

The New CMS Worksheet and Discharge Planning Standards

Monday, July 21st, 2014



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Speaker



- Sue Dill Calloway RN, Esq.
CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and
Education Consulting
- Board Member
Emergency Medicine Patient Safety
Foundation
- 614 791-1468
- sdill1@columbus.rr.com

Learning Objectives

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

You Don't Want One of These



The Conditions of Participation (CoPs)

- Regulations first published in 1986
 - CoP manual updated March 21, 2014 and 460 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

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

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

CMS Hospital CoP Manual

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

Table of Contents

(Rev. 105, 03-21-14)

Transmittals for Appendix A

Survey Protocol

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

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

CMS Survey and Certification Website

The screenshot shows the CMS.gov website interface. At the top, there is a navigation bar with links for Home, About CMS, Careers, Newsroom, FAQ, Archive, and social media icons for YouTube, Facebook, and Twitter. Below this is the CMS.gov logo and the text 'Centers for Medicare & Medicaid Services'. A search bar is located to the right of the logo. A horizontal menu contains eight categories: Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Insurance Oversight, Innovation Center, Regulations, Guidance & Standards, Research, Statistics, Data & Systems, and Outreach & Education. The breadcrumb trail reads: CMS Home > Medicare > Survey & Certification - General Information > Policy & Memos to States and Regions. On the left, a sidebar titled 'Survey & Certification - General Information' lists various topics, with 'Policy & Memos to States and Regions' highlighted. The main content area is titled 'Policy & Memos to States and Regions' and includes a description: 'CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.' Below the description, there are filter options: 'Select From The Following Options:' with radio buttons for 'Show all items' (selected) and 'Show only (select one or more options):'. The 'Show only' options include: 'Show only items whose [dropdown] is within the past [dropdown]', 'Show only items whose Fiscal Year is [dropdown]', and 'Show only items containing the following word [text input]'. A 'Show Items' button is at the bottom of the filter section. Below the button, it says 'There are 455 items in this list.'

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

Show entries: 10 ▾

Filter On:

Title ▾	Memo # ▾	Posting Date ▾	Fiscal Year ▾
Infection Control Breaches Which Warrant Referral to Public Health Authorities	14-36-All	2014-05-30	2014
Final Rule - Promoting Program Efficiency, Transparency, and Burden Reduction: Part II - Informational Only	14-33-ALL	2014-05-20	2014
Advance Copy of Revised F371: Interpretive guidance and Procedures for Sanitary Conditions, Preparation of Eggs in Nursing Homes	14-34-NH	2014-05-20	2014
Update of State Operations Manual (SOM) Chapter 5, Triaging Complaints & Referral of Complainants to Accrediting Organizations	14-35-ALL	2014-05-20	2014
Advance Copy – Single Use Device Reprocessing under Tag F441, Revisions to Interpretive Guidance in Appendix PP, State Operations Manual (SOM) on Infection Control	14-25-NH	2014-05-16	2014
Information for Applications to Extend the Due Date for the Installation of Automatic Sprinkler Systems in Existing Nursing Homes	14-29-LSC	2014-05-16	2014
Grant Solicitation for the Reinvestment of Federal Civil Money Penalty (CMP) Funds to Benefit Nursing Home Residents	14-30- NH	2014-05-16	2014
Provision of Electronic Health Record (EHR) “Navigators” during Hospital and Critical Access Hospital (CAH) Surveys	14-31- Hospitals/CAHs	2014-05-16	2014
The CMS Mitigating Factors Process for Solid Organ Transplant Programs – Notice of Proposed Rule-Making (NPRM) - Informational Only	14-32-Transplant	2014-05-16	2014

Transmittals

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Transmittals

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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/1st.asp>

2002 Transmittals

<http://wayback.archive-it.org/2744/20111201175723/http://www.cms.gov/Transmittals/2002Trans/1st.asp>

2001 Transmittals

<http://wayback.archive-it.org/2744/20111201175903/http://www.cms.gov/Transmittals/2001Trans/1st.asp>

2000 Transmittals

<http://wayback.archive-it.org/2744/20111201175848/http://www.cms.gov/Transmittals/2000Trans/1st.asp>

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

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
- Updating quarterly
 - Available under downloads on the hospital website at www.cms.gov

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

Access to Hospital Complaint Data

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
2000 Roanoke Boulevard, Mail Stop C3-21-16
Baltimore, Maryland 21244-1800



Center for Clinical Standards and Quality/Survey & Certification Group

Re: SAC: 13-21- ALL

DATE: March 21, 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 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.
- **Questions & 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

Updated Deficiency Data Reports

CMS.gov

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Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers. i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html

Deficiency Data Discharge Planning

Tag	Section	Nov 2013	Jan 2014	Mar 2014
799	Discharge Planning (DP)	20	20	21
800	DP Evaluation	25	25	26
806	DP Needs Assessment	58	58	60
807	Qualified DP Staff	8	8	10
810	Timely DP Evaluation	12	12	13

Deficiency Data Discharge Planning

Tag	Section	Nov 2013	Jan 2014	Mar 2014
811	Documentation & Evaluation	15	16	18
812	Discharge Planning	3	3	4
817	Discharge Plan	26	28	28
819	MD Required DP	3	3	3
820	Implementation of DP	53	53	60

Deficiency Data Discharge Planning

Tag	Section	Nov 2013	Jan 2014	Mar 2014
821	Reassess DP	37	49	49
823	List of HH Agencies	28	31	34
837	Transfer or Referral	37	38	42
843	Reassess DP Process	30	30	23
		Total 355	Total 364	Total 391

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**

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



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

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

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.

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

Starts at Tag Number 799

A-0799

(Rev.)

§482.43 Condition of Participation: Discharge Planning

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

Interpretive Guidelines §482.43

Hospital discharge planning is a process that involves determining the appropriate post-hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient's identified post-discharge needs. Newer terminology, such as "transition planning" or "community care transitions" is preferred by some, since it moves away from a focus primarily on a patient's hospital stay to consideration of transitions among the multiple types of patient care settings that may be involved at various points in the treatment of a given patient. This approach recognizes the shared responsibility of health care professionals and facilities as well as patients and their support persons throughout the continuum of care, and the need to foster better communication among the various groups. Much of the interpretive guidance for this CoP has been informed by newer research on care transitions, understood broadly. At the same time, the term "discharge planning" is used both in Section 1861(ee) of the Social Security Act as well as in §482.43. In this guidance, therefore, we continue to use the term "discharge planning."

When the discharge planning process is well executed, and absent unavoidable complications or unrelated illness or injury, the patient continues to progress towards the goals of his/her plan of care after discharge. However, it is not uncommon in the current health care environment for patients to be discharged from inpatient hospital settings only to be readmitted within a short timeframe for a related condition. Some readmissions may not be avoidable. Some may be

Discharge Planning 799 7-19-2013

- Standard: The hospital must have a discharge planning (DP) process that applies to all patients (799)
- The hospital must have written DP P&Ps (799)
 - To determine if will need post hospital services like home health, LTC, assisted living, hospice etc.
 - To determine what patient will need for safe transition to home
 - Called transition planning or community care transition
 - Need to incorporate new research on care transitions to prevent unnecessary readmissions

Discharge Planning 799

- Discharge planning is:
 - New DP guidelines based on this new research
 - It is a shared responsibility of health professionals and facilities
 - Hospital needs adequate resources to prevent readmissions
 - 1 in 5 patients readmitted within 30 days (20%)
 - 1 in 3 patients readmitted within 60 days (34%)
 - Good DP will help patient reach goal of plan of care after discharge

Discharge Planning 799

- CMS says the DP process is in effect for *all* patients
- However, CMS notes that the preamble made it clear it was meant to apply to inpatients and not outpatients
- DP presupposes hospital admission
- CMS suggests that hospitals voluntarily have an abbreviated post-hospital DP for same day surgery, observation, and certain ED patients
 - However, remember that all patients have a right to have a plan of care and be involved in the plan of care

Discharge Planning (DP) 799

- Hospital must take steps to ensure DP P&P are implemented consistently
- DP based on 4 stage DP process:
 - Screen all patients to determine if patient at risk such as screening questions by nursing admission assessment
 - Evaluate post-discharge needs of patients
 - Develop DP if indicated by the evaluation or requested by patient or physician
 - Consider putting it in written patient rights
 - Initiate discharge plan prior to discharge of inpatient

Discharge Planning P&P 799

- Suggests input from MS, board, home health agencies (HH), long term care facilities (LTC), primary care physicians, clinics, and others regarding the DP P&Ps
- Involve the patient in the development of the plan of care
- Must actively involve patients through out the discharge process
- Patient have the right to refuse and if so CMS recommends this be documented

Identify Patients in Need of DP 800

- Standard: The hospital must identify at an early stage all patients who are likely to suffer adverse consequences if no DP is done
 - Recommend all inpatients have a Discharge Plan
 - Most hospitals the nurse asks specific questions on the admission assessment
 - If **not** must have P&P and document criteria and screening process used to identify who is likely to need DP
 - Hospital must identify which staff are responsible are carrying out the evaluation to identify if patient needs DP

Case Management Consults

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.

Identify Patients in Need of DP 800

- CMS says factors the assessment should include:
 - Patient's functional status and cognitive ability
 - Type of post hospital care patient needs
 - Availability of the post hospital needed services
 - Availability of the patient or family and friends to provide follow up care in the home
- No national tool to do this
- Blue box advisory recommendation to do a discharge plan on all every inpatient

Nurses Admission Assessment

Part I: Admission Routine						
Date:	Time:	T:	P:	R:	O₂ Sat:	
Mode: <input type="checkbox"/> amb <input type="checkbox"/> gurney <input type="checkbox"/> w/c <input type="checkbox"/> other	B/P:		Rt	Lt:		
Via: <input type="checkbox"/> admitting <input type="checkbox"/> ER <input type="checkbox"/> OR <input type="checkbox"/> other	Height:	Weight:		<input type="checkbox"/> Stand	<input type="checkbox"/> Bed	<input type="checkbox"/> Stated
Admitting MD:			Family MD:			
Admitting Diagnosis:						
Chief Complaint: (per patient)						
Allergies:		Latex:		<input type="checkbox"/> balloons	<input type="checkbox"/> bananas	LATEX 4 or > - order latex free cart
<input type="checkbox"/> NKDA				<input type="checkbox"/> gloves	<input type="checkbox"/> pineapple	
Type of Reaction:				<input type="checkbox"/> mult OR	<input type="checkbox"/> avocados	<input type="checkbox"/>
Valuables List: (describe jewelry, clothing, etc.)						
<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Dentures	<input type="checkbox"/> Partial/bridge	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Refused safe	VALUABLE envelope to Safe <input type="checkbox"/>
Nurse Signature (if other than nurse completing remainder of assessment):						
Part II: Patient History						
Patient History: (major illnesses/operations/major injuries)						
<input type="checkbox"/> Hypertension	<input type="checkbox"/> COPD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anesthesia issues		
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> None		
<input type="checkbox"/> Stroke	<input type="checkbox"/> TB	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Mental Disorder			
<input type="checkbox"/> Cardiac other	<input type="checkbox"/> Respiratory other	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> General other			
Specify others not listed above and Surgeries:						
Alcohol/Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	Daily Amt:	<input type="checkbox"/> Quit		
Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	Daily Amt:	<input type="checkbox"/> Quit		
Admitting Diagnosis: AMI, Pneumonia, CHF:			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Vaccinations:						
Flu Shot within past 12 months		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused		
Pneumonia Shot in past 5 years		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused		
Family History:						
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Asthma <input type="checkbox"/> TB <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney <input type="checkbox"/> Anesthesia						

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

Functional Assessment

				SKIN ISSUES: Wd Care Referral <input type="checkbox"/>		MS: POC <input type="checkbox"/>		
NORTON SCALE	Norton Scale (Skin Risk Assessment)							<small>Reprinted with permission: Doreen Norton, Rhoda McLaren, and A.N. Eaton-Smith, An Investigation of Geriatric Nursing Problems in Hospitals, National Corporation for the Care of Old People (now Centre for Policy on Ageing), London, 1962.</small>
	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 <input type="checkbox"/>		
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			ADL: poc# 16 <input type="checkbox"/>		FUNCTION: Referral to Phys. Med. if change <input type="checkbox"/>		
1 = 25% of care								
0 = N/A - (acute time limited condition)								
FALL RISK	Fall Risk (Risk Assessment)							
	<input type="checkbox"/> Level I		<input type="checkbox"/> Level II - Has two or more of the following risk factors					
	any patient		<input type="checkbox"/> age >65					
			<input type="checkbox"/> history of falls (immed or within past 3 mo.)					
			<input type="checkbox"/> taking fall related medications (hypnotics, analgesics, psychotropics, antihypertensive, diuretic, laxative)					
			<input type="checkbox"/> mod to severe physical impairment (includes mobility or visual/hearing deficits)					
		<input type="checkbox"/> occasional or frequent cognitive impairment						
						FALL RISK II: poc#17 <input type="checkbox"/>		
Page 3 of 4				Patient label				

Blue Box Advisory Do a DP on all Inpatients

For Information – Not Required/Not to be Cited

Given the high level of readmissions that hospitals experience, a hospital would be well advised to assume that every inpatient requires a discharge plan to reduce the risk of adverse health consequences post-discharge. Providing a discharge plan for every inpatient means the hospital avoids the problems that result if it utilizes a screening process that fails to predict adequately which patients need a discharge plan to avoid adverse consequences.

This does not mean that every discharge plan will be equally detailed or complex; some may be comparatively simple, for example, focusing on clear instructions for self-care for patients whose post-care needs may be readily met in their home environment. On the other hand, other patients may have complex needs for care after discharge. It is common for many patients to be discharged with a need for numerous on-going services/therapies, such as intravenous (IV) medications, intensive physical and occupational therapy, remote monitoring, wound care, etc. The key is that the discharge plan must reflect a thorough evaluation of the patient's post hospital care needs and must address the needs identified.

Discharge Planning 800

- Must do at least 48 hours in advance of discharge
 - If patient's stay is less than 48 hours then must make sure DP is done before patient's discharge
- Must make sure no evidence that patient's discharge was delayed due to hospital's failure to do DP
- DP P&Ps must state how staff will become aware of any changes in the patient's condition
 - Change may require developing DP for the patient
- If patient is transferred must still include information on post hospital needs

DP Survey Procedure 800

- Surveyor to go to every inpatient unit to make sure timely screening to determine if DP is needed
 - Unless hospital does DP evaluation for all patients
- CMS instructs the surveyors to conduct discharge tracers on open and closed inpatient records
- Can hospital demonstrate there is evidence of DP if the stay is less than 48 hours
- Was criteria and screening process for DP evaluation applied correctly
- Was there process to update the discharge plan?

So What's in Your P&P?



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

DISCHARGE PLANNING

Effective Date: November 9, 2009

Policy #: AD-04

Page 1 of 4

- I. PURPOSE:** To specify discharge planning procedures to ensure that discharge planning begins at the time of admission and is updated throughout the duration of hospitalization.
- II. POLICY:** Each person admitted to Montana State Hospital will have an individualized aftercare plan specifying services and referrals needed upon discharge. Montana State Hospital staff will work closely with the patient, the patient's family/significant others and appropriate community agencies to ensure continuity of care is addressed and Montana state statute requirements are met.
- III. DEFINITIONS:**
 - A. Initial Discharge Plan – A document that provides basic information to begin discharge planning procedures early in the patient's stay.
 - B. Aftercare Plan – A document that addresses major aspects of a patient's living situation and treatment needs following hospitalization.
 - C. Discharge Summary – A recapitulation of the patient's hospital course including a summary of the aftercare plan.
- IV. RESPONSIBILITIES:**
 - A. Discharge Coordinator – the staff member who is assigned primary responsibility for coordinating aftercare planning procedures. This is usually the patient's social worker.
- V. PROCEDURE:**

Discharge Planning Evaluation 806

- Standard: The hospital must provide a DP evaluation to patients at risk, or as requested by the patient or doctor
- Must include the likelihood of needing post hospital services
 - Like home health, hospice, RT, rehab, nutritional consult, dialysis, supplies, meals on wheels, transport, housekeeping, or LTC
 - Is the patient going to need any special equipment (walker, BS commode, etc.) or modifications to the home
- Must include an assessment if the patient can do self care or others can do the care

Discharge Planning Evaluation 806

- Must have process for making patients or their representative aware they can request a DP evaluation
 - Put it in writing in the patient rights document
 - Have the nurse inform the patient and document it in the admission assessment
- Must have a process for making sure physicians are aware they can request a DP evaluation
 - Unless hospital does DP evaluation on every patient
 - Issue memo to physicians, include in orientation book for new physician orientation, and discuss at MEC meeting

Discharge Planning Evaluation 806

- Must evaluate if patient can return to their home
- If from a LTC, hospice, assisted living then is the patient able to return
- Hospitals are expected to have knowledge of capabilities of the LTC and Medical homes and services provided
 - May need to coordinate with insurers and Medicaid
 - Discuss ability to pay out of pocket expenses
- Expected to have know about community resources
 - Such as Aging and Disability Resources or Center for Independent Living

Discharge Planning Evaluation 806

- Discharge evaluation is more detailed in contrast to the screening process
- Used to identify the specific areas to address in the discharge plan
- Must evaluate if patient can do any self-care
 - Or family or friends
- The goal is to return the patient back to the setting they came from and to assess if they can return

Discharge Evaluation & Plan

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Menu

Rev. 04/09
Form # MP5423

DISCHARGE EVALUATION & PLAN PLAN OF CARE, REVIEWS & SUMMARY

ADMISSION EVALUATION

Admit Date _____ Reason for Admission (*Refer to admission, H + P and transfer forms for additional information*) _____

REHABILITATION POTENTIAL:

Resident believes self capable of increased independence in at least some ADL's Other _____
 Direct Care staff believes resident capable of increased independence in at least some ADL's _____

DISCHARGE POTENTIAL:

Excellent Good Fair Marginal Guarded Poor None

DISCHARGE anticipated within 90 days of admission?

Yes, Anticipated to: _____ Uncertain/Unknown due to: _____
 No, Reason(s):

<input type="checkbox"/> Requires 24 hr supervision	<input type="checkbox"/> Alternate Care setting not possible due to physical disability	<input type="checkbox"/> Mental Health status	<input type="checkbox"/> Financial limitations in meeting care needs
<input type="checkbox"/> Dependent on others for all ADL's	<input type="checkbox"/> Dependent psychologically on placement in facility	<input type="checkbox"/> Family refuses to provide care	<input type="checkbox"/> Resident refuses to leave facility
<input type="checkbox"/> Condition expected to deteriorate		<input type="checkbox"/> Family unable to meet needs due to other responsibilities	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Complicated medical care/regimen			

Resident and/or Resident Representative prefers to be discharged to: _____
Additional Comments: _____

Signature _____ Date _____

REVIEW OF FACTORS AFFECTING DISCHARGE PLAN

Refer to Comprehensive Evaluation dated: _____ for additional specific details in each area.

<h4>ADL FUNCTIONAL ABILITY</h4> <p><input type="checkbox"/> Ability to meet self-care needs not impaired <input type="checkbox"/> Unable to meet self-care needs <input type="checkbox"/> Ability to meet any self-care needs impaired in the following areas: <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Dressing <input type="checkbox"/> Personal Hygiene</p>	<h4>SUPPORT SERVICE REQUIREMENTS</h4> <p><input type="checkbox"/> No support service needs anticipated post-discharge. <input type="checkbox"/> Referrals needed in the marked areas: <input type="checkbox"/> Private physician <input type="checkbox"/> Personal (family/friends) support system</p>
--	--

Related Documents | Email | Twitter | Embed | Search Document | Search

Discharge Planning Checklist

HOSPITAL/MEDICAL CENTER



EMAIL: dmeclientcare@pmsionline.com
 REFER ONLINE: www.pmsionline.com

PHONE: 877.ASK.PMSI

FAX: 800.774.4111

Patient:		SS#:		Claim#:	
Address:		City:		State:	
Height:		Weight:		Institution:	
DOI:		Dx:		Discharge Date:	
Case Manager:		Ph:		Fax:	
Discharge Planner:		Ph:		Fax:	
PMSI Rep:		PMSI Rep Ext:			

SUPPLIES	MONTHLY QUANTITY	SUPPLIES	MONTHLY QUANTITY
Total Knee Replacement/Knee Repair/Knee Injury			
Home Health Care		Tub transfer (bench/shower)	
CPM		Chair	
Cold therapy unit		Sock aid	
Front-wheeled walker		Reacher	
Crutches		Knee brace	
3-in-1 commode			
Raised toilet seat			
Herniated Disc/Lumbar Laminectomy			
Home Health Care		3-in-1 commode	
Hospital bed rental		Raised toilet seat with arms	
Wheelchair rental		Shower chair	
Front-wheeled walker		Grab bars	
Cane		Sock aid	
Back brace		Long shoe horn	
TENS unit		Reacher	

Lower Extremity Fractures—Patella Ankle Tibia Fibula Femur Calcaneus

Table 2: Discharge Plan Checklist

Discharge Plan Checklist	Yes	No
1. The client's strengths, needs, abilities and preferences (SNAP) at the point prior to discharge are documented.
2. The gains from participating in the programme, or goals achieved are documented.
3. The likely post-discharge needs and issues are identified and conveyed to client and caregiver, if any.
4. Referral to other agencies for post-discharge needs are made, where necessary.
5. Caregivers are briefed on client needs, and informed with other resources available, including caregiver support groups, respite services and other community resources.
6. Contact details of a staff from the discharging organisation has been given to client and caregiver.
7. A designated staff had been assigned to follow-up with the client and caregiver, within a specified time-frame.

Discharge Evaluation & Plan 806

- Will the patient need PT, OT, RT, hospice, home health care, palliative care, nutritional consultation, dietary supplements, equipment, meals, shopping, housekeeping, transport, home modification, follow up appointment with PCP or surgeon, wound care etc.
 - Discuss if patient can pay out of pocket expenses
- Make sure if sent to LTC it does not exceed their care capabilities
- Hospitals are required to have knowledge of the capabilities of the LTC facilities and community services available including Medicaid home

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/>).*

CMS Your Discharge Planning Checklist

Your Discharge Planning Checklist:

For patients and their caregivers
preparing to leave a hospital, nursing home,
or other health care setting

[www.medicare.gov/Publications/Pubs/pdf/11376.pdf](http://www.medicare.gov/Publications/Publications/Pubs/pdf/11376.pdf)




CMS

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?	
<input type="checkbox"/> Ask where you will get care after discharge. Do you have options? Be sure you tell the staff what you prefer.	
<input type="checkbox"/> If a family member or friend will be helping you after discharge, write down the name and phone number.	
Your Condition	
<input type="checkbox"/> Ask the staff about your health condition and what you can do to help yourself get better.	
<input type="checkbox"/> 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.	

Taking Care of Myself: A Guide for When I Leave the Hospital



www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/goinghomeguide.pdf

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:

- 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

www.patientsafety.org/page/transtoolkit/

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

Discharge Evaluation & Plan 806

- Patient has a right to participate in the development and implementation of their plan of care
- CMS views discharge planning as part of the plan of care (POC)
- The patient is expected to be actively engaged in the development of the discharge evaluation
- Surveyor will make sure staff are following DP policies and procedures
- If hospital does not do one on every inpatient will assess how to determine if change in the patient's condition

Survey Procedure 806

- Will check to make sure documented in the medical record
- If from assisted living or LTC is there documentation facility has capability to provide necessary care?
- Surveyor will assess if patient needs special medical equipment or modifications to the home
- Surveyor will assess to make sure the patient or other can provide the needed care at home
- Will assess if insurance coverage would or would not pay for necessary services

Qualified Person to Do DP 807

- Standard: A RN, social worker (SW), or other appropriately qualified person must develop or supervise the development of the DP evaluation
- Written P&P must say who is qualified to discharge planning evaluation
- P&P must also specify the qualifications for staff other than RNs and SWs
- All must have knowledge of clinical, social, insurance, financial and physical factors to meet patient's post discharge needs

Multidisciplinary Team Approach

For Information – Not Required/Not to be Cited

A well designed discharge planning evaluation process uses a multidisciplinary team approach. Team members may include representatives from nursing, case management, social work, medical staff, pharmacy, physical therapy, occupational therapy, respiratory therapy, dietary, and other health care professionals involved with the patient's care. The team approach helps to ensure that all of the patient's post-discharge care needs are identified, so that they can be taken into consideration when developing the evaluation.

Discharge Planning

- Standard: the DP evaluation must be completed timely to avoid unnecessary delays (810)
- This means there has to be sufficient time after completion for post-hospital care to be made
- Cannot delay the discharge
 - Expects to be started within 24 hours of request or need
- Standard: The hospital must discuss the results of the DP evaluation with the patient (811)
 - Documentation of the communication must be in the medical record

Discharge Planning

- Standard: The hospital must discuss the results of the DP evaluation with the patient (811, continued)
 - Do not have to have the patient sign the document
 - Cannot present the evaluation as a finished product without participation of the patient
- Standard: The DP evaluation must be in the medical record (812)
 - Must be in the medical record to guide the development of the discharge plan
 - Serves to facilitate communication among team members

Discharge Planning

- Standard: RN, SW, or other qualified person must develop the discharge plan if the DP evaluation indicates it is needed (818)
 - DP is part of the plan of care
 - Best if interdisciplinary such as case manager, dietician, pharmacist, respiratory therapy, PT, OT, nursing, MS, etc.
- Standard: The physician may request a DP if hospital does not determine it is needed (819)

Implement the Discharge Plan 820

- Standard: The hospital must implement the discharge plan
 - Patient and family counseled to prepare them for post-hospital care
 - This include patient education for self care
 - It includes arranging referral to HH or hospice
 - It includes arranging transfers to LTC, rehab hospitals etc.
 - Arrange for follow up appointments, equipment etc.
 - Patient needs clear instructions for any problems that arise, who to call, when to seek emergency assistance

Implement the Discharge Plan 820

- Recommendations to reduce readmissions:
 - Improved education on diet, medication, treatment, expected symptoms
 - Use teach back or repeat back
 - Legible and written discharge instructions and may use checklists
 - Written in plain language (issue of low health literacy)
 - Provide supplies for changing dressings on wounds
 - Give list of all medication with changes (reconciled)
 - Document the above

For Information – Not Required/Not to be Cited

Additional actions hospitals might consider taking to improve the patient's post-discharge care transition:

- Scheduling follow-up appointments with the patient's primary care physician/practitioner and in-home providers of service as applicable;*
- Filling prescriptions prior to discharge;*
- If applicable, arranging remote monitoring technologies, e.g., pulse oximetry and daily weights for congestive heart failure (CHF) patients; pulse and blood pressure monitoring for cardiac patients; and blood glucose levels for diabetic patients; and*
- Follow-up phone calls within 24 -72 hours by the hospital to the patient after discharge.*

The communication with the patient to ensure implementation of the discharge plan does not stop at discharge. An initiative showing significant success in reducing preventable readmissions involves the hospital contacting the patient by phone in the first 24 to 72 hours after discharge. The phone contact provides an opportunity for the patient to pose questions and for the hospital to address any confusion related to medications, diet, activity, etc., and to reinforce the education/instruction that took place in the hospital prior to discharge. This also helps to reduce patient and family member anxieties as they manage post-hospital care needs.

Hospital staff placing the calls should be familiar with the patient's discharge plan and qualified to address typical questions that might be expected. They should also be knowledgeable about when to instruct the patient to seek a more immediate evaluation, including where to go for such evaluation. Although this follow-up phone call can serve as a customer service initiative for the hospital, the primary intent would be to provide an opportunity for

Survey Procedure 820

- Send necessary medical information (like discharge summary) to providers that the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first
- Surveyor will make sure referrals made to community based resources such as Department of Aging, elder services, transportation services, Centers for Independent Living, Aging and Disability Resource Centers, etc.
- If transfer, will make sure medical record information sent along with patient

Reassess the Discharge Plan 821

- Standard: The hospital must reassess the discharge plan if factors affect the plan (821)
- Changes can warrant adjustments to the discharge plan
- Have a system in place for routine reassessment of all plans
 - Many hospitals now have discharge planners or social workers who review the charts on a daily basis
 - If this is not done then need system to find out when there are changes

Freedom of Choice LTC HH 823

- Standard: If patient needs HH or LTC must provide patients a list (823)
 - Must inform the patient or family of their freedom to chose
 - Cannot specify or limit qualified providers
 - Must document that the list was provided
 - If in managed care organization, must indicate which ones have contracts with the MCO
 - Disclose if hospital has any financial interest
 - If unable to make preference must document why such as no beds available

For Information – Not Required/Not to be Cited

Hospitals may also refer patients and their families to the Nursing Home Compare and Home Health Compare websites for additional information regarding Medicare-certified skilled nursing facilities and home health agencies, as well as Medicaid-participating nursing facilities.

The data on the Nursing Home Compare website include an overall performance rating, nursing home characteristics, performance on quality measures, inspection results, and nursing staff information.

Home Health Compare provides details about every Medicare-certified home health agency in the country. Included on the website are quality indicators such as managing daily activities, managing pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned hospital care.

The hospital might also refer the patient and their representatives to individual State agency websites, Long-Term Care Ombudsmen Program, Protection and Advocacy Organizations, Citizen Advocacy Groups, Area Agencies on Aging, Centers for Independent Living, and Aging and Disability Resource Centers for additional information on long term care facilities and other types of providers of post-hospital care. Having access to the information found at these sources may assist in the decision making process regarding post-hospital care options.

Transfer or Referral 837

- Standard: Hospital must transfer or refer patients to the appropriate facility or agency for follow up care (837)
- Includes hospice, LTC, mental health, dialysis, HH, suppliers of durable medical equipment, suppliers of physical and occupational therapy etc.
- Could be referral for meals on wheels, transportation or other services
- Must send necessary medical record information
- Includes information necessary for transfer

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):*

Reassessment

843

- Standard: The hospital must reassess its DP process on an on-going basis and review the discharge plans to ensure they meet the patient's needs
 - Must track readmissions
 - Must choose at least one interval to track such as 7, 15, 30 days and review at least 10% of preventable readmissions
 - Recommend 30 days as the NQF endorsed readmission measures
 - Must review P&P to make sure DP is ongoing on at least a **quarterly** basis
 - Must track effectiveness of DP process through QAPI

Memo Includes Cross Walk to Old Tags

Crosswalk from Old to New Hospital Discharge Planning Tags

Old Tag	New Tag
Discharge Planning	
<p>A-0799 §482.43 Condition of Participation: Discharge Planning The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.</p>	<p>A-0799</p>
<p>A-0800 §482.43(a) Standard: Identification of Patients in Need of Discharge Planning The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.</p>	<p>A-0800 §482.43(a) Standard: Identification of Patients in Need of Discharge Planning The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.</p>
<p>A-0806 §482.43(b) Standard: Discharge Planning Evaluation (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.</p>	<p>A-0806 §482.43(b) Standard: Discharge Planning Evaluation (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. * * * (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.</p>
<p>A-0807 §482.43(b)(2) - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.</p>	<p>A-0807 §482.43(b)(2) - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.</p>
<p>A-0808 §482.43(b)(3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.</p>	<p>A-0806</p>

Additional Resources

- There are two additional resources
 - Tips based on the literature to reduce unnecessary readmissions
 - CMS has a discharge planning worksheet
 - The 3 CMS worksheets are very important
 - Will be used in 2014 for surveys including validation surveys with some modification
 - It is imperative that all hospitals be familiar with the discharge planning worksheet

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

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

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

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

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

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

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.

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

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

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 one of the four approved AO 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

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

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

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?

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?	<input type="radio"/> Yes <input type="radio"/> No	
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	
If yes, check all that apply: <input type="radio"/> Same day surgery patients <input type="radio"/> Observation patients who are not subsequently admitted <input type="radio"/> ED patients who are not subsequently admitted <input type="radio"/> Other		
2.3 Is a discharge plan prepared for each inpatient?	<input type="radio"/> Yes, skip to question 2.8 <input type="radio"/> No, go to question 2.4	

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

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

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.

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. **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.

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

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

Nurses Admission Assessment

Part I: Admission Routine						
Date:	Time:	T:	P:	R:	O₂ Sat:	
Mode: <input type="checkbox"/> amb <input type="checkbox"/> gurney <input type="checkbox"/> w/c <input type="checkbox"/> other	B/P:		Rt	Lt:		
Via: <input type="checkbox"/> admitting <input type="checkbox"/> ER <input type="checkbox"/> OR <input type="checkbox"/> other	Height:	Weight:	<input type="checkbox"/> Stand <input type="checkbox"/> Bed <input type="checkbox"/> Stated			
Admitting MD:			Family MD:			
Admitting Diagnosis:						
Chief Complaint: (per patient)						
Allergies:		Latex:		<input type="checkbox"/> balloons	<input type="checkbox"/> bananas	LATEX 4 or > - order latex free cart
<input type="checkbox"/> NKDA				<input type="checkbox"/> gloves	<input type="checkbox"/> pineapple	
Type of Reaction:				<input type="checkbox"/> mult OR	<input type="checkbox"/> avocados	<input type="checkbox"/>
Valuables List: (describe jewelry, clothing, etc.)						
<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Dentures	<input type="checkbox"/> Partial/bridge	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Refused safe	VALUABLE envelope to Safe <input type="checkbox"/>
Nurse Signature (if other than nurse completing remainder of assessment):						
Part II: Patient History						
Patient History: (major illnesses/operations/major injuries)						
<input type="checkbox"/> Hypertension	<input type="checkbox"/> COPD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anesthesia issues		
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> None		
<input type="checkbox"/> Stroke	<input type="checkbox"/> TB	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Mental Disorder			
<input type="checkbox"/> Cardiac other	<input type="checkbox"/> Respiratory other	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> General other			
Specify others not listed above and Surgeries:						
Alcohol/Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	Daily Amt:	<input type="checkbox"/> Quit		
Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	Daily Amt:	<input type="checkbox"/> Quit		
Admitting Diagnosis: AMI, Pneumonia, CHF:			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Vaccinations:						
Flu Shot within past 12 months		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused		
Pneumonia Shot in past 5 years		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused		
Family History:						
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Asthma <input type="checkbox"/> TB <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney <input type="checkbox"/> Anesthesia						

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

Functional Assessment

				SKIN ISSUES: Wd Care Referral <input type="checkbox"/>		MS: POC <input type="checkbox"/>	
NORTON SCALE	Norton Scale (Skin Risk Assessment)						
	<small>Reprinted with permission: Doreen Norton, Rhoda McLaren, and A.N. Eaton-Smith, An Investigation of Geriatric Nursing Problems in Hospitals, National Corporation for the Care of Old People (now Centre for Policy on Ageing), London, 1962.</small>						
	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 <input type="checkbox"/>	
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					ADL: poc# 16 <input type="checkbox"/>	
1 = 25% of care					FUNCTION: Referral to Phys. Med. if change <input type="checkbox"/>		
0 = N/A - (acute time limited condition)							
FALL RISK	Fall Risk (Risk Assessment)						
	<input type="checkbox"/> Level I		<input type="checkbox"/> Level II - Has two or more of the following risk factors				
	any patient		<input type="checkbox"/> age >65				
			<input type="checkbox"/> history of falls (immed or within past 3 mo.)				
			<input type="checkbox"/> taking fall related medications (hypnotics, analgesics, psychotropics, antihypertensive, diuretic, laxative)				
			<input type="checkbox"/> mod to severe physical impairment (includes mobility or visual/hearing deficits)				
		<input type="checkbox"/> occasional or frequent cognitive impairment					
						FALL RISK II: poc#17 <input type="checkbox"/>	
Page 3 of 4				Patient label			

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

Discharge Evaluation & Plan

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Menu

Rev. 04/09
Form # MP5423

DISCHARGE EVALUATION & PLAN PLAN OF CARE, REVIEWS & SUMMARY

ADMISSION EVALUATION

Admit Date _____ Reason for Admission (Refer to admission, H + P and transfer forms for additional information) _____

REHABILITATION POTENTIAL:

Resident believes self capable of increased independence in at least some ADL's Other _____
 Direct Care staff believes resident capable of increased independence in at least some ADL's _____

DISCHARGE POTENTIAL:

Excellent Good Fair Marginal Guarded Poor None

DISCHARGE anticipated within 90 days of admission?

Yes, Anticipated to: _____ Uncertain/Unknown due to: _____
 No, Reason(s):

<input type="checkbox"/> Requires 24 hr supervision	<input type="checkbox"/> Alternate Care setting not possible due to physical disability	<input type="checkbox"/> Mental Health status	<input type="checkbox"/> Financial limitations in meeting care needs
<input type="checkbox"/> Dependent on others for all ADL's	<input type="checkbox"/> Dependent psychologically on placement in facility	<input type="checkbox"/> Family refuses to provide care	<input type="checkbox"/> Resident refuses to leave facility
<input type="checkbox"/> Condition expected to deteriorate		<input type="checkbox"/> Family unable to meet needs due to other responsibilities	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Complicated medical care/regimen			

Resident and/or Resident Representative prefers to be discharged to: _____
Additional Comments: _____

Signature _____ Date _____

REVIEW OF FACTORS AFFECTING DISCHARGE PLAN

Refer to Comprehensive Evaluation dated: _____ for additional specific details in each area.

<h4>ADL FUNCTIONAL ABILITY</h4> <p><input type="checkbox"/> Ability to meet self-care needs not impaired <input type="checkbox"/> Unable to meet self-care needs <input type="checkbox"/> Ability to meet any self-care needs impaired in the following areas: <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Dressing <input type="checkbox"/> Personal Hygiene</p>	<h4>SUPPORT SERVICE REQUIREMENTS</h4> <p><input type="checkbox"/> No support service needs anticipated post-discharge. <input type="checkbox"/> Referrals needed in the marked areas: <input type="checkbox"/> Private physician <input type="checkbox"/> Personal (family/friends) support system</p>
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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

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.

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.

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).

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:

- ❖ Discharge planning experience;
- ❖ Knowledge of social and physical factors that affect functional status at discharge; and
- ❖ 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

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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

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 also ask for evidence of how hospital 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

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

Discharge Planning Evaluation CMS MLN



Discharge Planning

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 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)

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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	

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?

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?	<input type="radio"/> Yes <input type="radio"/> 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.)	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	

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

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

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%

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)

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

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 admission

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

	Patient/Record #1 <input type="radio"/> Open <input type="radio"/> Closed	Patient/Record #2 <input type="radio"/> Open <input type="radio"/> Closed	Patient/Record #3 <input type="radio"/> Open <input type="radio"/> Closed	Patient/Record #4 <input type="radio"/> Open <input type="radio"/> Closed	Patient/Record #5 <input type="radio"/> Open <input type="radio"/> Closed
Patient location prior to this admission, or to the admission under review for closed medical records:	<input type="radio"/> Home <input type="radio"/> NH, SNF, assisted living or other residential healthcare facility	<input type="radio"/> Home <input type="radio"/> NH, SNF, assisted living or other residential healthcare facility	<input type="radio"/> Home <input type="radio"/> NH, SNF, assisted living or other residential healthcare facility	<input type="radio"/> Home <input type="radio"/> NH, SNF, assisted living or other residential healthcare facility	<input type="radio"/> Home <input type="radio"/> 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? a. Before or at time of admission b. After admission but at least 48 hours prior to discharge c. N/A – all admitted patients receive a discharge plan d. None of the above	a. <input type="radio"/> b. <input type="radio"/> c. <input type="radio"/> d. <input type="radio"/>	a. <input type="radio"/> b. <input type="radio"/> c. <input type="radio"/> d. <input type="radio"/>	a. <input type="radio"/> b. <input type="radio"/> c. <input type="radio"/> d. <input type="radio"/>	a. <input type="radio"/> b. <input type="radio"/> c. <input type="radio"/> d. <input type="radio"/>	a. <input type="radio"/> b. <input type="radio"/> c. <input type="radio"/> d. <input type="radio"/>
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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A

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

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)

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.

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).

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:

- ❖ Discharge planning experience;
- ❖ Knowledge of social and physical factors that affect functional status at discharge; and
- ❖ Knowledge of appropriate community services and facilities that can meet the patient's post-discharge clinical and social needs.

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.

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 ?

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 home health compare

DP Evaluation Includes an Assessment



Discharge Planning

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:

- ❖ The patient's biopsychosocial needs;
- ❖ The patient's return to the pre-acute care hospital/post-acute care facility environment, including:
 - 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;
 - 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;
 - 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

**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;
- ❖ Information obtained from the patient and family/caregivers (such as financial and insurance coverage); and
- ❖ 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:

- ❖ The patient's capacity for self-care;
- ❖ The availability of appropriate services and facilities;
- ❖ The patient's preferences, as applicable; and
- ❖ The availability, willingness, and ability of family/caregivers to provide care.



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)

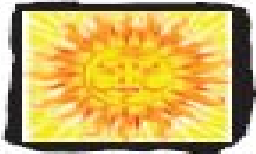
If Admitted From a LTC or Other Facility

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4	Patient/Record #5
<p>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?</p> <p>NOTE: Only choose N/A if the patient was not admitted from a residential facility.</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
<p>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?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
<p>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)</p>					
<p>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)?</p>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<p>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)</p>					
<p>4.15 Was the patient (or the patient's representative, if applicable) involved in a discussion of the evaluation results?</p>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Discharge Planning Tracers

- If patient discharged home is their initial **implementation** 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 NPSG.03.06.01

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?

Project RED Tools Revised 2013



A Research Group at
Boston University Medical Center



Boston University School of Medicine

Funded by the Agency for Healthcare Research and Quality, National Heart, Lung and Blood Institute, the Blue Cross Blue Shield Foundation, and the Patient-Centered Outcomes Research Institute.

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Project RED (Re-Engineered Discharge)

Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 12 discrete, mutually reinforcing components and has been proven to reduce rehospitalizations and yields high rates of patient satisfaction. Virtual patient advocates are currently being tested in conjunction with the RED. In addition, Project RED has started to implement the re-engineered discharge at other hospitals serving diverse patient populations. We are also looking at the transitional needs from inpatient to outpatient care of specific populations (i.e., those with...

Latest Project RED News

Release of Toolkit to Reduce Hospital Readmissions in the News

There has been a wide range of coverage about the release of the newly expanded RED toolkit, which we released on March 13. A summary of the article has appeared on web sites and trade publications, such as **Modern Healthcare**, **AHA News**, **American Medical Informatics Association** (under Public Policy Updates), **National Network of Libraries of Medicine**, **North Dakota Hospital Association**, **Smart Brief**, **Wisconsin Office of Rural Health**. Additionally, there were 10 re-tweets about the toolkit.



AHRQ Releases Toolkit to Reduce Hospital Readmissions

Every year millions of patients are readmitted to hospitals, and many of those stays could have been prevented. The Re-Engineered Discharge (RED) Toolkit, funded by the Agency for Healthcare Research and Quality, can help hospitals reduce readmission rates by replicating the discharge process that resulted in 30 percent fewer hospital readmissions and emergency room visits. Developed by the Boston University Medical Center, the newly expanded toolkit provides guidance to implement the RED for all patients, including those with limited English proficiency and from diverse cultural backgrounds. By helping hospitals plan and monitor the implementation of the RED process, the toolkit ensures a smooth and effective transition from hospital to home. **Download the toolkit here.** To order copies of the instructional manual, contact the AHRQ Publications Clearinghouse at AHRQPubs@ahrq.hhs.gov or call (800) 358-9295.



Photo: Gienn Kulbako



www.bu.edu/fammed/projectred/



Health Care Information

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Clinicians & Providers

Education & Training

Hospitals & Health Systems

Hospital Resources

- ▶ The Guide to Patient and Family Engagement in Hospital Quality and Safety
- ▶ Emergency Department Tools and Resources
- ▶ Emergency Severity Index
- ▶ Engaging Patients and Families in the Quality and Safety of Hospital Care
- ▶ The Hospital Built Environment
- ▶ Improving Patient Safety Systems for Patients with Limited English Proficiency
- ▶ Quality Indicators™ Toolkit for Hospitals
- ▶ Re-Engineered Discharge (RED) Toolkit
- ▶ Transforming Hospitals

Project RED (Re-Engineered Discharge) Training Program

The Project RED (Re-Engineered Discharge) training program is designed to help hospitals re-engineer their discharge process. Using the study modules and supporting materials, hospitals will become familiar with Project RED's processes and components, determine metrics for evaluating impact, and learn how to implement Project RED.

This content was developed from an AHRQ project that ran from 2009 to 2012 and is based on an early version of the RED Toolkit. Select for the latest version of the [RED Toolkit](#).

Introduction

The Project RED (Re-Engineered Discharge) intervention is a patient-centered, standardized approach to discharge planning. Initially developed through research conducted by Dr. Brian Jack of the Boston University Medical Center and funded by the Agency for Healthcare Research and Quality (AHRQ), Project RED improves patient preparedness for self care and reduces preventable readmissions.

This training program is designed to help you implement Project RED program within your hospital. Using the study modules and supporting materials, you will:

- Become familiar with Project RED's processes and components.
- Determine metrics for evaluating the impact of the intervention.
- Learn how to implement Project RED.

Several strategies associated with successful performance improvement are included on these pages. Links to supplemental tools also are provided to help you design your project and re-design your discharge process.

Course Content

The education sessions are organized into four modules. Hospital teams should access the modules in sequential order

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.

	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.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
4.18h Arranging essential durable medical equipment, e.g. oxygen, wheel chair, walker, hospital bed, commode, etc., if applicable.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
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.					

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)

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

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

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?

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

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/>).*

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

CMS Your Discharge Planning Checklist

Your Discharge Planning Checklist:

For patients and their caregivers
preparing to leave a hospital, nursing home,
or other health care setting

[www.medicare.gov/Publications/Pubs/pdf/11376.pdf](http://www.medicare.gov/Publications/Publications/Pubs/pdf/11376.pdf)




CMS

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?	
<input type="checkbox"/> Ask where you will get care after discharge. Do you have options? Be sure you tell the staff what you prefer.	
<input type="checkbox"/> If a family member or friend will be helping you after discharge, write down the name and phone number.	
Your Condition	
<input type="checkbox"/> Ask the staff about your health condition and what you can do to help yourself get better.	
<input type="checkbox"/> 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.	

Taking Care of Myself: A Guide for When I Leave the Hospital



www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/goinghomeguide.pdf

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:

- 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

www.patientsafety.org/page/transtoolkit/

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

How to Prevent Unnecessary Readmission and Important Discharge Information



Discharge Planning

- Discharge planning is important in today's environment especially in light of reform laws
- If hospital do not do this right and the result is a continued higher than average readmission rate
 - Some hospitals (66%) have been financially penalized by CMS losing 280 million dollars after 10-1-2012 and in 2014 it's 217 million
- 20% of Medicare patients are readmitted within 30 days and 34% within 60 days
- Hospitals need to reengineer the discharge process

CMS Readmission Program Website

Readmissions Reduction Program

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Background

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

Readmissions Measures

In the FY 2012 IPPS final rule, CMS finalized the readmission measures for Acute Myocardial Infarction, (AMI) Heart Failure (HF) and Pneumonia (PN) and the calculation of the excess readmission ratio, which will then be used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital. CMS finalized the calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios. The excess readmission ratio includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty. Finally, CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio is based on discharges occurring during the 3-year period of July 1, 2008 to June 30, 2011. For more information on the readmissions measures, please refer to the FY 2012 IPPS Final Rule in the Downloads section below.

Payment Adjustment

CMS continues implementation of this program in the FY 2013 IPPS rule. In the FY 2013 IPPS final rule, CMS finalized which hospitals are subject to the Hospital Readmissions Reduction Program, the methodology to calculate the hospital

Readmission Rates Vary

- Readmission rates vary widely in the US
- Too often quality of care during transition from hospital to home is not good
- Data shows readmission rate for MI and CHF vary
- Found only modest association between performance on discharge measures and patient readmission rates
 - See A. K. Jha, E. J. Orav, and A. M. Epstein, Preventing Readmissions with Improved Hospital Discharge Planning, NEJM Dec 31, 2009 361 (27):2637-2645

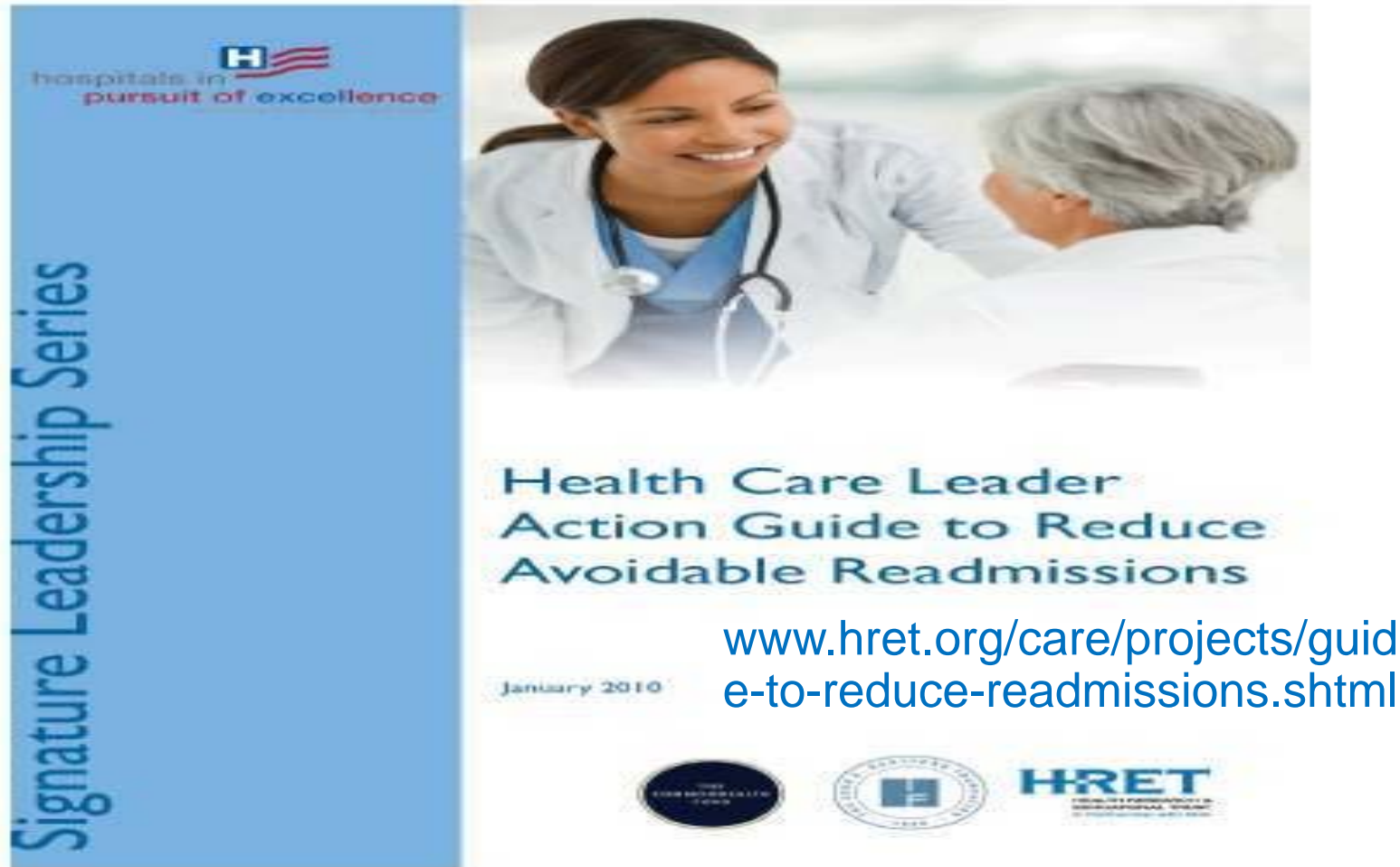
Readmissions and Discharges

- One in 5 hospital discharges (20%) is complicated by adverse event within 30 days
 - 20% were readmitted within 30 days with 1/3 leading to disability
- Often leads to visits to the ED and rehospitalization
- 6% of these patients had preventable adverse events
- 66% were adverse drug events
 - The incidence and severity of adverse events affecting patients after discharge from the hospital. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. Ann Intern Med. 2003;138:161-167


AHA Guide to Reduce Avoidable Readmissions

- AHA had committees look at the issue of how to reduce unnecessary hospital readmissions
 - AHA published several memos and a 2010 Health Care Leader Guide to Reduce Avoidable Readmissions
 - Issues memo on Sept 2009 on Reducing Avoidable Hospital Readmissions
 - Includes evaluation of post acute transition process which is the process of moving from the hospital to home or other settings

AHA Guide to Reduce Readmissions






Signature Leadership Series

hospitals in  pursuit of excellence

Health Care Leader
Action Guide to Reduce
Avoidable Readmissions

January 2010

www.hret.org/care/projects/guide-to-reduce-readmissions.shtml

Free Readmission Newsletter

READMISSIONS UPDATE eNEWSLETTER

Covering the Latest Developments in Medicare Readmissions Policy, Pilots, and Practice

VOLUME 3 - ISSUE 36
JANUARY 8, 2013

Welcome to the Medicare Readmissions Update eNewsletter

Editor: Philip L. Ronning

This issue sponsored by the Medical Home Summit

FEATURED 2012
MEDICARE-MEDICAID
PAYMENT SUMMIT
STREAMING AUDIO

READMISSIONS UPDATES



Medicare Discloses Hospitals' Bonuses, Penalties Based on Quality

CMS has published bonuses and penalties for nearly 3,000 hospitals under the Hospital Value-Based Purchasing Program. Revised payments begin in January 2013. According to Kaiser Health News analysis, 1,557 hospitals will be rewarded with more money and 1,427 will be penalized. The maximum amount any hospital could gain or lose was 1 percent of its regular Medicare payments. "While the numbers of winners and

CMS Initiatives Around
Preventable
Readmissions



Readmissions eNewsletter
[readmissions@healthcareenewsletters.com]

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

CMS Your Discharge Planning Checklist

Your Discharge Planning Checklist:

For patients and their caregivers
preparing to leave a hospital, nursing home,
or other health care setting

[www.medicare.gov/Publications/Pubs/pdf/11376.pdf](http://www.medicare.gov/Publications/Publications/Pubs/pdf/11376.pdf)



CMS

CMS

- Discharge planners should be a member of the hospital committee to prevent unnecessary readmissions
- Discharge planners and transition coaches may actually make the physician appointments
- Ensure medication information is clearly understood by the patients and use pharmacists when needed in the process
- CMS discharging planning standards start at tag number 799

Things to Consider

- Form a committee on redesigning the discharge process
- Do a literature search and pull articles
- Look at the different transition studies that have been done and which ones have been successful
 - Care Transition, Transition of Care, RED, RED 2, Guided care, H2H, IHI Transforming Care at the Bedside, STAAR, Boost, GRACE, Interact, Evercare, etc.
- Have physician dictate discharge summary as soon as patient is discharge
- Hospitals needs to get it into the hands of the primary care physician and document this in the chart

Things to Consider

- Medical staff should dictate what needs to be in the discharge summary beyond what CMS and TJC require
- Hospital should schedule all follow up appointments with practitioners for the patients
- Hospital should put in writing for the patient and in the discharge summary
 - Any tests that are pending that are not back yet
 - Any future tests and these should be scheduled before the patient leaves the hospital

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

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).

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 Hospitalist's Perspective

Checklist Element	Particulars	Must Keep	Optional
Medication Education	<ul style="list-style-type: none"> • Written schedule of medication • Include Purpose (reason) and (if apt) Cautions(s) for each medication • Clinical Pharmacist involvement (especially if cognitive impairment, or ≥ 3 Medication changes) 	<p style="text-align: center;">x</p> <p style="text-align: center;">x</p>	x
Cognition	<p>Rather than a Folstein score, some description mention of mental capacity such as:</p> <ul style="list-style-type: none"> • Lucid (full capacity for understanding and executive function, such as being able to follow instructions) • Forgetful (some senescence or impairment of memory) • Dementia (or "Brain Failure" - incapable of reliable recall and/or executive function) 		<p style="text-align: center;">x</p> <p style="text-align: center;">x</p> <p style="text-align: center;">x</p>
Discharge Summary	<p>Needs to be written with the receiving caregiver in mind, including:</p> <ul style="list-style-type: none"> • Presenting problem(s) that precipitated hospitalization • Primary and secondary diagnoses • Key findings and test results • Brief hospital course • Discharge Med Reconciliation (see above) • Condition at discharge (including functional status and cognitive status, if relevant) • Discharge Destination (and rationale if not obvious) 	<p style="text-align: center;">x</p> <p style="text-align: center;">x</p> <p style="text-align: center;">x</p> <p style="text-align: center;">x</p> <p style="text-align: center;">x</p> <p style="text-align: center;">x</p>	Cognitive status

Things to Consider

- Ensure education on all new meds and use teach back to ensure education and give information in writing
- Ensure patient is given a copy of the plan of care
- Give patient in writing their diagnosis and written information about their diagnosis
- Have patient repeat back in 30 seconds understanding of their discharge instructions
- Includes symptoms that if they occur what you want to do and who to call

Things to Consider

- Call back all patients discharged and review information and reinforce discharge instructions
- Have a call back number that patients and families can use 24 hours a day, seven days a week
- Reconciling the discharge plan with national guidelines and critical pathways when relevant
- Assess your hospital's readmission rate
- Pull charts and review for any patient who is readmitted within 30 days
- Have prescriptions filled in advance and brought to hospital to go over at discharge

Project RED Tools Revised 2013



A Research Group at
Boston University Medical Center



Boston University School of Medicine

Funded by the Agency for Healthcare Research and Quality, National Heart, Lung and Blood Institute, the Blue Cross Blue Shield Foundation, and the Patient-Centered Outcomes Research Institute.

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Project RED (Re-Engineered Discharge)

Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 12 discrete, mutually reinforcing components and has been proven to reduce rehospitalizations and yields high rates of patient satisfaction. Virtual patient advocates are currently being tested in conjunction with the RED. In addition, Project RED has started to implement the re-engineered discharge at other hospitals serving diverse patient populations. We are also looking at the transitional needs from inpatient to outpatient care of specific populations (i.e., those with...

Latest Project RED News

Release of Toolkit to Reduce Hospital Readmissions in the News



There has been a wide range of coverage about the release of the newly expanded RED toolkit, which we released on March 13. A summary of the article has appeared on web sites and trade publications, such as **Modern Healthcare**, **AHA News**, **American Medical Informatics Association** (under Public Policy Updates), **National Network of Libraries of Medicine**, **North Dakota Hospital Association**, **Smart Brief**, **Wisconsin Office of Rural Health**. Additionally, there were 10 re-tweets about the toolkit.

AHRQ Releases Toolkit to Reduce Hospital Readmissions

Every year millions of patients are readmitted to hospitals, and many of those stays could have been prevented. The Re-Engineered Discharge (RED) Toolkit, funded by the Agency for Healthcare Research and Quality, can help hospitals reduce readmission rates by replicating the discharge process that resulted in 30 percent fewer hospital readmissions and emergency room visits. Developed by the Boston University Medical Center, the newly expanded toolkit provides guidance to implement the RED for all patients, including those with limited English proficiency and from diverse cultural backgrounds. By helping hospitals plan and monitor the implementation of the RED process, the toolkit ensures a smooth and effective transition from hospital to home. **Download the toolkit here.** To order copies of the instructional manual, contact the AHRQ Publications Clearinghouse at AHRQPubs@ahrq.hhs.gov or call (800) 358-9295.

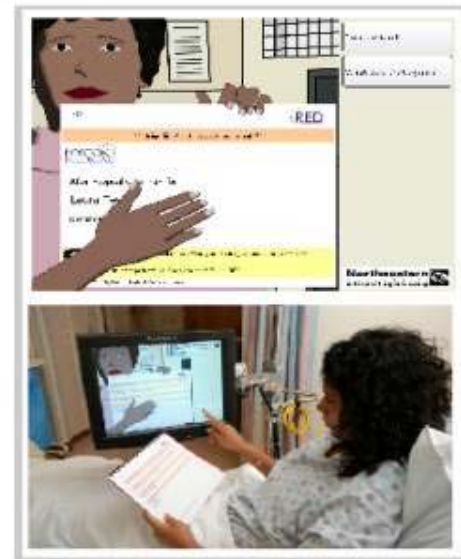


Photo: Gienn Kulbako



www.bu.edu/fammed/projectred/



Clinicians & Providers

Education & Training

Hospitals & Health Systems

Hospital Resources

- ▶ The Guide to Patient and Family Engagement in Hospital Quality and Safety
- ▶ Emergency Department Tools and Resources
- ▶ Emergency Severity Index
- ▶ Engaging Patients and Families in the Quality and Safety of Hospital Care
- ▶ The Hospital Built Environment
- ▶ Improving Patient Safety Systems for Patients with Limited English Proficiency
- ▶ Quality Indicators™ Toolkit for Hospitals
- ▶ Re-Engineered Discharge (RED) Toolkit
- ▶ Transforming Hospitals

Project RED (Re-Engineered Discharge) Training Program

The Project RED (Re-Engineered Discharge) training program is designed to help hospitals re-engineer their discharge process. Using the study modules and supporting materials, hospitals will become familiar with Project RED's processes and components, determine metrics for evaluating impact, and learn how to implement Project RED.

This content was developed from an AHRQ project that ran from 2009 to 2012 and is based on an early version of the RED Toolkit. Select for the latest version of the [RED Toolkit](#).

Introduction

The Project RED (Re-Engineered Discharge) intervention is a patient-centered, standardized approach to discharge planning. Initially developed through research conducted by Dr. Brian Jack of the Boston University Medical Center and funded by the Agency for Healthcare Research and Quality (AHRQ), Project RED improves patient preparedness for self care and reduces preventable readmissions.

This training program is designed to help you implement Project RED program within your hospital. Using the study modules and supporting materials, you will:

- Become familiar with Project RED's processes and components.
- Determine metrics for evaluating the impact of the intervention.
- Learn how to implement Project RED.

Several strategies associated with successful performance improvement are included on these pages. Links to supplemental tools also are provided to help you design your project and re-design your discharge process.

Course Content

The education sessions are organized into four modules. Hospital teams should access the modules in sequential order

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.

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			

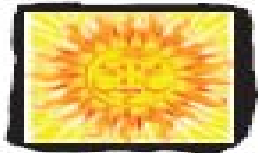
Questions for my appointment

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

Medication List



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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The End! Questions???



- Sue Dill Calloway RN, Esq.
CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and
Education Consulting
- Board Member
Emergency Medicine Patient Safety
Foundation
- 614 791-1468
- sdill1@columbus.rr.com