Discharge Planning Essentials

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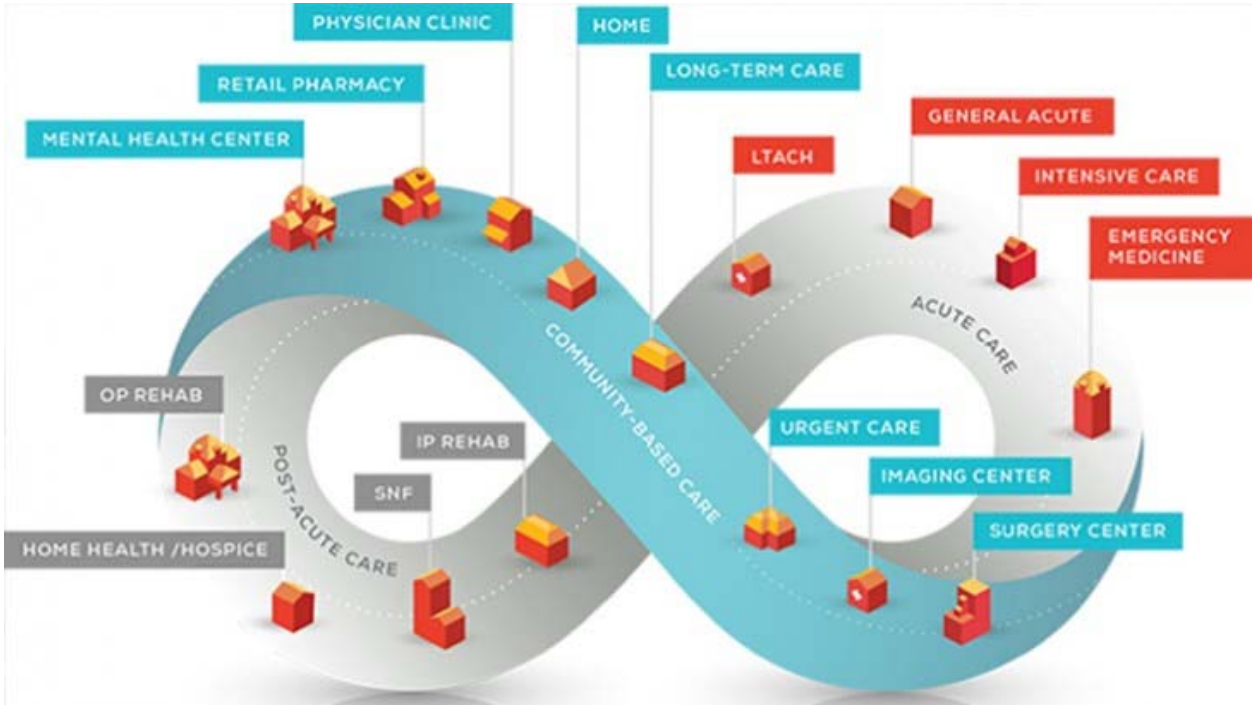
Objectives:

- Challenges of Discharge Planning
- Define best practice
- Outline financing of Post Acute Care
- Differences between discharge locations

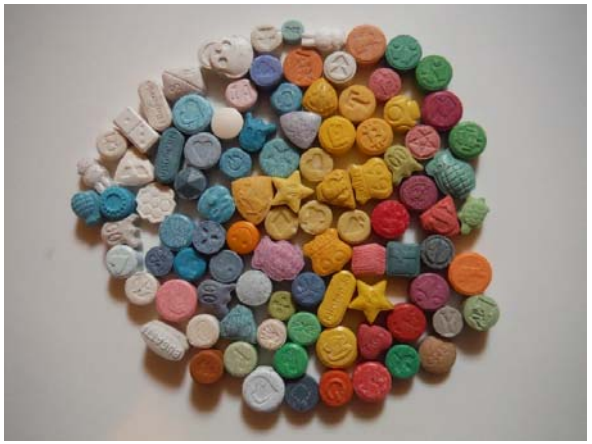


What can go wrong with a bad care transition?

1. Wrong treatment
2. Delay in recognizing change
3. Adverse events
4. Patient complaints
5. Increased healthcare costs
6. RE-ADMISSION

"How much longer you gonna be in here? The bread ran out last week and now the coffee and butter are gone."

What can go wrong?



Medication discrepancies can be common

- 14-30% of patients discharged from hospital to home experienced ≥ 1 medication discrepancy. [A]
- Inadequate hospital discharge information according to receiving SNF nurses: [B]
  - Problems with medication orders, pain management
  - Little psychosocial or functional history
  - Inaccurate information regarding current health status

[A]Coleman et al. Arch Intern Med 2005; 165:1842-47; Kwan Y et al. Arch Intern Med 2007;167:1034-40
[B]King, BJ et al. The consequences of poor communication during transitions from hospital to skilled nursing facility: a qualitative study. J Am Geriatr Soc. 2013 Jul;61(7):1095-102.

What can go wrong?

Recommended follow up often not done

- Example here includes CT scans and GI work up
- Of recommended workups, 35.9% were not completed

Workup Type	Total No. (%)	Completed Yes	Completed No
Diagnostic procedure	115 (47.9)	50.4	49.6
Subspecialty referral	85 (35.4)	72.6	27.4
Laboratory test	40 (16.7)	85.0	15.0
Total	240 (100)	64.1	35.9

Moore C, McGinn T, Halm E. Tying up loose ends. Arch Intern Med 2007;167:1305-11.

Who will provide help for the patient?

What Durable Medical Equipment (DME) will be needed?

- Covered by Medicare (mostly)
- Specific Requirements
- Five year rule

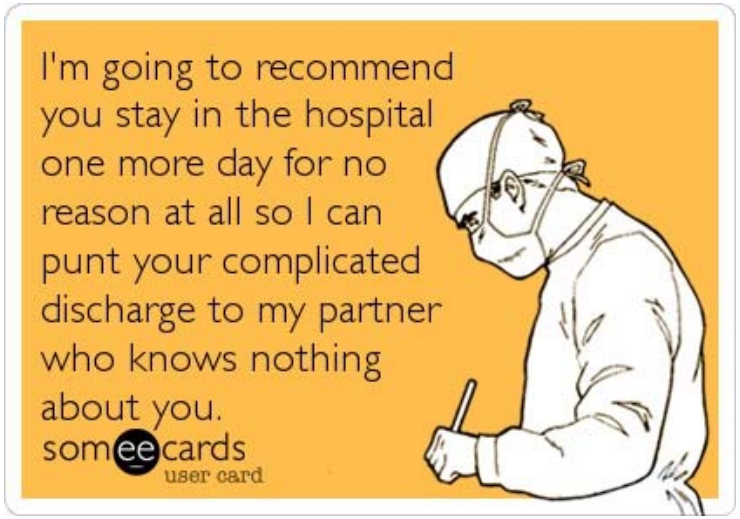
Courtesy of Jeremy Boal, MD and Spinlife.com

What Non Durable Equipment will be needed?

- Adult Incontinence Supplies
- Booties
- Gloves
- Wound care supplies
  covered by Medicare if certified home health aid involved in woundcare
- Not covered by Medicare
- Usually covered by Medicaid

Discharges are CARE TRANSITIONS:

- **Movement of a patient from one care setting to another**
- All team members should participate
- Begin early
- Post-hospital: many different sites
  - Appropriate level of care
  - Ready to receive patient
- KNOW the interdisciplinary team and what they offer



Best practice: What to include in a Discharge Summary.

- **Patient's clinical status/what happened/next steps**
- Medication changes
- Follow-up labs
- Follow up appointments
- Functional status/cognitive status
- Goals and preferences (DNAR?)
- Includes:
    - Education of the patient and family
    - Coordination among the health professionals at ALL sites

Coleman EA, Boult C. J Am Geriatr Soc 2003;51:556-7.

Recommendations on Principles and Standards for Managing Transitions in Care Between the Inpatient and Outpatient Settings from ACP, SGIM, SHM, AGS, ACEP, and SAEM

1. All transitions must include a ***transition record***
   Discharge summary: **Not a cut and paste of H&P**
2. Transition responsibility
3. Coordinating clinicians
4. Patient and family involvement and ownership of the transition record
5. Communication infrastructure
6. Timeliness
7. Community standards

Snow, V., Beck, D., Budnitz, T., Miller, D. C., Potter, J., Wears, R. L., Weiss, K. B. and Williams, M. V. (2009), Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. J. Hosp. Med., 4: 364–370.

The payment system matters at the time of discharge

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CMS Payment System

Medicare

- >65 years, ESRD, or disabled qualify
- Administered FEDERAL level
- Part A: hospital care, home health services/skilled nursing care, and hospice
- Part B: physician visits, Durable medical equipment, 80%, monthly fee
- Part C (must have A and B to have C)
  - Medicare health plans=Medicare Advantage plans
- Part D- the medications, all can choose, many different plans

Medicaid

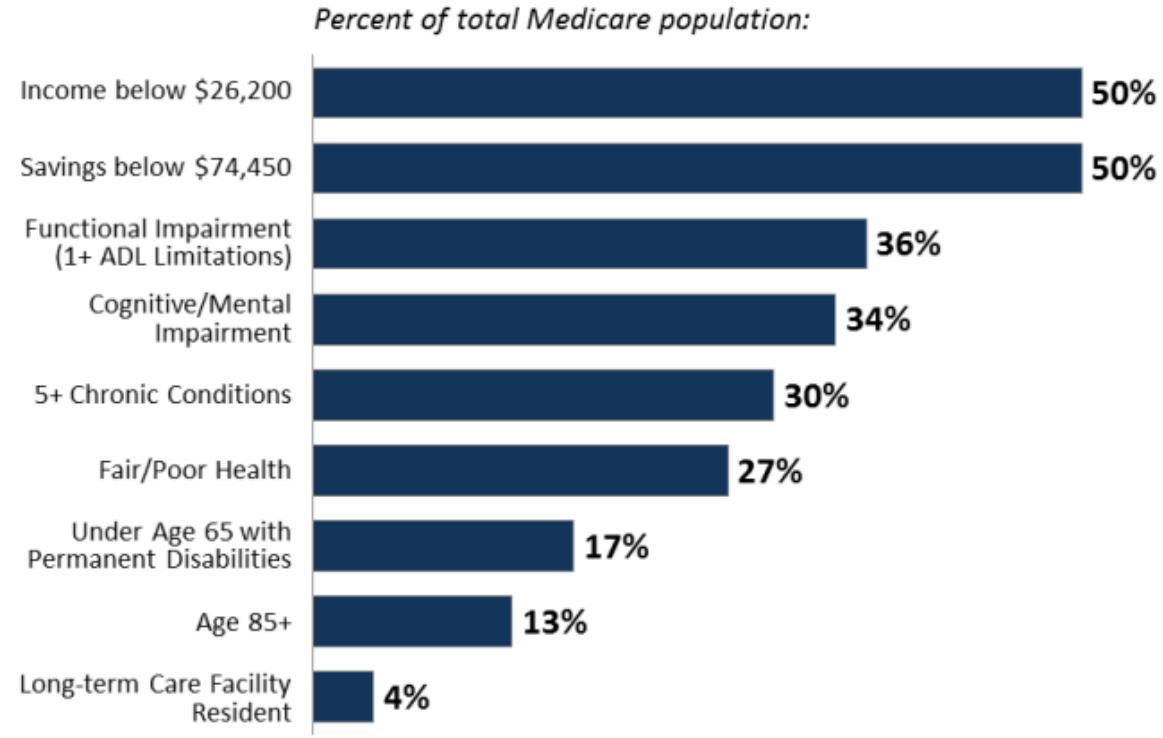
- Administered STATE level with federal matching funds
- Medical assistance for people with limited resources, “categories”
- Level of state participation varies
- Rx Medications covered for DUALs (Medicare and Medicaid)
- All states pay NH care
- NC MEDICAID EXPANSION

Source: CMS website and Gina Upchurch, senior PharmAssist

Who are Medicare beneficiaries?

Figure 1

Characteristics of the Medicare Population



NOTE: ADL is activity of daily living.
SOURCE: Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2013 Cost and Use file; Urban Institute/Kaiser Family Foundation analysis of DYNASIM data, 2017 (for income and savings).

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www.kff.org

Affordable care act (ACA) and care transitions:

- Centers for Medicare and Medicaid services = CMS
- Medicare Innovation Center allocated $500 million to foster community-based care transition programs
- https://innovation.cms.gov/
- Over 40 new payment models
- Focus on reducing cost by changing the way we manage patients **especially during transitions**

Naylor et al. Health Affairs. April 2011 vol. 30 no. 4746-754

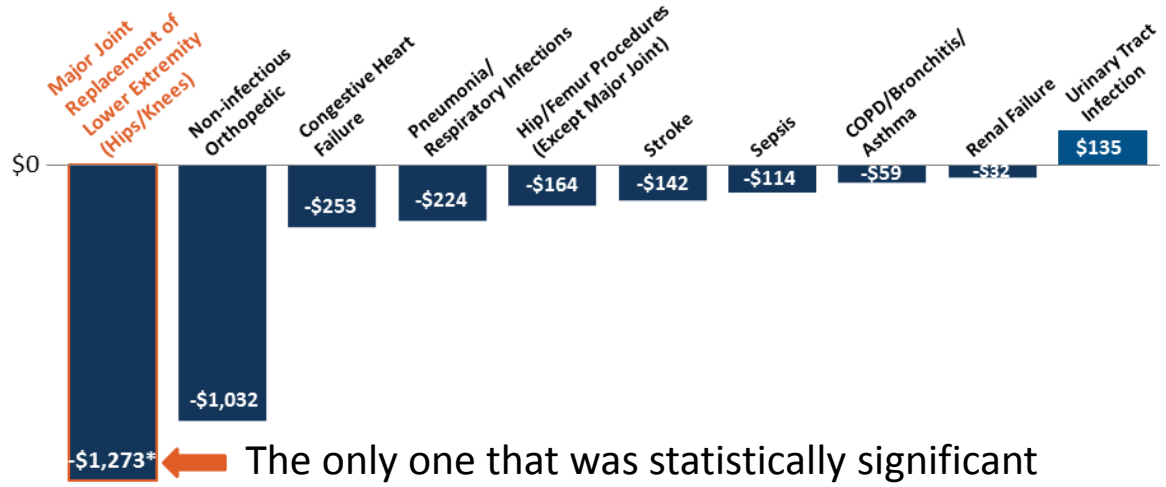
Types of APMs

- Alternative Payment Models (APMs)
  - Accountable care organizations (ACOs)
  - Bundled payments
  - Next Generation ACO Model
    - 2018: Post-Discharge Home Visit Waiver (in some locations)
- CMS implementing bundled payments that encompass longer episodes of care, more clinical services, and multiple clinicians and health care organizations:
  - **CCJR** Comprehensive care for joint replacement
  - **OCM** Oncology Care Model
  - **BPCI** Bundled Payments for Care Improvement Models

Bundled payment models and Medicare savings

Major joint replacements of lower extremity (hips/knees) was the only clinical group that achieved statistically significant Medicare savings per episode in BPCI Model 2

Difference in Medicare spending per episode, relative to comparison group, among the 10 clinical groups with the highest number of episodes):



No. of Episodes:	40,974	2,591	13,552	9,523	2,823	3,802	10,484	8,286	2,927	2,394

NOTES: *Statistically significant difference from comparison group ($p < 0.05$). Services included in BPCI Model 2 bundle: inpatient care, physician care, post-acute care, and all related services. Of the 23 clinical groups that had enough episodes for statistical analysis, the only group with statistically significant results was Major Joint Replacement of the Lower Extremity.

SOURCE: KFF analysis of results shown in The Lewin Group, *CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report*, October 2017.

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What about patients who have Medicaid?

- Hospitalizations/clinic visits
- Prescriptions (Excluding prescriptions for Medicare beneficiaries)
- Vision Care
- Dental Care
- Medicare Premiums
- Nursing Home Care
- Personal Care Services (PCS), Medical Equipment, and Other Home Health Services
- In-home care under the Community Alternatives Program (CAP)
- Mental Health Care

north carolina medicaid

Sites of Post Acute Care
for Medicare beneficiaries

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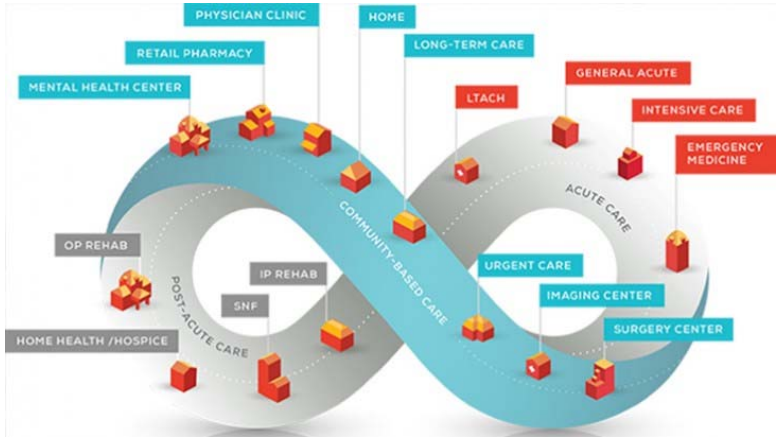
Sites of Post Acute Care:

1. SUBACUTE REHAB (SAR)
   at Skilled Nursing Facility (SNF) short term stay
2. ACUTE REHAB or
   Inpatient Rehabilitation Facility (IRF)
3. LONG TERM ACUTE CARE (LTAC)
4. LONG TERM CARE (LTC) at Skilled Nursing Facility (SNF) often people transition from SAR to LTC in a SNF.
5. Home with home health
6. Home
7. Hospice



Sites of Post Acute Care

Site	Requirements	Funding
Inpatient Rehabilitation Facility ACUTE REHAB Run by PM&R	Patient must tolerate 3 hours of therapy per day requiring multiple disciplines (e.g. PT/OT/SLP) Usually post CVA, post amputation, other specific CPTs	Medicare Part A pays 100% for days 1-20 copay for days 21-100 with Part A covering the rest Pt pays 100% after day 100

Sites of Post Acute Care

Site	Requirements	Funding
LONG TERM ACUTE CARE hospital (LTAC/LTACH)	Complex med needs. Hospital level but not that sick; too sick for SNF ~20-30 days e.g. vent wean; IV ABX; complex wound care	Medicare Medicaid Some commercial

LTAC EXAMPLE: Select Specialty Hospital

- 24-hour Respiratory Therapists
- ACLS Certified Nursing Care
- Case Management and Discharge Planning
- Clinical Pharmacy Services
- Daily Physician Visits
- **Vent Weaning**
- Bariatric Care

Select Specialty is an LTAC in Durham with branches nationwide

Sites of Post Acute Care

Site	Requirements	Funding
Skilled Nursing Facility (SNF) SUBACUTE REHAB (SAR)	Pt requires skilled nursing care Unable to tolerate 3h of therapy per day 2 skilled needs Inpatient criteria for 3 midnights (unless waiver from ACO or Medicare advantage plan)	Medicare Part A pays100% of charges for days 1-20 Days 21–100: cost after any other deductibles is roughly $167.50 in coinsurance per day of each benefit period (in 2018) – **depends on pt insurance.** Days 101 and beyond: all costs

Care team in a Skilled Nursing Facility (SAR/LTC)

- Interdisciplinary team in a SNF:
  - Social work onsite: LSW
  - Nursing: RN, LPN, CNA, RN wound care
  - Therapies: PT/OT/SLP
  - Medical staff: MD/DO, PAs, NPs
    Rounds at facility often 5 days per week, available 24h/day
  - Clinical services: podiatry, vision, mental health, clinical pharmacist, dietician, dentist, radiology (portable), labs (sent out)

Ancillary Services in SNF (SAR/LTC)

- ✓Phlebotomy/Laboratory
- ✓Radiology
- ✓EKG
- ✓IVs: usually just PICC
- ✓Echocardiography/Holter monitors
- ✓No Dobhoffs or Central Lines or ventilators
- ✓Can have PEGs

Sites of Post Acute Care

Site	Requirements	Funding
Home Health	MD orders (usually PCP) must certify that patient is homebound Intermittent RN, PT, SLP, wound care, DM education, home safety evaluation	Medicare Part A pays 100% for most professional services (e.g. PT/OT/ST) and HHA **Short term** after discharge Home health care services LONG TERM are NOT covered.

Home health care quick tip:

Once one skilled service established other services may be available.

- Start with RN for wound care or med management…
- Social work
- Home health aide services
- Occupational therapy
- Nutrition

Attending physicians must sign off on HH orders

Other team members in home health:

Home Health Aide (HHA)

- Medicare funded short term
- Pt. must have concurrent acute skilled care
- A few hours per day
- Full range of ADLs
- From Certified Home Health Agency (CHHA); VN supervision

Personal Care (PC) Homemaker

- Chronic duration
- No need for concurrent acute skilled care
- IADLs & light ADLs
- Authorized by Area Agency on Aging (AAA)
- Funding from AAA

Sites of Post Acute Care

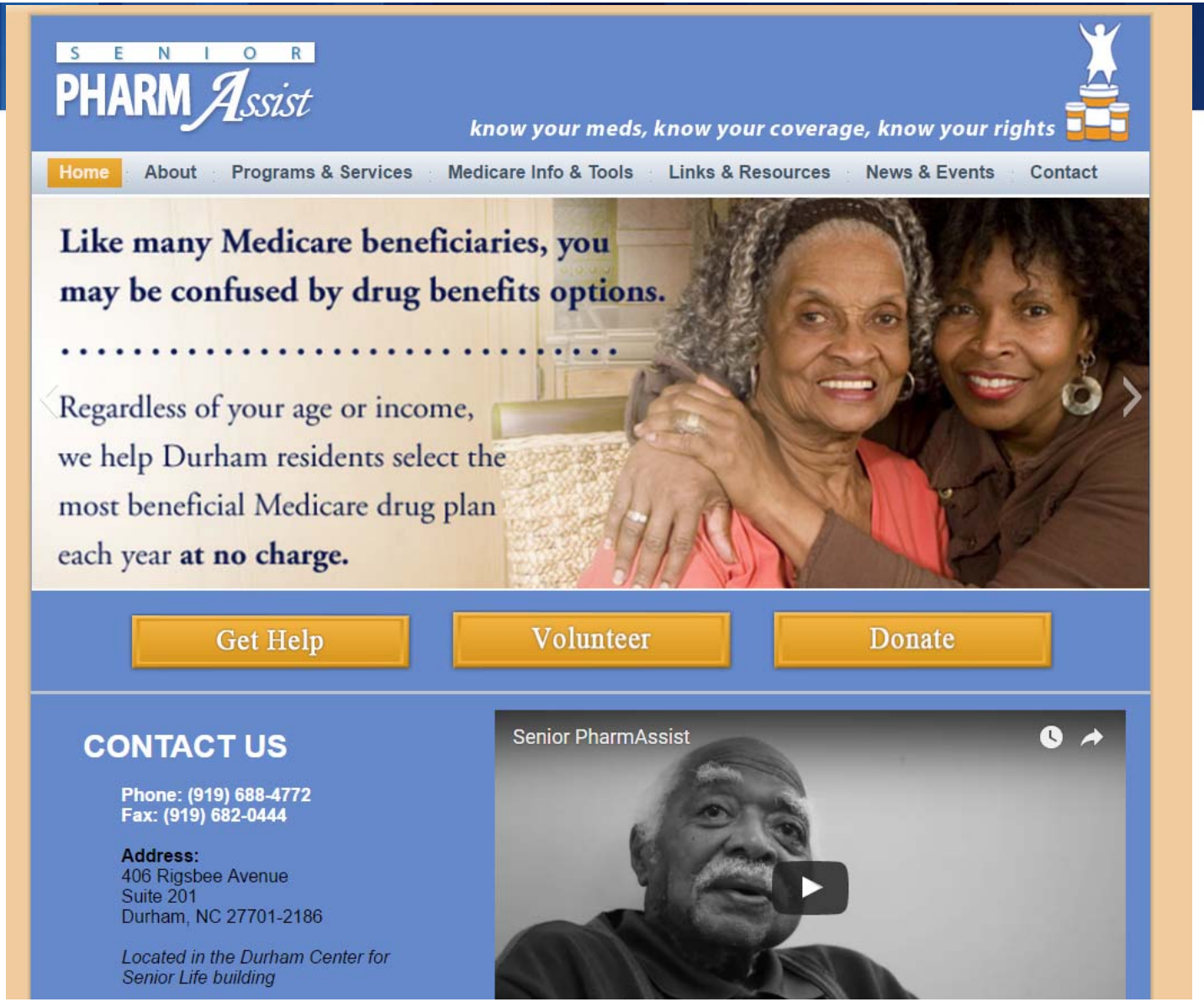
Site	Requirements	Funding
Hospice (home or facility-based)	MD must certify that life expectancy is < 6 months	Medicare A pays for most professional services and meds related to terminal illness MD services under Part B

Permanent Housing Alternatives for Older Adults

1. Senior Housing
2. Continuing Care Retirement Communities (CCRCs)
3. Long term care (LTC) – living in a SNF
4. Assisted Living Facilities (ALFs)
   - Have a la carte nursing service options similar to SNF NOT paid for by MEDICARE
   - May need PT/OT assessment for ALF to confirm eligible (not too deconditioned)
5. Residential Care Facilities, Board and Cares, Group homes

Senior PHARM-Assist

You need to know about it
Refer Durham County patients
Demystifies Medicare
Help with med coverage



Transitions of care initiatives are many

Evidence-based, developed to improve patient outcomes

- Care Transitions Intervention **(CTP)** Eric Coleman, MD @ Colorado
  http://caretransitions.org/about-the-care-transitions-intervention/
- Transitional Care Model **(TCM)** Mary Naylor, MD @ Penn
  http://www.nursing.upenn.edu/ncth/transitional-care-model/
- Better Outcomes for Older Adults through Safe Transitions **(BOOST)** SHM
  http://www.hospitalmedicine.org/BOOST/
- Geriatric Resources for Assessment and Care of Elders **(GRACE)** Indiana University
  http://medicine.iupui.edu/iucar/research/grace/
- **Project RED** (Re-Engineered Discharge), AHRQ
  https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf