Discharge Planning

Case / Care Management

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Objectives

- Develop understanding of the principles that inform optimum discharge planning (e.g. promoting continuity of care, ongoing nature of the process, patient and/or family engagement in process)

- Gain an awareness of strategies for effective consultation with clients and care providers in and around the time of discharge (i.e. promoting a sense of power versus powerlessness in the client)

- Understand the discharge planning process as a preventive endeavor focused on identifying client-specific risks for readmission to hospital or long-term care facilities and development of appropriate mitigation strategies
Definition: “activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and possibly other health professionals; its goal is to enhance continuity of care. It begins on admission” (Mosby’s Medical Dictionary, 2013, p. 543)
Barriers

- History of acute illness...
  ...likely with history of delayed care second to financial concerns
- Social supports lacking
- Discharged with complex/multiple diagnoses and ongoing needs
- Expectation that patients are involved in care and discharge planning
- Volume of information and retention
Hallmarks of Good Discharge Planning

- **Patient/family-centered**
  - Meeting patient / family needs
  - Fostering independence
  - Respecting patient choice
  - Promoting patient satisfaction

- **Efficient**
  - Overcome obstacles in process
  - Minimize waste (time and services)
  - Identifying ‘at risk’ patients early
  - Patient/family receive timely, accurate information & participate in process

- **Effective**
  - Positive outcomes with minimal complications
  - Avoiding readmission

- **Safe**
  - Goal: Minimize unwanted clinical events
  - Detailed exchange of information
    - Med record
    - Labs
    - Risk factors
    - What has worked and what has not, historically?

- **Provides equitable care**
  - Appreciating diversity
Centers for Medicare & Medicaid Services (CMS)—Medicare Learning Network (MLN)

- Outreach and Education

  **Discharge Planning Booklet**
  - General overview of different discharge planning responsibilities, by facility type

  **Your Discharge Planning Checklist**
  - [http://www.medicare.gov/Pubs/pdf/11376.pdf](http://www.medicare.gov/Pubs/pdf/11376.pdf)
  - For the client, a means of participating in discharge planning process, documenting progress
CMS Update

New “guidance” for discharge planning, 5/17/13

- Emphasizes familiarity with capabilities and capacities (service limits) between entities
- Promotes patient / family engagement in discharge planning
- Acknowledges need to temper planning relative to financial capacities
- Requires survey evaluation of discharge plan and post-discharge implementation

http://www.medicareadvocacy.org/cms-updates-guidance-for-hospital-discharge-planning/
Effective Discharge Planning...

...“helps decrease avoidable hospital days, prevents unplanned readmissions, and provides a process that helps patients understand their discharge. It also increases patient, family, and staff satisfaction and improves management”

-Smith, S. (2013)

How does it do this?

✓ Guided interview
✓ Education
✓ Attention to retention of education in assessment.
✓ Assignment of high-risk patients to case management
✓ Attention to etiology of unplanned hospital readmissions:
  • Clarification of role delineation, patient education, team collaboration, case management, patient literacy, written discharge plan, post discharge plan, and quality control.
Goals:

- Show the clinical process in action
- Provide a client point of view
  - Power versus powerlessness
- Consider the MFP/Pathways angle
  - Specific for LTC-to-community placement
    - Not same as inpatient hospitalization –to-home transition...
      ...but similar in some ways
Case Study

- Mary, is a single adult female with history of near-annual hospital admission for acute exacerbations of chronic pancreatitis over the past 4 years.
- Residing in LTC for the past 3 years.
- Medically Complex: Primary diagnoses of pancreatitis (chronic), heart failure (HF), and history of stroke...
  - ...but limiting focus in the case study to one diagnosis (chronic pancreatitis) for sake of illustration
  - Chronic pain, complicated medication and dietary regimens.
  - High likelihood for ongoing need of psychosocial interventions
Case Study

• Mary was last admitted to hospital for ‘pancreatitis’ one year ago, after a month of unplanned weight loss (~10 pounds) and large-volume, foul smelling, fatty stools
• Mary’s disease process is complicated by Diabetes and she has been insulin dependent for 2 years
• Pain level at home is usually a ‘3’ on a scale of 0–10, but today it started at ‘6’ and has continued to climb.
  • Mary is admitted through the Emergency Department with acute pancreatitis.
Poll Question

- Effective discharge planning helps increase a participant’s health literacy and decreases unnecessary hospitalizations?

  True  
  False
Discharge Planning Begins on Admission

‘IDEAL’ Discharge Planning

- Include the patient and family as full partners
- Discuss with the patient and family the five keys areas to prevent problems at home
- Educate the patient and family throughout the hospital stay
- Assess how well doctors and nurses explain the diagnosis, condition, and next steps in their care—use teach-back
- Listen to and honor the patient and family’s goals, preferences, observations, and concerns

Agency for Healthcare Research & Quality (AHRQ)
Case Study

Admission assessment (RN or social worker)

• Holistic overview of client
  Identifying needs:
  ✓ Social support
  ✓ Health literacy
  ✓ Education (medications)
  ✓ Compounding stress
    • Financial
    • frustration with health system and insurance (barriers)
    • Chronic pain, history of medical procedures
  ✓ Alcohol and tobacco resources
  ✓ Dietary
Case Study

• Disciplines involved
  • Nurse Case Manager
  • Endocrinologist / GI Specialist
  • Podiatrist
  • Cardiologist
  • Social Worker
  • Pharmacist
  • Other

• Disciplines document interventions and resources/services appropriate for recovery and follow-up care
Case Study

Re: Pancreatitis — *critical areas for disciplines to assess:*

**Medication management** (i.e. consistency)

Clinical Pharmacist

- Verify physician orders
- Reconcile admission medications with medications from home
- Collaborate with care team specific to discharge needs
- Reconcile medications upon discharge
- Assist with patient medication questions
- Patient’s understanding of how medication works, client’s administration habit / history

**Dietary assessment and education**

Dietician

- Confirms 24 hour diet recall with client
- Confirms patient’s understanding of how diet affects pancreatitis / symptoms

**Psychosocial assessment and interventions**

Case Manager / Social Worker

- Financial, psychosocial, substance use
Approach: Empowerment VS. Disenfranchisement

What are conditions for empowerment?

- Promoting engagement in the process
  - Conducting “a holistic in-depth and detailed description of a phenomenon [i.e. interviews] using a variety of data collection methods (Patton, 1990; Eriksson, 1991).”
  - Numerous interviews (opportunities for clients to learn the process, grow comfortable with it, and engage)
  - Interviewing strategies: Motivational interviewing, (etc.)
Power in language

• Institutional discourse VS. ‘Everyday’ speak

Institutional Responsibility:

  o Avoid acronyms and other new words
  o Use idioms carefully
  o Provide a health context for numbers and mathematical concepts
  o Take a pause
  o Be an active listener
  o Address quizzical looks
  o Create a welcoming and supportive environment
Discharge Planning

Communication

**Approach:** Promoting Engagement

**Ask about and listen** to the patient and family’s needs

- Use open-ended questions
- Listen to, respect, and act on what the patient and family say
- Help patients articulate their concerns when needed
- Get a translator’s assistance if the patient or family member cannot understand

**Help the patient and family understand the diagnosis, condition, and next steps**

- Give timely and complete information—take every opportunity to educate the patient and family
- Use plain language
- Invite the patient or family to ask questions and take notes
**Discharge Planning Communication**

**Approach:** Promoting Engagement

**Clues that patient has general literacy issues:**
- Incompletely filled-out forms
- Frequently missed appointments
- Poor compliance
- Inability to identify the name, purpose, or timing of medication
- Not asking any questions
- Reaction to written materials
  - “I forgot my glasses. Can you read it to me?”
  - “I will read it at home.”
<table>
<thead>
<tr>
<th>PCP</th>
<th>Patient Admission Orders</th>
<th>Establish Clinical Pathway</th>
<th>Educate patient about diagnosis, tests, and studies</th>
<th>Participate in DC Rounds</th>
<th>Initiate DC orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse / RN</td>
<td>Admission Assessment</td>
<td>Medication Reconciliation</td>
<td>Provide care and treatment</td>
<td>Educate patient about diagnosis, tests, and studies</td>
<td>Reinforce Discharge Plan</td>
</tr>
<tr>
<td>Discharge Advocate</td>
<td>Identify target patient</td>
<td>Initiate daily discharge huddle</td>
<td>Initiate After Hospital Plan</td>
<td>Collect data re Process and Outcome metrics</td>
<td>Schedule Post discharge f/u appointment</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Verify MD orders</td>
<td>Create MAR</td>
<td>Assist with medication reconciliation</td>
<td>Assist with medication teaching</td>
<td>Initiate post discharge phone call</td>
</tr>
</tbody>
</table>

Agency for Healthcare Research & Quality (AHRQ)
Re: Pancreatitis — *critical areas to address in the discharge plan:*

**Medication management** (i.e. consistency)

Clinical Pharmacist

- **Education**: Pancreatic enzyme therapy and need for consistency in administration

**Dietary education**

Dietician

- **Education**: Understand categories of food and implications for pancreatic enzyme formation/pancreatic insufficiency
  - Works with Mary to complete a small, frequent meal plan of foods she enjoys eating and that are bland and low fat and contain very little caffeine

**Detailed psychosocial interventions**

Social Worker

- **Referral**: Outpatient psychotherapy, alcohol cessation program, tobacco quit helpline
- **Education**: community resources and pharmaceutical company resources to help Mary afford her medication copayments

**Complex care coordination and discharge planning**

Nurse Case Manager (care team liaison)

- Meets with client to confirm understanding of recommendations and to incorporate client preferences
- Creates detailed plan of care with services implemented, outstanding, and projected date of discharge
Assessing the Product

Completion of care plan details (AHRQ)
- Percent of care plans with medication list included
- Percent of care plans with care needs included (e.g., exercise, diet, main problem, when to call doctor)
- Percent of care plans with follow-up appointments listed
- Percent of care plans with pre-arranged discharge resources identified (e.g., home health, durable medical equipment)
- Percent of care plans with pending tests listed
Implementation

Written discharge plan
• In patient’s language and written at literacy level
• Frequently a ‘free text’ document, but...
  • Consider challenges like education, health literacy, and problems of retention
    • E.g. Pictographs (Zeng-Treeitler, Kim, & Hunter, 2008; Choi, J., 2013)

Logistics
• Arranging appropriate services and appointments

Evaluation
• Completion of care plan details (AHRQ)
• Follow-up (face-to-face, phone)
MFP Case Review

Pre-Transition Checklist

- Reconciling long-term care (LTC) discharge plans with transition agency and MFP clinical team care plan recommendations
  - Continuation of mixed multi-/inter-disciplinary case management approach
  - Supports transition to implementation of the discharge plan through a shift toward logistical considerations
Pre-Transition Checklist

Medical Diagnoses/Illnesses

- Arrange medical physician clearance/approval for transition (and psychiatric clearance if participant seeing psych in nursing home)
- Monitor for ER visits and hospitalizations
  - Recommend that the participant have no hospitalizations/ER visits for at least 6 months prior to transition
- Coordinate with the NH staff to initiate education on illnesses, medications, illness management, independence in ADLs, PT/OT as indicated (etc.)
Caregivers

- Assess for services the participant will need assistance with
  - PT / OT, medication management, etc.
- Coordinate who will provide these services and develop a schedule
Pre-Transition Checklist

Environmental/Housing

- Complete Housing application
- Assess if home modifications are necessary
  - Arrange approval
  - Secure bids
  - Evaluate when the modifications will be completed
- Coordinate telephone service
  - Verify functionality
- Coordinate an EHRS service
  - Verify functionality
  - Coach participant the need to maintain these after transition.
- Coordinate with the participant on furniture needs, household needs—purchase these. Deliver these to the participant’s post-transition home.
- Develop a Schedule / verify moving date
Pre-Transition Checklist

Finances

- Coordinate the notification of SSA, bank, (etc.) of change of address
- Assess for money management services and refer
Providers

- Coordinate primary care provider services in the community and verify that services/care will be provided to the participant
  - Determine name/location/contact information
  - Coordinate the first appointment prior to Nursing Home discharge or within 1-2 days of discharge
  - Coach the participant on the need to attend the first and all subsequent appointments. Coordinate transportation
- Coordinate care with specialists: Endocrinology, podiatry, ophthalmology, etc.
  - Obtain name/location/contact information/date/time
    - Coach the participant on the need to attend the appointment(s)
    - Coordinate transportation.
- Coordinate PA/PSLF services and Home Health services (RN for diabetic education and VNHA for palliative care) by obtaining a prescription from the NH physician
  - Develop the referral
  - Coordinate the date/time of first home visit
  - Coach the participant on the Home Health agency name/contact information/first home visit
  - Coach the participant on the need to cooperate with ongoing home care services.
Medications and Medical Supplies

- Assess current list of medications: prescription and over-the-counter
  - Update Form G
- Develop a list of needed medical supplies:
  - Glucometer and supplies, syringes and supplies, sharps container, , Incontinence pads; oxygen, etc.
- Coordinate with the NH to have the prescriptions written ahead of time
- Coordinate pharmacy services and locate a pharmacy to fill the prescriptions on an ongoing basis
  - Coordinate delivery of the prescriptions prior to NH discharge
  - Obtain prescription medications and purchase over-the counter medications prior to NH discharge
- Coordinate delivery of supplies by locating a home medical supply company to obtain needed supplies, including refills as appropriate
  - Support the participant in developing a system to obtain additional supplies as needed
  - Provide the participant the supplies name and contact information.
Pre-Transition Checklist

DME

- Assess that the participant owns the DME currently being used
- Develop a list of needed DME
  - wearable Emergency Home Response System-EHRS; wheelchair and cushion; Walker; Grab bars; Shower chair/bench; Lift Chair, (etc.)
- Coordinate delivery
- Monitor functionality and safety of DME
- Monitor the participant knows how to use properly
Transportation

- Assess options for the participant after transition
- Coordinate transportation from the NH to the home in the community
Advance Directives/Guardian

- Assess for the presence of a guardian
  - Obtain documentation
  - Include the guardian on all decisions regarding transition
- Assess for the presence of Advance Directives: Power of Attorney for Health Care; Power of Attorney for Finances/Property; Living Will; Full Code, Do Not Resuscitate (DNR) order, or specifics
  - Obtain copies
- Assess the participant’s desire to create a Power of Attorney for Health Care
  - Collaborate with the family and the NH Social Worker on initiating and developing this document.
Pre-Transition Checklist

MFP Process and Documentation

- Email UIC to alert to a potential transition. Complete all MFP Forms “paperwork.” Allow UIC at least 2 weeks to review the claims and paperwork and to develop the Case Review guide.
- Complete the Quality of Life survey- before the participant leaves the NH. Fax to the MFP Administrative team in Mahomet IL: 217.586.6059
Poll Question

The purpose of the MFP Case Review staffing is to ________________.

- Notify banks of an upcoming change of address
- Ensure continuity of care from the LTC facility to the community
- Initiate health education for the participant
Evaluation

- Follow-up phone calls and home visits by quality assurance staff of hospital

- **MFP/Pathways**
  - Mandated ‘30-day’ follow-up, post-transition and post-critical incident
Questions


http://www.medicareadvocacy.org/cms-updates-guidance-for-hospital-discharge-planning/

