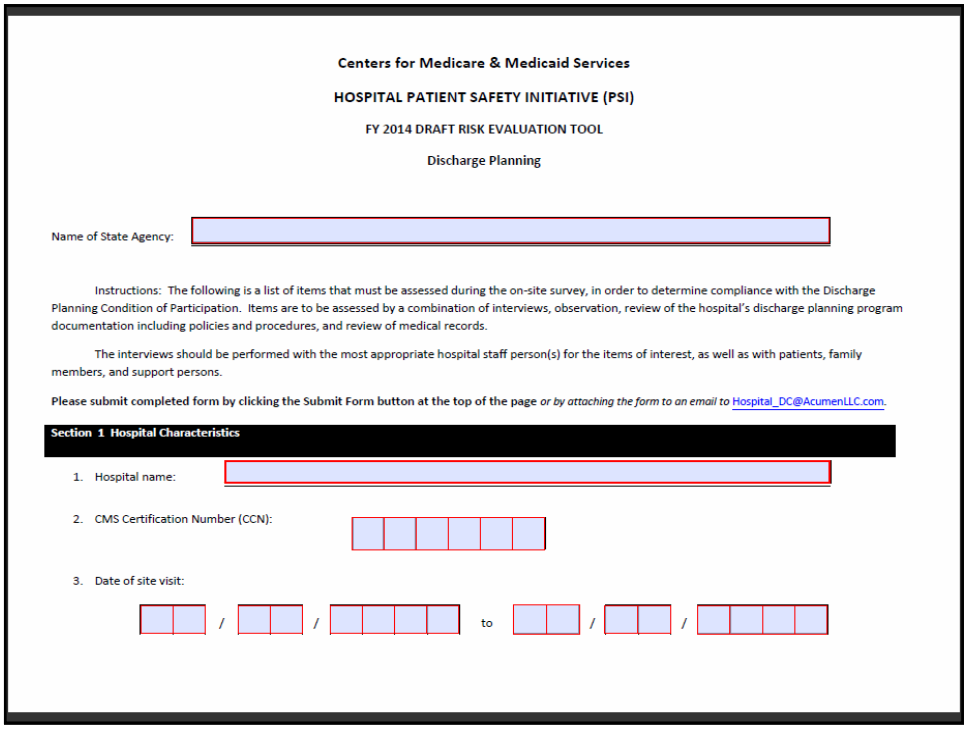

**Centers for Medicare & Medicaid Services**

**HOSPITAL PATIENT SAFETY INITIATIVE (PSI)**

**FY 2014 DRAFT RISK EVALUATION TOOL**

**Discharge Planning**

Name of State Agency:

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Discharge Planning Condition of Participation. Items are to be assessed by a combination of interviews, observation, review of the hospital's discharge planning program documentation including policies and procedures, and review of medical records.

The interviews should be performed with the most appropriate hospital staff person(s) for the items of interest, as well as with patients, family members, and support persons.

**Please submit completed form by clicking the Submit Form button at the top of the page** *or by attaching the form to an email to* Hospital_DC@AcumenLLC.com.

**Section 1 Hospital Characteristics**

1. Hospital name:
2. CMS Certification Number (CCN):
3. Date of site visit:

/ / to / /

# Discharge Planning Worksheet P&P

- Is there a discharge planning process for certain categories of outpatients such as **observation, ED** patients and **same day surgery patients**?
  - Could add questions to the assessment tool and include in questions asked in pre-admission tests for OP surgery
- Are **discharge P&P** in effect for all inpatients?
  - Is there evidence on every unit that there is discharge planning activities?
  - Are staff following the discharge planning P&P?

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# Discharge Planning P&P

**Section 2 Discharge Planning – Policies and Procedures**

| Elements to be assessed | | Surveyor Notes |
|---|---|---|
| 2.1 Implementation of discharge planning policies and procedures for inpatients: | | |
| 2.1a For every inpatient unit surveyed is there evidence of applicable discharge planning activities? | ☐ Yes ☐ No | |
| 2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures? | ☐ Yes ☐ No | |
| **NOTE: If no for either 2.1a or 2.1b the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to identification of patients needing discharge planning, 42 CFR 482.43(a) (Tag A-0800); discharge planning evaluation, 42 CFR 482.43(b) (Tag A-0806); and/or developing and implementing the discharge plan, 42 CFR 482.43(c) (Tag A-0818)** | | |
| 2.2 Does the discharge planning process apply to certain categories of outpatients? | ☐ Yes ☐ No | |
| If yes, check all that apply:<br>☐ Same day surgery patients<br>☐ Observation patients who are not subsequently admitted<br>☐ ED patients who are not subsequently admitted<br>☐ Other | | |
| 2.3 Is a discharge plan prepared for each inpatient? | ☐ Yes, skip to question 2.8<br>☐ No, go to question 2.4 | |

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# Are Staff Aware of Your DP Policy?

**DISCHARGE PLANNING**

**PURPOSE:**

To promptly identify patient discharge needs.

To coordinate timely discharge planning during the hospital stay so that patient needs are met and continuity of care is not interrupted by discharge from the acute care setting.

**POLICY:**

I. Discharge Planning begins on admission and continues throughout the hospital stay as needs are identified and care is planned to meet those identified needs.

II. Following identification of anticipated discharge needs, the nurse and/or physician shall consult the appropriate department for assistance in meeting the patient's needs. In addition, the family and/or significant other shall be notified as soon as possible regarding the discharge needs of the patient as appropriate so that they can be involved in the decision making and ongoing care for the patient.

III. Discharge Planning screening criteria included in the Admission Assessment must be completed **within 8 hours of admission by the RN or RN Applicant** and are utilized to determine if either Case Management or Social Services should be consulted.
***(See Nursing Policy A- 12, Admission, Transfer and Discharge Assessments).***
http://team.uhsystem.com/uhsprivate/inpatientnursing/A-12.pdf

**A. Social Services Consults**

Social Services shall be consulted and recommendations incorporated into the Plan of Care when a patient meets any of the following admission screening criteria:

1. Adoption Case
2. Medication assistance
3. Crisis and/or supportive counseling
4. Elderly, adult and child protective service cases

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**B. Case Management Consults**

Case Management shall be consulted when a patient meets any of the following admission screening criteria and any recommendations incorporated into the Plan of Care:

1. Lacks transportation
2. Disabled and living alone
3. Durable Medical Equipment
4. Physical/Occupational/Speech Therapy after discharge
5. Unable to manage self-care/prior Home Health Services
6. Frequent hospital admissions for poorly controlled chronic disease
7. Admission from a nursing home or another state agency
8. Teenage obstetric (<16 years)
9. No source of income
10. No place to live
11. Lacks clothing
12. Any post discharge/extended care needs

**Additional screening criteria for psychiatry only:**

1. No leisure activities
2. Substance abuse
3. No job skills
4. No family support
5. No source of income.

**C. Assessments within 48 Hours**

Assessments are performed within 48 hours of consult, if deemed necessary by the social worker/case manager. The case manager/social worker is available by telephone and pager for emergencies. After hours, weekends, and holidays, the house manager should be contacted for emergency consults.

**Diabetes Education**

Anticipated discharge needs may also be addressed by consulting specialized educators in Diabetes Education. Diabetes Education should be consulted for newly diagnosed

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# What's In Your Policy and Procedure?

**Patient Discharge**

| | |
|---|---|
| **Policy** | To optimize compliance with a patient's post-hospital plan of care, an assessment of the patient's actual and potential discharge planning needs shall be initiated upon admission. A multidisciplinary team that includes the physician, registered nurse, care manager, and social worker, together with the other members of the health care team, shall perform the assessment. A plan to meet these needs shall be developed, and interventions to meet specific discharge planning goals shall be designed. The plan shall be monitored and revised as necessary throughout the patient's hospital stay.<br><br>Verbal communications concerning discharge or the discharge planning process shall be conducted in layman's terms using the patient's preferred language. Written discharge instructions shall also be provided, using materials that have been translated into the patient's preferred language whenever possible. If the patient is a minor, the preferred language of the responsible parent or guardian shall be used.<br>**Note**: For security reasons, communication regarding the discharge of TDCJ offender patients is coordinated through TDCJ Care Management. Information of this nature shall only be released to authorized security and medical staff on a need-to-know basis.<br><br>When patients are being discharged to hospice, home health, or skilled nursing facilities (SNF), the care management team will work with the patient and/or their family to determine which service they will retain, taking into consideration such things as the patient's funding source, physical location of the patient and support personnel in relation to the service, patient/family preference based upon past experience, and other relevant factors based upon the patient's needs. UTMB providers will not recommend or show preference for one service over another and shall leave the choice of the service provider to the patient and/or |

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# Discharge Planning Worksheet 2.4

- For patients not initially identified as in need of discharge plan, does the P&P address for **updating** this based on changes in a patient's condition? (800)
  - Many hospitals have the nurse doing the admission assessment ask a set of predetermined questions to see if assistance is needed
  - How do you update this when there is a change?
  - Note that hospital in which case managers and nurse discharge planners see the patients or review their charts **everyday** to make sure there is no change in condition, this will stream line the process and ensure compliance

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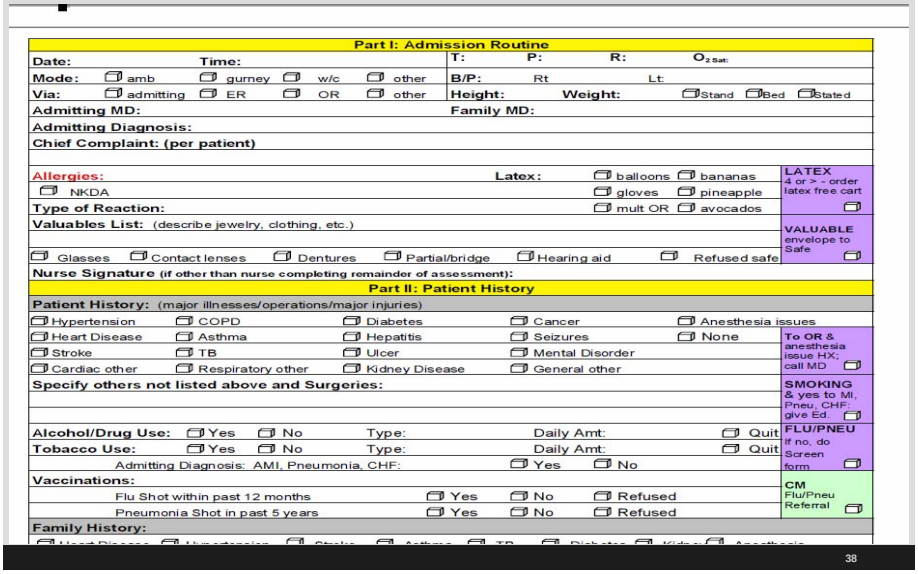
# Nurses Admission Assessment



**Part I: Admission Routine**

| | |
|---|---|
| **Date:** **Time:** | **T:** **P:** **R:** **$O_{2\ Sat:}$** |
| **Mode:** ☐ amb ☐ gurney ☐ w/c ☐ other | **B/P:** Rt Lt: |
| **Via:** ☐ admitting ☐ ER ☐ OR ☐ other | **Height:** **Weight:** ☐Stand ☐Bed ☐Stated |
| **Admitting MD:** | **Family MD:** |
| **Admitting Diagnosis:** | |
| **Chief Complaint: (per patient)** | |

**Allergies:** **Latex:** ☐ balloons ☐ bananas — **LATEX** 4 or > – order latex free cart ☐

☐ NKDA ☐ gloves ☐ pineapple

**Type of Reaction:** ☐ mult OR ☐ avocados

**Valuables List:** (describe jewelry, clothing, etc.) — **VALUABLE** envelope to Safe ☐

☐ Glasses ☐ Contact lenses ☐ Dentures ☐ Partial/bridge ☐ Hearing aid ☐ Refused safe

**Nurse Signature** (if other than nurse completing remainder of assessment):

**Part II: Patient History**

**Patient History:** (major illnesses/operations/major injuries)

| | | | | |
|---|---|---|---|---|
| ☐ Hypertension | ☐ COPD | ☐ Diabetes | ☐ Cancer | ☐ Anesthesia issues |
| ☐ Heart Disease | ☐ Asthma | ☐ Hepatitis | ☐ Seizures | ☐ None |
| ☐ Stroke | ☐ TB | ☐ Ulcer | ☐ Mental Disorder | |
| ☐ Cardiac other | ☐ Respiratory other | ☐ Kidney Disease | ☐ General other | |

**Specify others not listed above and Surgeries:**

**To OR &** anesthesia issue HX; call MD ☐

**SMOKING** & yes to MI, Pneu, CHF: give Ed. ☐

**Alcohol/Drug Use:** ☐ Yes ☐ No Type: Daily Amt: ☐ Quit

**Tobacco Use:** ☐ Yes ☐ No Type: Daily Amt: ☐ Quit

**FLU/PNEU** If no, do Screen form ☐

Admitting Diagnosis: AMI, Pneumonia, CHF: ☐ Yes ☐ No

**Vaccinations:**

| | | | |
|---|---|---|---|
| Flu Shot within past 12 months | ☐ Yes | ☐ No | ☐ Refused |
| Pneumonia Shot in past 5 years | ☐ Yes | ☐ No | ☐ Refused |

**CM** Flu/Pneu Referral ☐

**Family History:**

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Asthma ☐ TB ☐ Diabetes ☐ Kidney ☐ Anesthesia

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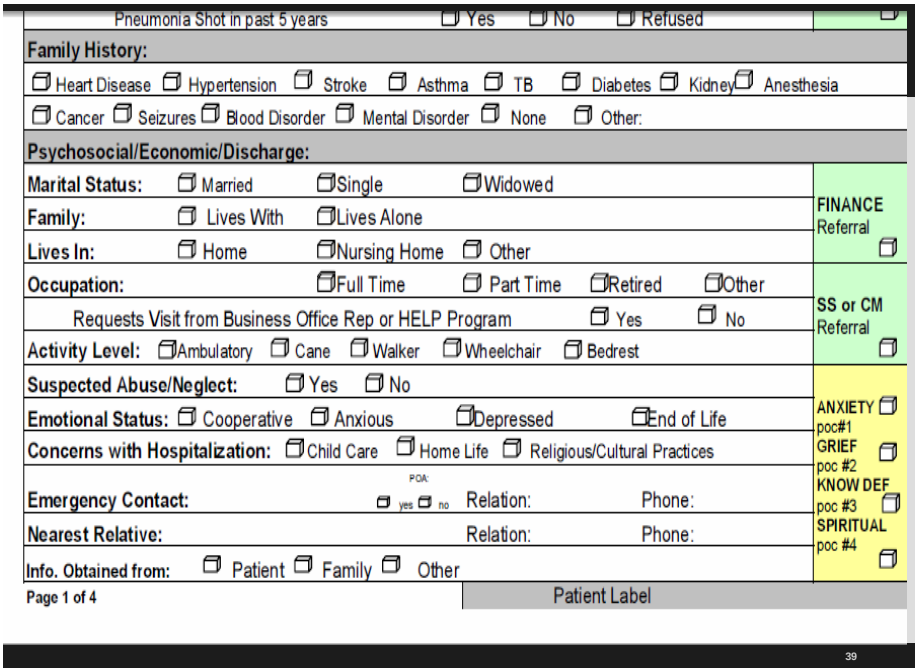

Pneumonia Shot in past 5 years ☐ Yes ☐ No ☐ Refused

**Family History:**

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Asthma ☐ TB ☐ Diabetes ☐ Kidney ☐ Anesthesia

☐ Cancer ☐ Seizures ☐ Blood Disorder ☐ Mental Disorder ☐ None ☐ Other:

**Psychosocial/Economic/Discharge:**

**Marital Status:** ☐ Married ☐ Single ☐ Widowed

**Family:** ☐ Lives With ☐ Lives Alone

**Lives In:** ☐ Home ☐ Nursing Home ☐ Other

**Occupation:** ☐ Full Time ☐ Part Time ☐ Retired ☐ Other

Requests Visit from Business Office Rep or HELP Program ☐ Yes ☐ No

**Activity Level:** ☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bedrest

**Suspected Abuse/Neglect:** ☐ Yes ☐ No

**Emotional Status:** ☐ Cooperative ☐ Anxious ☐ Depressed ☐ End of Life

**Concerns with Hospitalization:** ☐ Child Care ☐ Home Life ☐ Religious/Cultural Practices

**Emergency Contact:** POA: ☐ yes ☐ no Relation: Phone:

**Nearest Relative:** Relation: Phone:

**Info. Obtained from:** ☐ Patient ☐ Family ☐ Other

FINANCE Referral ☐

SS or CM Referral ☐

ANXIETY ☐ poc#1
GRIEF ☐ poc #2
KNOW DEF ☐ poc #3
SPIRITUAL poc #4 ☐

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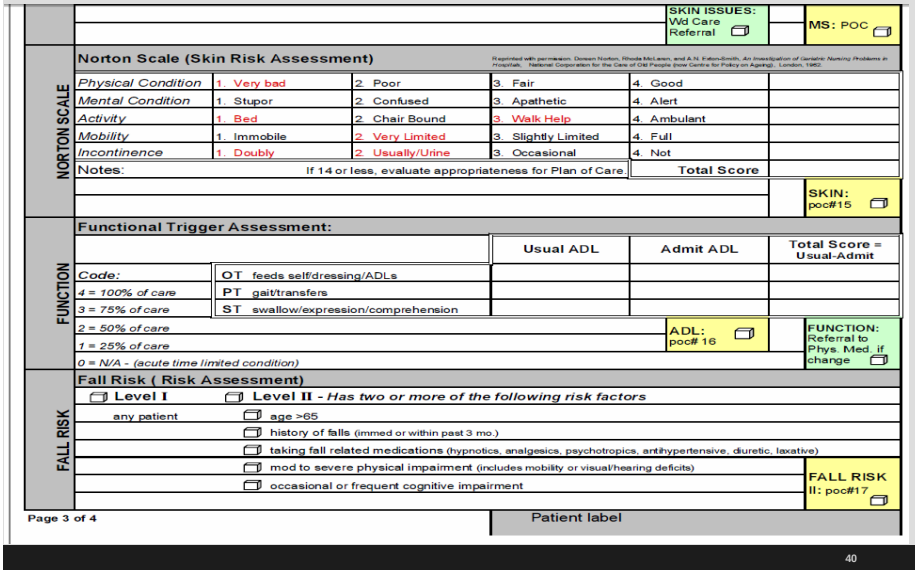
# Functional Assessment



SKIN ISSUES: Wd Care Referral ☐ | MS: POC ☐

**NORTON SCALE**

**Norton Scale (Skin Risk Assessment)**



| | | | | | |
|---|---|---|---|---|---|
| *Physical Condition* | 1. Very bad | 2. Poor | 3. Fair | 4. Good | |
| *Mental Condition* | 1. Stupor | 2. Confused | 3. Apathetic | 4. Alert | |
| *Activity* | 1. Bed | 2. Chair Bound | 3. Walk Help | 4. Ambulant | |
| *Mobility* | 1. Immobile | 2. Very Limited | 3. Slightly Limited | 4. Full | |
| *Incontinence* | 1. Doubly | 2. Usually/Urine | 3. Occasional | 4. Not | |
| Notes: If 14 or less, evaluate appropriateness for Plan of Care | | | | Total Score | |

SKIN: poc#15 ☐

**FUNCTION**

**Functional Trigger Assessment:**

| | | Usual ADL | Admit ADL | Total Score = Usual-Admit |
|---|---|---|---|---|
| *Code:* | OT feeds self/dressing/ADLs | | | |
| *4 = 100% of care* | PT gait/transfers | | | |
| *3 = 75% of care* | ST swallow/expression/comprehension | | | |

*2 = 50% of care*
*1 = 25% of care*
*0 = N/A - (acute time limited condition)*

ADL: poc# 16 ☐

FUNCTION: Referral to Phys. Med. if change ☐

**FALL RISK**

**Fall Risk ( Risk Assessment)**

☐ **Level I** any patient

☐ **Level II** - *Has two or more of the following risk factors*

- ☐ age >65
- ☐ history of falls (immed or within past 3 mo.)
- ☐ taking fall related medications (hypnotics, analgesics, psychotropics, antihypertensive, diuretic, laxative)
- ☐ mod to severe physical impairment (includes mobility or visual/hearing deficits)
- ☐ occasional or frequent cognitive impairment

FALL RISK II: poc#17 ☐

Page 3 of 4 | Patient label

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# Discharge Planning Worksheet 2.4

- Are the inpatient unit staff aware of how, when, and whom to notify of such changes in order to trigger a discharge planning evaluation? (Tag 800)
- An example would be a patient who is expected to go home in the morning and develops a pulmonary emboli and condition changes
- Do the nurses on the unit pick up the phone and call the RN discharge planners or social workers so they know there is a change in the condition and perhaps now they need a discharge planning evaluation done

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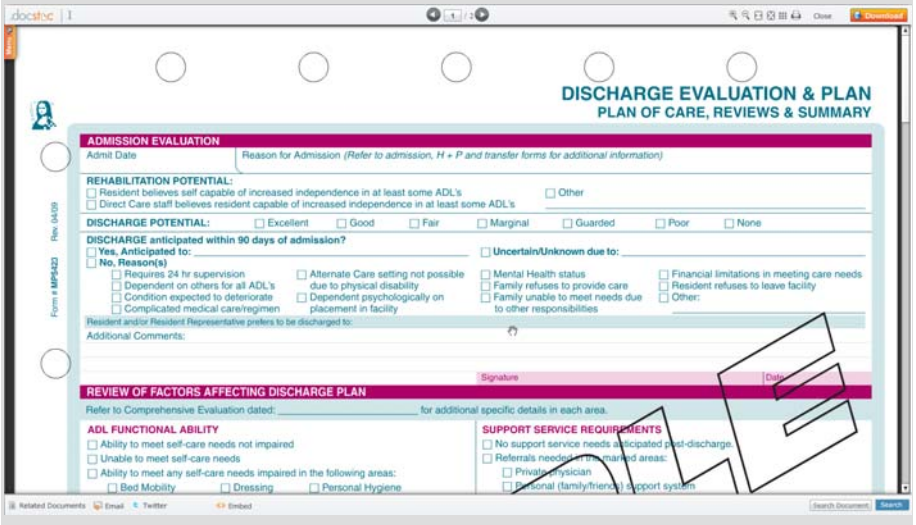
# Discharge Evaluation & Plan

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# Discharge Planning Evaluation 2.5

- The following questions are asked for a patient who does not have a **discharge planning evaluation**
- Does hospital have a process for **notifying patients** they can request a discharge planning evaluation?
  - Or process for the patient representative to request (806)
  - Note that hospitals should consider putting this in their written **patient rights**
  - Don't just hand it to the patient but rather have the registration person tell the patient about this right
  - Note hospitals could also mention this during the nursing admission assessment and document it

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# Give Patients A Copy of Their Rights

**Your Rights as a Hospital Patient in New York State**

**Glossary**

**Discharge Notice** —

A New York State hospital discharge notice should include information on your discharge date and how to appeal if you disagree with the notice. A discharge notice must be provided to all patients (except Medicare patients who receive a copy of an "Important Message from Medicare") **in writing** hours before they leave the hospital. **Medicare patients must request a written discharge notice ("The Important Message from Medicare") if they disagree with discharge.** If requested, the notice must be provided. Once the notice is provided and if the Medicare patient disagrees with the notice, an appeal can be processed.

**Discharge Plan —**

All patients (including Medicare patients) in New York State hospitals must receive **a written discharge plan** before they leave the hospital. This plan should describe the arrangements for any health care services you may need after you leave the hospital. **The necessary services described in this plan must be secured or reasonably available before you leave the hospital.**

**Discharge Planning —**

Discharge planning is the process by which hospital staff work with you and your family or someone acting on your behalf to prepare and make arrangements for your care once you leave the hospital. This care may be self care, care by family members, home health assistance or admission to another health care facility. Discharge planning includes assessing and identifying what your needs will be when you leave the hospital and planning for appropriate care to meet those needs when you are discharged. **A plan must be provided to you in writing before you leave the hospital.** Discharge planning usually involves the patient, family members or the person you designate to act on your behalf, your doctor and a member of the hospital staff. Some hospitals have staff members who are called "discharge planners." In other hospitals, a nurse or social worker may assist in discharge planning.

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# CMS Discharge Planning Medicare Learning

ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

| | |
|---|---|
| **Discharge Planning Process** | Medicare-participating acute care hospitals/post-acute care facilities must identify patients who need or have requested a discharge plan at an early stage of their hospitalization. The discharge planning process must be thorough, clear, comprehensive, and understood by acute care hospital/post-acute care facility staff.<br><br>The physician may make the final decision as to whether a discharge plan is necessary. If a physician requests a discharge plan, you must develop such plan, even if the interdisciplinary team determines that it is not necessary (as applicable).<br><br>Depending on the patient's needs, discharge planning may be completed by personnel in multiple disciplines who have specific expertise. You may designate discharge planning responsibilities to appropriate qualified personnel such as registered nurses, social workers, or other qualified personnel. These individuals should have:<br>• Discharge planning experience;<br>• Knowledge of social and physical factors that affect functional status at discharge; and<br>• Knowledge of appropriate community services and facilities that can meet the patient's post-discharge clinical and social needs. |

Discharge Planning www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Discharge-Planning-Booklet-ICN908184.pdf 3

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# Discharge Planning Worksheet 2.5

- Can the hospital show that they conducted the DP evaluation upon request? (806)
- Can both the discharge planning and unit nursing staff describe the process for the patient or the patient's representative to request a discharge planning evaluation
- They must be able to do this even if the hospital's screening criteria did not indicate that one was needed (Tag 806)
- Surveyor is suppose to interview the patient to make sure they knew how to request one

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## Discharge Planning Worksheet 2.5

- Will interview **doctors** and make sure they know they can request a discharge planning evaluation (806 and 819)
- If doctor not aware will ask hospital to provide evidence on how it informs the MS about this
- If doctor not aware will also ask for evidence of how it informs the medical staff about this
- Again, if the hospital does an DP evaluation on every inpatient this section will not be applicable and the hospital avoids jumping through many of the hoops

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## Physicians Can Request a DP Evaluation

- Note that the hospital could include this information in new physician orientation
- Note the Chief Medical Officer could write a memo to all physicians and advise that they can request a DP evaluation
- Best way is to place on order in the medical record
- This only has to be done if the hospital does not do a DP evaluation on all patients

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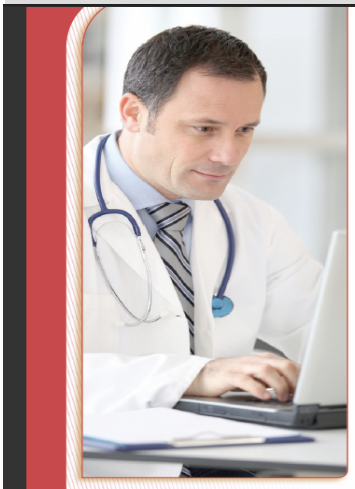
# Discharge Planning Evaluation CMS MLN



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

***Discharge Planning Evaluation***

Unless you develop a discharge planning evaluation for every patient, you must have a process to notify patients, patient's representatives, and attending physicians that they may request an evaluation. You must also convey that the discharge planning evaluation will be completed upon request.

The discharge planning evaluation determines the patient's continuing care needs after he or she leaves the acute care hospital/post-acute care facility setting. Appropriate qualified personnel must complete discharge planning evaluations:

- For every patient who is identified at potential risk of adverse health consequences without a discharge plan; and
- If the patient, the patient's representative, or the attending physician requests such evaluation.

Depending on the patient's clinical condition and anticipated LOS, you should complete the discharge planning evaluation as soon as possible after admission and update it periodically during the patient's stay.

You must include the discharge planning evaluation in the patient's clinical record. It considers the patient's care needs immediately upon discharge and whether the needs are expected to remain constant or lessen over time. The discharge planning evaluation identifies appropriate after-acute care hospital/post-acute care

Discharge Planning 5

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# Discharge Planning Worksheet

- Will ask staff to describe the process for physicians to order a discharge plan (819)
- Does P&P provide a process for ongoing reassessment of discharge plan in case of **changes** to the patient's condition (819)?
- Does hospital discharge planning P&P include a process for ongoing reassessment of the discharge plan based on changes in the patient's condition, changes in available support including changes in post hospital care requirements? (821)

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| Elements to be assessed | | Surveyor Notes |
|---|---|---|
| 2.5d Interview patients (or their representatives if applicable). If they say they were not aware they could request a discharge planning evaluation, can the hospital provide evidence the patient or representative received notice they could request an evaluation? | ○ Yes<br>○ No<br>○ N/A | |
| 2.5e Interview attending physicians. If they are not aware they can request a discharge planning evaluation, can the hospital provide evidence of how it informs the medical staff about this? | ○ Yes<br>○ No<br>○ N/A | |
| **NOTE: If no to any part of question 2.5, the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to 42 CFR 482.43(b)(1) (Tag A-0806)** | | |
| 2.6 Interview attending physicians. If they are not aware they can request a discharge plan regardless of the outcome of the discharge planning evaluation, can the hospital provide evidence of how it informs the medical staff about this? | ○ Yes<br>○ No<br>○ N/A | |
| **NOTE: If no to 2.6, the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to 42 CFR 482.43(c)(2) (Tag A-0819)** | | |
| 2.7 Can discharge planning personnel describe a process for physicians to order a discharge plan to be completed on a patient, regardless of the outcome of the patient's evaluation? | ○ Yes<br>○ No | |
| **NOTE: If no to 2.7, the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to 42 CFR 482.43(c)(2) (Tag A-0819)** | | |
| 2.8 Does the hospital discharge planning policy include a process for ongoing reassessment of the discharge plan based on changes in patient condition, changes in available support, and/or changes in post-hospital care requirements? | ○ Yes<br>○ No | |

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# Section 3 QAPI DP and Reassessment

- Does hospital review discharge planning process on an ongoing manner as through **PI**?
- Does hospital track readmission rates as part of discharge planning? (843 and 283)
  - Does assessment include if readmission was potentially preventable?
  - If preventable then did the hospital make changes to the planning process?

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# QAPI

**Section 3 Discharge Planning – Reassessment and QAPI**

| Elements to be assessed | | Surveyor Notes |
|---|---|---|
| 3.1 Does the hospital review the discharge planning process in an ongoing manner, e.g. through QAPI activities? | ☐ Yes ☐ No | |
| 3.2 Does the hospital track its readmissions as part of its review of the discharge planning process? (Ask to see some readmissions data to confirm tracking occurs.) | ☐ Yes ☐ No | |
| 3.3 Does the hospital's assessment of readmissions include an evaluation of whether the readmissions were potentially due to problems in discharge planning or the implementation of discharge plans? | ☐ Yes ☐ No ☐ N/A | |
| 3.4 If the hospital identified preventable readmissions and problems in the discharge planning process were identified as a possible cause, did it make changes to its discharge planning process to address the problems? | ☐ Yes ☐ No ☐ N/A | |
| **NOTE: If no to any question from 3.1 through 3.4, the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to 42 CFR 482.43(e) (Tag A-0843) and possibly QAPI 42 CFR 482.21(c) (Tag A-0283)** | | |
| 3.5 Does the hospital have a process for collecting and considering feedback from post-acute providers in the community about the effectiveness of the hospital's discharge planning process? | ☐ Yes ☐ No | |

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# Discharge Planning Worksheet

- Does hospital track readmission rates as part of discharge planning? (843 and 283)
  - Consider asking patient why they thought readmission occurs
  - Remember study that reduced readmissions if appointment made within 1-4 days after discharge
  - The study found that the timing of the visit was very important

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## Timing of Physician Follow Up Appt

- Timing of the physician follow up appointment may be important
  - One hospital found if patient saw doctor day 1-4 the chance of readmission is less than 6%
  - If appointment 6-10 days after discharge readmission rate was 6 to 13%
  - If visits on day 25 then chance went up to 29%
  - Readmission rate increased 1% for every day between discharge and the first physician visit
  - Article published Jan 8, 2014, Detroit Medical Center, Media Health Leaders

55

## Timing of Appointment

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  - Readmission rate increased 1% for every day between discharge and the first physician visit
  - Article published Jan 8, 2014, Detroit Medical Center, Media Health Leaders

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# Discharge Planning Worksheet

- Does hospital collect feedback from post-acute providers for effectiveness of the hospital's discharge planning process?
  - This would include places like LTC, assisted living or home health agencies
  - Consider holding monthly meetings with the home health agencies and long term care facility staff
  - Note recent study that found doing this can reduce readmissions by 20%

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# Monthly Meetings LTC and HH

- Hospitals should consider working with their state QIO
  - JAMA study found that hospitals working with QIOs in communities across the country experienced twice the reduction in readmissions compared with those that did not (Jan 23, 2013)
- Consider holding monthly meeting with your various partners such as nursing homes and home health staff
  - One study showed this reduced readmissions by 20.8% (Jan 2014 IPRO-NY's QIO)

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# Discharge Planning Tracers

- Has a discharge planning tracer Section 4
- Surveyors is to review five patient records
- One inpatient who has DP evaluation and discharge plan under development
- Surveyor is to review the closed medical record of two or three patients who was discharged with DP evaluation and discharge plan
- Will try and include one patient who was readmitted within 30 days

59

**Section 4 Discharge Planning Tracers**

**Review 5 patient records in this section. The records selected should include a combination of patients admitted from home as well as from residential healthcare facilities.**

**Include at least 1 current inpatient who received a discharge planning evaluation and has a discharge plan under development.**

**Do not include records of any inpatient who was transferred to another short-term acute care hospital**

**When possible, include the record of at least 1 inpatient who was readmitted within 30 days of a prior admission, but only evaluate the current admissi**

**For closed records, only select records that include a discharge planning evaluation and a discharge plan.**

| | **Patient/Record #1** ○ Open ○ Closed | **Patient/Record #2** ○ Open ○ Closed | **Patient/Record #3** ○ Open ○ Closed | **Patient/Record #4** ○ Open ○ Closed | **Patient/Record #5** ○ Open ○ Closed |
|---|---|---|---|---|---|
| **Patient location prior to this admission, or to the admission under review for closed medical records:** | ○ Home ○ NH, SNF, assisted living or other residential healthcare facility | ○ Home ○ NH, SNF, assisted living or other residential healthcare facility | ○ Home ○ NH, SNF, assisted living or other residential healthcare facility | ○ Home ○ NH, SNF, assisted living or other residential healthcare facility | ○ Home ○ NH, SNF, assisted living or other residential healthcare facility |
| 4.1 When was the screening done to identify whether the inpatient needed a discharge planning evaluation?<br>a. Before or at time of admission<br>b. After admission but at least 48 hours prior to discharge<br>c. N/A – all admitted patients receive a discharge plan<br>d. None of the above | a. ○<br>b. ○<br>c. ○<br>d. ○ | a. ○<br>b. ○<br>c. ○<br>d. ○ | a. ○<br>b. ○<br>c. ○<br>d. ○ | a. ○<br>b. ○<br>c. ○<br>d. ○ | a. ○<br>b. ○<br>c. ○<br>d. ○ |
| **NOTE: If response 4.1d is selected, the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to 42 CFR 482.43(a)** (Tag A-0800) | | | | | |
| 4.2 Can hospital staff demonstrate that the hospital's criteria and screening process for a discharge planning evaluation were correctly applied? | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A |

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# Discharge Planning Tracers

- Will mark worksheet to show if it was an open medical record where the patient is still in the hospital or
- A closed medical record where the patient has been discharge
- Should include a combination of patient's admitted from home as well as from LTC, assisted living, or other residential healthcare facility
- Don't include review of medical records of patients transferred to another acute care hospital

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# Discharge Planning Tracers 4.3

- Was the screening done to identify if the inpatient needed a discharge planning evaluation? (800)
  - Includes at the time of admission, after an admission but at least 48 hours prior to discharge, or N/A
  - In some hospitals all patients get a discharge plan
- Can staff demonstrate that the hospital's criteria and screening process for discharge evaluation were correctly applied (800)?
- Was discharge planning evaluation done by **qualified person** (SW, RN) as defined in the P&P? (807 evaluation or 818 plan)

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# DP by Qualified Staff

ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

| | |
|---|---|
| **Discharge Planning Process** | Medicare-participating acute care hospitals/post-acute care facilities must identify patients who need or have requested a discharge plan at an early stage of their hospitalization. The discharge planning process must be thorough, clear, comprehensive, and understood by acute care hospital/post-acute care facility staff.<br><br>The physician may make the final decision as to whether a discharge plan is necessary. If a physician requests a discharge plan, you must develop such plan, even if the interdisciplinary team determines that it is not necessary (as applicable).<br><br>Depending on the patient's needs, discharge planning may be completed by personnel in multiple disciplines who have specific expertise. You may designate discharge planning responsibilities to appropriate qualified personnel such as registered nurses, social workers, or other qualified personnel. These individuals should have:<br>❖ Discharge planning experience;<br>❖ Knowledge of social and physical factors that affect functional status at discharge; and<br>❖ Knowledge of appropriate community services and facilities that can meet the patient's post-discharge clinical and social needs. |

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# Discharge Planning Tracers

- Are the results of the discharge planning evaluation documented in the chart? (812)
- Did the evaluation include an assessment of the patients post-discharge care needs?
- Examples:
  - Patient need home health referral
  - Patient needs bedside commode
  - Patient needs home oxygen
  - Patient needs post hospital physical therapy
  - Meals on wheels, etc.

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# Discharge Planning Tracers

- Did the evaluation include an **assessment** of: (806)
  - Patient's ability to perform ADL (feeding, personal hygiene, ambulation, dressing, bladder control etc.)?
  - Family support  or patient ability to do self care?
  - Whether patient will need specialized medical equipment or modifications to their home?
  - Is support person or family able to meet the patient's needs and assessment of community resources ?

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# Discharge Planning Tracers

- Did the evaluation include an **assessment** of: (806)
- Was patient given a list of HHA or LTC facilities in the community and must be **documented** in the record and the list appropriate (806)
- If the hospital provided the list were the facilities geographically appropriate for the patient (823)
- An example would be selection of a LTC facility that is close to the patient's home
- One hospital has patient sign an attestation about freedom of choice and include information on community resources and LTC and hospital compare

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# DP Evaluation Includes an Assessment

**ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)**

| | |
|---|---|
| ***Discharge Planning Evaluation*** | facility care services and facilities as well as the availability of such services and facilities. It includes an assessment of:<br>❖ The patient's biopsychosocial needs;<br>❖ The patient's return to the pre-acute care hospital/post-acute care facility environment, including:<br>• If the patient was admitted from his or her private residence, whether specialized medical equipment or permanent physical modifications to the home are required and the feasibility of acquiring such equipment or modifications;<br>• Whether the patient is capable of addressing his or her care needs through self-care. If the patient is not able to address his or her care needs through self-care, whether family or friends are available who are willing and able to provide the required care at the times needed or who you could train to sufficiently provide such care;<br>• Availability of community-based services (such as Hospice or palliative care, medical equipment and related supplies, transportation services, and meal services) if neither the patient nor the family or informal caregivers can address all of the patient's required care needs; and |

Discharge Planning 6

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**ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)**

| | |
|---|---|
| ***Discharge Planning Evaluation*** | • If the patient was admitted from a facility (such as a NF or SNF) and he or she wishes to return to the facility, whether it has the capability to provide the patient's after-acute care hospital/post-acute care facility care requirements;<br>❖ Information obtained from the patient and family/caregivers (such as financial and insurance coverage); and<br>❖ The patient's and family/caregiver's understanding of the patient's discharge needs. |
| ***Discharge Planning*** | You must discuss results of the discharge planning evaluation with the patient or the individual acting on his or her behalf. You should offer the patient a range of realistic options to consider for after-acute care hospital/post-acute care facility care, depending on:<br>❖ The patient's capacity for self-care;<br>❖ The availability of appropriate services and facilities;<br>❖ The patient's preferences, as applicable; and<br>❖ The availability, willingness, and ability of family/ caregivers to provide care. |

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# Discharge Planning Tracers To LTC

- Separate set of questions if patient admitted from LTC or assisted living
  - Did evaluation include if LTC has capacity for patient to go back there?
  - Does it include assessment if insurance coverage will cover it if they go back there? (806)
  - Was the discharge planning evaluation timely to allow for arrangements if the patient needs to go back there (810)
  - Was the patient's representative involved in these discussions? (811 and patient rights 130)
  - Discharge plan needs to match the patient's needs (811, 130) and any changes in condition were documented (821)

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# If Admitted From a LTC or Other Facility

| | Patient/Record #1 | Patient/Record #2 | Patient/Record #3 | Patient/Record #4 | Patient/Record #5 |
|---|---|---|---|---|---|
| 4.12 If the patient was admitted from a residential facility, did the evaluation assess whether that facility has the capability to provide necessary post-hospital services to the patient (i.e. is the same, higher, or lower level of care required) and can those needs be met in that facility?<br><br>NOTE: Only choose N/A if the patient was not admitted from a residential facility. | Yes<br>No<br>N/A | Yes<br>No<br>N/A | Yes<br>No<br>N/A | Yes<br>No<br>N/A | Yes<br>No<br>N/A |
| 4.13 Did the evaluation include an assessment of the patient's insurance coverage (if applicable) and how that coverage might or might not provide for necessary services post-hospitalization? | Yes<br>No<br>N/A | Yes<br>No<br>N/A | Yes<br>No<br>N/A | Yes<br>No<br>N/A | Yes<br>No<br>N/A |
| **If no to 4.12 or 4.13 the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to 42 CFR 482.43(b)(4) (Tag A-0806)** | | | | | |
| 4.14 Was the discharge planning evaluation completed in a timely basis to allow for appropriate arrangements to be made for post-hospital care and to avoid delays in discharge (including to a post-acute care setting)? | Yes<br>No | Yes<br>No | Yes<br>No | Yes<br>No | Yes<br>No |
| **NOTE: If no to 4.14, the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to 42 CFR 482.43(b)(5) (Tag A-0810)** | | | | | |
| 4.15 Was the patient (or the patient's representative, if applicable) involved in a discussion of the evaluation results? | Yes<br>No | Yes<br>No | Yes<br>No | Yes<br>No | Yes<br>No |

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# Discharge Planning Tracers

- If patient discharged home is their initial i**mplementation** of the discharge plan?
- Did staff provide training to patient including recognized methods such as **teach back** or simulation labs**?**
- Were the written discharge instructions legible and use non-technical language (low health literacy)
- Was a list of all medication patient will take after discharge given with a clear indication of any changes?
  - TJC has 5 EPs on medication reconciliation NPSG03.06.01

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# Medication List From RED

**What medicines do I need to take?**

**Each day, follow this schedule:**

| Morning Medicines | | | |
|---|---|---|---|
| Medicine name (generic and name brand) and amount | Why am I taking this medicine? | How much do I take? | How do I take this medicine? |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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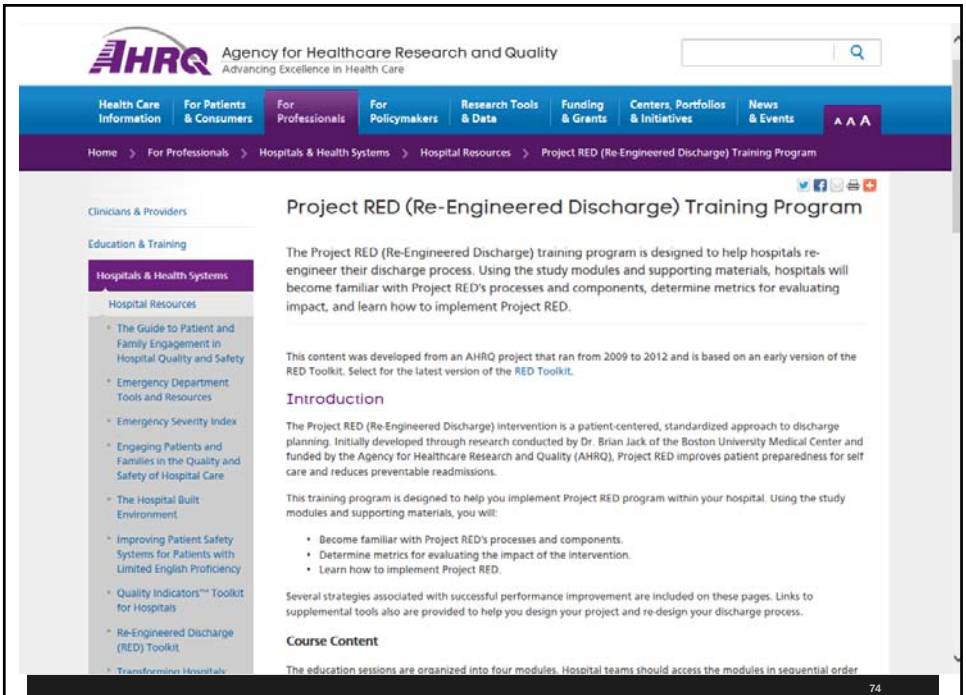
# Project RED Tools Revised 2013

# Discharge Planning Tracers

- Will look for evidence of hospital of patients and support persons on admission and discharge
- Was patient referred back for follow up with their PCP or a health center?
- Was there a referral to PT, mental health, HHA, hospice, OT etc. as needed?
- Was there a referral for community based resources such as transportation services, Department of Aging, elder services, transport services etc.?
- Arranged for needed equipment such as oxygen, commode, wheel chair etc.

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| | Patient/Record #1 | Patient/Record #2 | Patient/Record #3 | Patient/Record #4 | Patient/Record #5 |
|---|---|---|---|---|---|
| 4.18f Referrals, if applicable, to specialized ambulatory services, e.g. PT, OT, HHA, hospice, mental health, etc. | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A |
| 4.18g Referrals, if applicable, to community-based resources other than health services, e.g. Depts. of Aging, elder services, transportation services, etc. | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A |
| 4.18h Arranging essential durable medical equipment, e.g. oxygen, wheel chair, walker, hospital bed, commode, etc., if applicable. | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A |
| 4.18i Sending necessary medical information to providers the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first.<br><br>NOTE: Only use N/A if the patient was transferred to a post-acute care facility or if the patient has a scheduled follow-up appointment with the attending physician. | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A | ○ Yes ○ No ○ N/A |

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# Discharge Planning Worksheet

- If transferred to another inpatient facility was the discharge summary ready and sent with patient?
- The following controversial section was changed in the final revision
  - Was discharge summary sent **before first post-discharge appointment** or within 7 days of discharge?
  - Was follow up appointment scheduled?
- Now says send necessary medical record information to providers the patient was referred prior to the first post-discharge appointment or 7 days, whichever comes first (820)

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# Appointments for Follow Up

**When are my next appointments?**

| | |
|---|---|
| Day | Date |
| Time asdfasdf | |
| Doctor's name | Specialty |
| Address | |
| Reason for appointment | |
| Doctor's phone number | |

**Questions for my appointment**

Check any of the boxes below and write notes to remember what to discuss with your doctor.

I have questions about:

- ☐ My medicines
- ☐ My test results
- ☐ My pain
- ☐ Feeling stressed

Other questions or concerns

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# Discharge Summary in the Hands of PCP

Medical Transcription **Discharge Summary Sample # 1:**

**DATE OF ADMISSION:** MM/DD/YYYY

**DATE OF DISCHARGE:** MM/DD/YYYY

**DISCHARGE DIAGNOSES:**

1. Vasovagal syncope, status post fall.
2. Traumatic arthritis, right knee.
3. Hypertension.
4. History of recurrent urinary tract infection.
5. History of renal carcinoma, stable.
6. History of chronic obstructive pulmonary disease.

**CONSULTANTS:** None.

**PROCEDURES:** None.

**BRIEF HISTORY:** The patient is an (XX)-year-old female with history of previous stroke; hypertension; COPD, stable; renal carcinoma; presenting after a fall and possible syncope. While walking, she accidentally fell to her knees and did hit her head on the ground, near her left eye. Her fall was not observed, but the patient does not profess any loss of consciousness, recalling the entire event. The patient does have a history of previous falls, one of which resulted in a hip fracture. She has had physical therapy and recovered completely from that. Initial examination showed bruising around the left eye, normal lung examination, normal heart examination, normal neurologic function with a baseline decreased mobility of her left arm. The patient was admitted for evaluation of her fall and to rule out syncope and possible stroke with her positive histories.

**DIAGNOSTIC STUDIES:** All x-rays including left foot, right knee, left shoulder and cervical spine showed no acute fractures. The left shoulder did show old healed left humeral head and neck fracture with baseline anterior dislocation. CT of the brain showed no acute changes, left periorbital soft tissue swelling. CT of the maxillofacial area showed no facial bone fracture. Echocardiogram showed normal left ventricular function, ejection fraction estimated greater than 65%.

**HOSPITAL COURSE:**

1. Fall: The patient was admitted and ruled out for syncopal episode. Echocardiogram was normal, and when the patient was able, her orthostatic

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# Discharge Planning Worksheet Transfers

- Was the necessary medical record information ready at the time of transfer if patient sent to another facility (837)
  - Note CMS has requirements for the transfer form
- Was there any part of the discharge plan that the hospital failed to implement that resulted in a delay in discharge (820)
- Was there documentation in the medical record of results of tests pending at the time of discharge both to the patient and the post hospital provider?
- Was patient readmitted within 30 days?

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*The "medical information" that is necessary for the transfer or referral includes, but is not limited to:*

- *Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;*
- *Brief description of hospital course of treatment;*
- *Patient's condition at discharge, including cognitive and functional status and social supports needed;*
- *Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);*
- *List of allergies (including food as well as drug allergies) and drug interactions;*
- *Pending laboratory work and test results, if applicable, including information on how the results will be furnished;*
- *For transfer to other facilities, a copy of the patient's advance directive, if the patient has one; and*
- *For patients discharged home:*
  - *Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);*

# Were Any of the Following Done?

- Were any of the following services initiated while patient was in the hospital:
- Scheduled follow up appoint,
- Filled prescription
- Pharmacist met with patient or family
- Pharmacist reviewed discharge medications prior to discharge
- Home setting visited by hospital staff
- Discharge planning checklist given to patient such as CMS, AHRQ, CAPA checklist

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# CMS DP Checklist for Patients

***For Information– Not Required/Not to be Cited***

*Providing a discharge planning tool to patients and their family or other support persons may help to reinforce the discharge plan. Use of the tools may encourage patients' participation in developing the plan as well as provide them an easy-to-follow guide to prepare them for a successful transition from the hospital. The tool should be given to patients on admission, reviewed throughout their stay, and updated prior to discharge.*

*Examples of available tools include:*

- *Medicare's "Your Discharge Planning Checklist," (available at http://www.medicare.gov/publications/pubs/pdf/11376.pdf)*
- *Agency for Healthcare, Research and Quality's (AHRQ) "Taking Care of Myself: A Guide For When I Leave the Hospital," (available at http://www.ahrq.gov/qual/goinghomeguide.pdf)*
- *Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient Toolkit" (available at http://www.patientsafety.org/page/transtoolkit/).*

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# CMS Discharge Checklist

- CMS website recommends the discharge planning team use a checklist to make transfer more efficient
- It is available at www.medicare.gov
- Previously research showed the value of hospital discharge planners using a discharge checklist
- We need to dictate the discharge summary immediately when the patient is discharged
- We need to document that it is in the hands of the family physician

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# CMS Your Discharge Planning Checklist


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NAME: _____

Reason for admission: _____

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver are important members of the planning team. A caregiver is a family member or friend who may be helping you after discharge. Below is a checklist of important things you and your caregiver should know to prepare for discharge.

**Instructions:**

- Use the checklist early and often during your stay.
- Talk to your doctor and the staff (for example, a discharge planner, social worker, or nurse) about the items on the checklist.
- Check the box next to each item when you and your caregiver complete it. ☑
- Use the notes column to write down important information like names and phone numbers.
- Skip any items that don't apply to you.

| ACTION ITEMS | NOTES |
|---|---|
| **What's Ahead?** | |
| ☐ Ask where you will get care after discharge. Do you have options? Be sure you tell the staff what you prefer. | |
| ☐ If a family member or friend will be helping you after discharge, write down the name and phone number. | |
| **Your Condition** | |
| ☐ Ask the staff about your health condition and what you can do to help yourself get better. | |
| ☐ Ask about problems to watch for and what to do about them. Write down a name and phone number to call if you have problems. | |

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Taking Care of Myself:
A Guide for When I Leave the Hospital
www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/goinghomeguide.pdf
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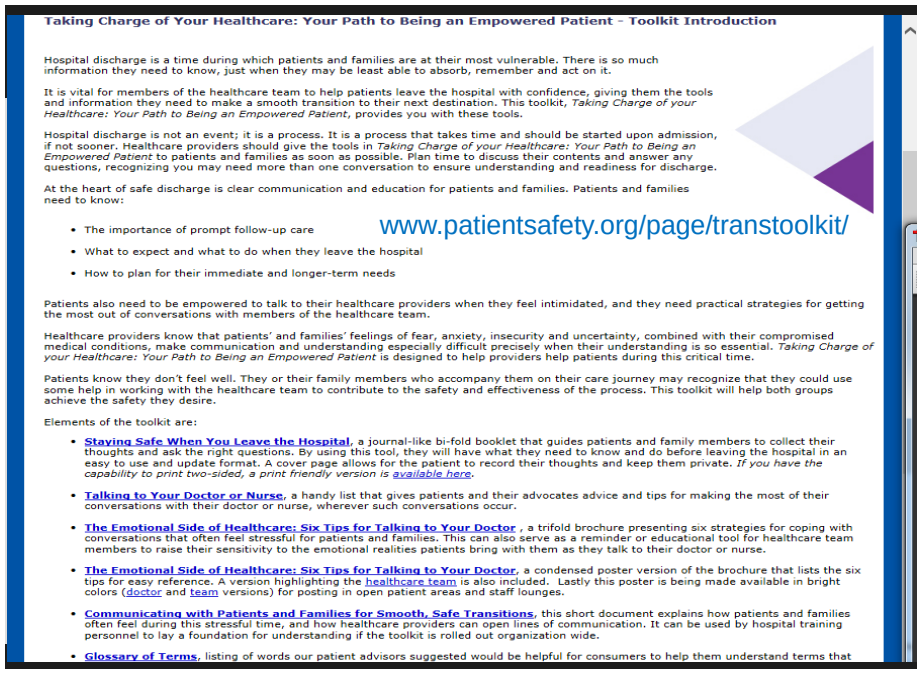
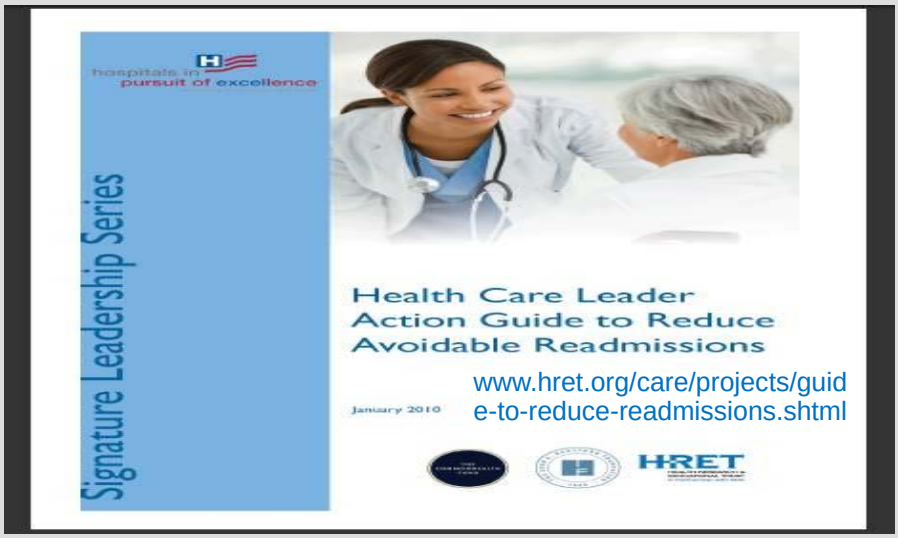

Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient - Toolkit Introduction
Hospital discharge is a time during which patients and families are at their most vulnerable. There is so much information they need to know, just when they may be least able to absorb, remember and act on it.
It is vital for members of the healthcare team to help patients leave the hospital with confidence, giving them the tools and information they need to make a smooth transition to their next destination. This toolkit, Taking Charge of your Healthcare: Your Path to Being an Empowered Patient, provides you with these tools.
Hospital discharge is not an event; it is a process. It is a process that takes time and should be started upon admission, if not sooner. Healthcare providers should give the tools in Taking Charge of your Healthcare: Your Path to Being an Empowered Patient to patients and families as soon as possible. Plan time to discuss their contents and answer any questions, recognizing you may need more than one conversation to ensure understanding and readiness for discharge.
At the heart of safe discharge is clear communication and education for patients and families. Patients and families need to know:
www.patientsafety.org/page/transtoolkit/
The importance of prompt follow-up care
What to expect and what to do when they leave the hospital
How to plan for their immediate and longer-term needs
Patients also need to be empowered to talk to their healthcare providers when they feel intimidated, and they need practical strategies for getting the most out of conversations with members of the healthcare team.
Healthcare providers know that patients' and families' feelings of fear, anxiety, insecurity and uncertainty, combined with their compromised medical conditions, make communication and understanding especially difficult precisely when their understanding is so essential. Taking Charge of your Healthcare: Your Path to Being an Empowered Patient is designed to help providers help patients during this critical time.
Patients know they don't feel well. They or their family members who accompany them on their care journey may recognize that they could use some help in working with the healthcare team to contribute to the safety and effectiveness of the process. This toolkit will help both groups achieve the safety they desire.
Elements of the toolkit are:
Staying Safe When You Leave the Hospital, a journal-like bi-fold booklet that guides patients and family members to collect their thoughts and ask the right questions. By using this tool, they will have what they need to know and do before leaving the hospital in an easy to use and update format. A cover page allows for the patient to record their thoughts and keep them private. If you have the capability to print two-sided, a print friendly version is available here.
Talking to Your Doctor or Nurse, a handy list that gives patients and their advocates advice and tips for making the most of their conversations with their doctor or nurse, wherever such conversations occur.
The Emotional Side of Healthcare: Six Tips for Talking to Your Doctor , a trifold brochure presenting six strategies for coping with conversations that often feel stressful for patients and families. This can also serve as a reminder or educational tool for healthcare team members to raise their sensitivity to the emotional realities patients bring with them as they talk to their doctor or nurse.
The Emotional Side of Healthcare: Six Tips for Talking to Your Doctor, a condensed poster version of the brochure that lists the six tips for easy reference. A version highlighting the healthcare team is also included. Lastly this poster is being made available in bright colors (doctor and team versions) for posting in open patient areas and staff lounges.
Communicating with Patients and Families for Smooth, Safe Transitions, this short document explains how patients and families often feel during this stressful time, and how healthcare providers can open lines of communication. It can be used by hospital training personnel to lay a foundation for understanding if the toolkit is rolled out organization wide.
Glossary of Terms, listing of words our patient advisors suggested would be helpful for consumers to help them understand terms that

# AHA Guide to Reduce Readmissions

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# Free Readmission Newsletter


Readmissions eNewsletter
[readmissions@healthcareenewsletters.com]

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# Things to Consider

- Use a discharge checklist for staff to use
  - Pa Patient Safety Authority has one called "Care at Discharge" at http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/Pages/home.aspx
  - Society of Hospital Medicine has one at www.hospitalmedicine.org/AM/Template.cfm?Section=Quality_Improvement_Tools&Template=/CM/ContentDisplay.cfm&ContentID=8363
- Give patients a copy of the CMS checklist "Your Discharge Planning Checklist" at www.medicare.gov/Publications/Pubs/pdf/11376.pdf
- Give a list of medications with times and reason for taking

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# PaPSA Checklist

**Suggested Elements for a Discharge Checklist**

Patient Name: _____ Physician Name: _____

Admission Date: _____ Discharge Date: _____

Primary Diagnosis: _____ Secondary Diagnoses: _____

Procedure(s): _____

_____ ***Interpreter needed for patient with language/culture barrier***

**Please check when task is completed.**

**Patient Education**

___ Educate patient and/or family members about diagnoses, disease, and procedure(s).
___ Educate patient and/or family members about follow-up care for procedure(s), if indicated.
___ Provide patients with procedure and/or disease-specific educational materials.
___ Reconcile discharge medication list.
___ Educate patient and/or family members about the prescribed medications including medication administration, drug action, and side effects.
___ Provide written material for prescribed medications with all information noted above.

**Services to Provide**

___ Review pending test results and instruct patient about whom to call for results.
___ Schedule follow-up appointments with physicians and/or specialists as indicated.
___ Provide referrals for services ordered by physician (i.e., physical therapy, occupational therapy).

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See Society of Hospital Medicine at http://www.hospitalmedicine.org/AM/Template.cfm?Section=Quality_Improvement_Tools&Template=/CM/ContentDisplay.cfm&ContentID=8363

**Ideal Discharge for the Elderly Patient: A Hospital Checklist**

| Checklist Element | Particulars | Must Keep | Optional |
|---|---|---|---|
| Medication Education | • Written schedule of medication<br>• Include Purpose (reason) and (if apt) Cautions(s) for each medication<br>• Clinical Pharmacist involvement (especially if cognitive impairment, or ≥ 3 Medication changes | x<br>x | <br><br>x |
| Cognition | Rather than a Folstein score, some description mention of mental capacity such as:<br>• Lucid (full capacity for understanding and executive function, such as being able to follow instructions)<br>• Forgetful (some senescence or impairment of memory)<br>• Dementia (or "Brain Failure" - incapable of reliable recall and/or executive function) | | <br>x<br><br>x<br><br>x |
| Discharge Summary | Needs to be written with the receiving caregiver in mind, including:<br>• Presenting problem(s) that precipitated hospitalization<br>• Primary and secondary diagnoses<br>• Key findings and test results<br>• Brief hospital course<br>• Discharge Med Reconciliation (see above)<br>• Condition at discharge (including functional status and cognitive status, if relevant)<br>• Discharge Destination (and rationale if not obvious) | <br>x<br><br>x<br>x<br>x<br><br>x | <br><br><br><br><br><br>Cognitive status |

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# Outstanding Labs or Tests

**Outstanding Labs or Tests**

Are any lab tests/studies pending? ☐ yes ☐ no ☐ unknown

PENDING LAB TEST/STUDIES

| Lab test/ study name | Date done | Name of clinician to review/location | Day/Date subject will see clinician to discuss results? |
|---|---|---|---|
| 1. | | Same as PCP | Same as PCP |
| 2. | | | |
| 3. | | | |

Some tests have been done while you have been in the hospital, but the results are not yet ready. A (test/study name) was done on (date of test/study). (Name of PCP) will review the results and discuss them with you during your appointment.

Depending on the results of your lab test(s)/studies, your doctor might adjust your treatment. We just talked about your scheduled appointment with (name of PCP). It is very important that you see your doctor on (date/time to see PCP) to find out if anything needs to be done or changed as a result of these tests. Again, if there is anything you don't understand or you are having trouble making an appointment, please call me. If I am not there, leave a message and we will call you back.

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# The End! Questions???

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