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Objectives

1. Recall the unique elements of the Case Manager’s clinical assessment.
2. Identify a framework for assessing the long-term needs of the hospital patient.
3. Review how to provide a safe discharge based on the CM assessment.
4. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
5. Evaluate case management protocols and penalties.
An Overview

• The clinical assessment for discharge planning includes a combination of:
  • Clinical information from the chart
  • Socio-economic information from the patient
  • Support systems in place
  • Prior physical & cognitive function
  • Knowledge of clinical outcomes for patient’s diagnosis
Unique stories

• Each patient story presents it’s own unique set of variables
• All the elements must be considered to develop the best plan for each particular patient
• There is no “cookie cutter” approach
• What is a great plan for one patient may be totally wrong for another
It’s all about the Patient

• The patient is the most important person in the story
• Each patient is a unique individual – no two stories alike
• Discharge planning must be tailored to meet the individual patient’s needs
• It’s OK for the patient to make a bad decision
  • We must support whatever they decide to do
The Nurse as an Advocate

- We stand for the patient
- We honor their wishes
- We treat every patient with respect and dignity
- We protect their benefits
- We include them in the decision making
- We work with the other disciplines to provide the best plan for the patient
Start at the beginning of the story....

• Chart review
  • ED reports/H&P
    • What brought them to the hospital?
    • Fall? Clinical symptoms?

• Nurses notes
  • Dirty? clothes filthy? evidence of skin breakdown?

• Check labs – anemia? INR off the chart? Dig toxic?
What you need to find in the chart....

- What is the medical diagnosis or condition now?
  - What are the implications of the disease process?
  - How long are they expected to be in the hospital?
  - What would be the needs at discharge?
  - Does the patient have the resources to cope with this diagnosis?
  - In what setting?
Found in the History & Physical

• Medical history
  • Info on long term chronic illness
  • Current problems
  • Previous medical dx give clues to patient’s experience with rehab/equipment already at home

• Social history
  • Support structure

• Medications
  • How many? Too many? Anti depressants? High use of pain meds?
In the rest of the chart……

• Review labs, radiology reports
  • Reveals course of tx, discharge needs
  • Watch trends in labs

• Review therapy notes
  • Gives information on functional level

• Bedside nursing notes
  • O2 sats/eating 50% of trays or route of nutrition?/orthostatic hypotension?
The Interview – the other part of the assessment

- Verifies the information in the chart review
- Have an idea of what type of discharge plan would be best before you enter
- *Never* exclude the patient
  - Address your remarks to the patient even if the family member will be making the decisions and the cognitive ability of the patient is in question
- Always keep in mind how you would wish to be treated in this situation
The Patient Interview

• To collect information
• Add to the information collected from the chart
• Does it all make sense?
• How cognitive is the patient to make decisions?
• Allow the patient to be part of the decision making process
• Patient/family buy-in to change
• Be direct, be honest
Interview Skills

- Knock on the door (even if it is open)
- Ask permission for their time
- Respect privacy – come back if visiting (unless patient indicates it’s OK)
- Solve comfort issues first to have their attention (pain med/blanket/repositioned)
- Sit at eye level – maintain eye contact
- Lean in
- Use touch
- Take a face sheet to keep yourself oriented and for notes
- Avoid taking a great deal of notes or appearing to engrossed in documentation
Focus on the Patient

• Include the patient in the discharge planning process
• Active listening
• Offering options
• Education
• Pull in family and friends if allowed
• Accept limitations
• Work with what you have
• Allow bad decisions
Build a Rapport

- You must be viewed as a trustworthy partner
- Be direct and clear in your communications
- Avoid medical jargon
- The patient/family will appreciate clarity even if the news is not good
- Keep your word
Active Listening

• Be prepared to listen to the story
• Not every complaint/venting requires a solution
• Find common ground
• Respect the life they have lived
• Sympathy vs. Empathy
• Throw out the stereotypes
Types of questions

• Direct – demand specific answers
  • Do you live in a one story or two story?
  • How many steps at home?
  • Do you have any equipment at home?

• Open-ended
  • So, you live alone. How’s that working out?
  • How do you do your shopping?

• Are you getting “pat” answers? Can they stay on topic?
• Can they problem solve?
• Can they verbalize your recommendations, rephrase your answers? (Patients with dementia will answer in the same word pattern)
The answers you will find....

- Can they problem solve?
- Listen carefully. Don’t interrupt.
- Pay attention. What else is going on?
- Does the information add up?
- Does the information you are getting jive with the chart information?
Offering Options

- Changing one’s home can be frightening
- There is always more than one solution
- Be willing to change the plan to meet the needs of the patient
- Accept their alternatives
- Allow their ownership of the plan
Education

• Working with the patient/family on the discharge plan provides education opportunities
• About their health benefits
• About community resources
• About limitations
“The Village”

- Will a patient allow the village in?
- Every adult is legally responsible for their own finances and obligations
  - Adult children are not responsible
- Work with what you have
- Let the patient direct which family/friends to involve
Accepting Limitations

• For who? You or the patient?
• Allowing patients to make bad decisions
• Document their statements in quotes
• Can you accept the limitations that the patient has to live with?
• Even community resources can fail you
• Living in the real world
Elements of your Assessment

- Prior level of functioning
- Support systems
- Resources – both financial & community
- Current functional ability
- Needs for a safe discharge to maximize full recovery
- Patient/family acceptance of the plan
Documentation of your Assessment

• Document as soon as possible after the interview
  • It’s easy to forget which details go with which patient
• Go back with information (OK to say “I don’t know.”)
• Ask for more information if needed from interdisciplinary team members (can PT try the patient on stairs?)
• Follow the CMS regulatory guidelines for documentation
New Guidelines from CMS

• 42 CRF 482.43 Conditions of Participation – Discharge Planning – Standards
  • Identification of patients in need of discharge planning
  • Discharge planning evaluation
  • Discharge plan
  • Transfer or referral
  • Reassessment

• Each one of the detailed standards covers the basics of good discharge planning
• Nothing new in this regulation – just puts good discharge planning in the regulations
• Applies to Inpatients not to patients in other areas (OP or ED)
Develop a tool to identify patients that need a plan

• (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.

• (This can be an addendum to your department policy on discharge planning – but it is important to have a printed list.)
Discharge Planning evaluation

• 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.

  • (2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

  • (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.
Discharge Planning Eval. 2

• (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.

• (5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

• (6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.
The Discharge Plan

• **(1)** A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

• **(2)** In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

• **(3)** The hospital must arrange for the initial implementation of the patient's discharge plan.

• **(4)** The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

• **(5)** As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.
The Discharge Plan continued…

• **(6)** The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

• **(i)** This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.
• (ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post hospital extended care services through individuals and entities that have a contract with the managed care organizations.

• (iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.
The Discharge Plan continued

• **(7)** The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

• **(8)** The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.
Transfers/Referrals & Reassessment

• **(d) Standard: Transfer or referral.** The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

• **(e) Standard: Reassessment.** The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.
Documenting the Assessment

- All elements described in the CoP’s must be in the chart documentation
- Surveyors will be looking for all elements
- Prompts/check boxes/options built into an EMR
- Narrative – tell a story
- Your documentation should show how the assessment elements brought you to the discharge plan
- Document why the discharge plan devised is the best and safest for the patient
- *Not documented, not done*
Protect your license by documenting

- When patients chose to go a different path – one not recommended, the documentation needs to reflect this
- Document word for word in quotes
  - “I don’t care if there is oxygen in the house, I won’t stop smoking in my house”
- Document dates and times, full names and phone numbers
- Chart as it happens.
Just the facts

- Write factual notes – “Patient states…..” or Patient refuses to hire help at home or transfer to SNF for rehab; “I would rather be found dead on the floor.”
- Refrain from stating the patient is ‘non-compliant’ – that’s an opinion, not a fact
- Refrain from any use of judgmental language – always be respectful in documentation
- Your documentation will tell the story if questioned later
- Case Managers can be sued for unsafe discharges
Finish the story

• Collecting all the information – through chart assessment and patient interview gives the whole picture of the patient
• Be sure to document the final decisions and plans prior to discharge
• Consider if your plan is SAFE
• Will it prevent a readmission?
• The physician decides the medical story; your assessment puts all the resources in place for the patient to have a safe recovery
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Thank you!
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