Discharge Planning & Follow-up with Residents, Family, Team and Community Providers
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Learning Objectives
- Understand the overall concepts of discharge planning in a nursing facility
- Identify current key transitional care programs
- Identify protective and risk factors associated with discharge planning
- Understand the role of self-determination in discharge planning
- Understand the role of post-discharge follow-up

Federal Regulations
Setting the Stage: §483.20 Resident Assessment- Minimum Data Set 3.0 (XVI) Discharge potential
Section 0 Participation in Assessment and Goal Setting
Return to Community

Transitions to the Community
Some facilities discharge over 30 individuals a month!
Across the nation there are 757,938 actively planning discharge from a nursing facility

Upcoming Concerns
- By 2030, 7 million will be 85+
- State proposed caps on Medicaid spending
- Shifting criteria for long-term care eligibility


Incentives for Change
- Section 3026 of Affordable Care Act has 500 million attached for care transitions
- AoA is funding DRC's to implement care transitions.
- 16 states – funded with 68 Million in 2010:
- For example, cutting avoidable hospital readmission in CA by just ONE day could save Medicare and Medi-Cal $227 million
Current Transitional Care

Challenges of transitioning individuals between settings:

- Systems level barriers
- Professional level barriers
- Personal level barriers

Systems Level Barriers

- Lack of integrated care systems
- Lack of longitudinal responsibility across settings
- Lack of standardized forms and processes
- Incompatible information systems
- Ineffective communication
- Failure to recognize cultural educational or language differences
- Compensation and performance incentives not aligned with goal of maximizing care coordination and transitions
- Payment is for services rather than incentivized outcomes
- Care providers do not learn care coordination and team-based approaches in school
- Lack of valid measures of the quality of transitions

[Bonner, Schneider, Weissman, 2010]

Professional Level Barriers

- Settings
- Information
- Knowledge
- Accountability

[Coleman, NTOCC, 2003]

Person Level Barriers

- Responsibility for Care coordination
- Common thread between sites is the patient/family
- Navigating the care continuum without tools or skills

Impact for Nursing Facility Discharge Planning

- Increased numbers of residents will not be staying in the facility long term
- Increased importance for social work skills in discharge planning
- Increased involvement with families to support community discharge
- Increased rates of residents having multiple placements
Comparison of Transitional Care Models

<table>
<thead>
<tr>
<th>Category</th>
<th>Populartion</th>
<th>Setting</th>
<th>Professional Staff</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transitions Intervention (CTI)</td>
<td>Community Dwelling patients 65 &amp; Older</td>
<td>Home</td>
<td>Transitions coach</td>
<td>Home</td>
</tr>
<tr>
<td>Transitional Care Model (TCM)</td>
<td>High-risk elderly patients with chronic illness</td>
<td>Hospital and Home</td>
<td>Transitional care nurse</td>
<td>Hospital and Home</td>
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<tr>
<td>Project BOOST</td>
<td>Older adults</td>
<td>Hospital and Home</td>
<td>Transitional care nurse</td>
<td>Hospital and Home</td>
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</tbody>
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Person in Environment

(Heirs & Wandel, 1996)

Protective Factors

- Fracture diagnosis
- Fewer than 3 ADL dependencies
- Male, married
- African American or Hispanic
- Family involvement and support
- Primary payer source: Medicare
- Bladder continence
- Ambulatory
- Self-rated good health
- Younger than 80
- Lack of mental illness
- Good cognition, lack of dementia diagnosis
- Lack of recent multiple hospitalizations or nursing home placements

Risk Factors

- Age (advanced age)
- Female, widowed, childlessness
- Lives alone
- Lack of family or lack of caregiver support
- Need assistance with greater than 4 ADLs or IDALs
- Incontinence (bladder or bowel)
- Poor self-rated health
- Poor cognition (dementia)
- Mental illness (major depression or other long term psychiatric illness)
- Length of stay, either too short or too long >90 days or <90 days
- Ineligible for Medicare/Medicaid programs
- Multiple hospitalizations or nursing home placements
- Non-attachment to discharge plans in the past

Weighing Protective and Risk Factors

(Aykan, 2003; Coleman & Berenson, 2004; Kasper, 2005; Liu, 1994; McLaugh, 1993; Yafee et al, 2001)
Self-Determination

Quality of Life
Weighing Risks
Informed Choice

Lack of Resources for Discharge

- 74.2% Inadequate Financial Resources for needs
- 73.1% Unaffordable Assisted Living
- 59.2% indicate families are unable to provide long term needs
- 55.9% Inadequate Numbers of Real Homes
- 51.5% indicate acquiring community mental health services are problematic
- 49.4% indicate overall community resources are a problem

Case Example

Mrs. Janet R is an 87 year old childless widow who has been at Martin Rehabilitation and Retirement Center for 33 days for treatment of a fractured hip. She has an apartment in a rural community where there are limited resources. She has only Medicare. She is ineligible for Medicaid because her monthly income exceeds the current allowable limits. As a former teacher, she has some devoted friends who visit regularly. One friend noted that Mrs. R's apartment is extremely cluttered. Her PHQ-9 score was an "8". Her cognition BIMS score was 12/15. She ambulates very slowly with a walker and has stress incontinence. She is an insulin dependent diabetic that she manages herself. However, the nursing staff have noted that she occasionally "cheats" on her diet. She is determined to return home.

Evaluation and Intervention

Strengths
Risks
Best Discharge Practice

- What is best practice?
- How do social workers promote good discharge?
- When, where, how does this take place?

Interventions

- Maintain good rapport with facility staff
- Build good liaisons with community resources
- Advocate for length of stays consistent with resident needs
- Explore creative options
- Mediation—family/resident/facility/insurance

Timing

- 72 hour meetings
- Care plan meetings
- Pre-discharge planning meetings
- Gathering relevant material/information for discharge

Communication for Planning

- Identify clearly who is going to complete what task?
- What equipment is needed, who is going to order it?
- When will it arrive? How will the arrival be followed up?
- How will this equipment/supplies be paid for?

Putting It All Together: Who, What, When, and How?

- Face to Face Encounter Forms—Required for home care services
- Multiple page referral forms
- Social work contribution
Post Discharge Follow-up

30% of social workers make follow-up phone calls.

Post-Discharge Challenges

- Services did not come as planned
- Family reports greater health problems
- Community nurse reports decline in health
- Individual reports needing more help

Improving Discharges and Transitions of Care

- Improve communication
- Implement electronic medical records
- Points of accountability sending & receiving
- Increase case management
- Expand role of pharmacist
- Develop performance measures

Improvements for Care Transitions

- Shift from the concept of discharge to transfer with continuous management
- Begin transfer planning upon or before admission
- Incorporate 72 hour discharge plan meetings
- Incorporate individuals/caregivers preferences into plan
- Identify social supports and function (how will this person care for herself after transfer?)
- Collaborate across settings to formulate and execute a common care plan.

Summary

- Good discharge planning is essential for increasing short-stays
- There are 3 proven transitional care models: CTI, TCM and BOOST
- PIE provides an inclusive model: Protective and Risk Factors
- Include the role of self-determination and informed choice for discharge planning
- Post-discharge follow-up is important to ensure service continuity
General Online Resources

Face to Face Guidelines:

Your Discharge Planning Checklist:

Area Agencies on Aging (AAA) and Aging and Disability Resource Centers (ADRC):
www.eldercare.gov/Eldercare.NET/Public/index.aspx

Ask Medicare:
www.medicare.gov/caregivers

Long Term Ombudsman Program:
www.eldercare.gov

Senior Medical Patrol Programs:
www.smpresource.org

Centers for Independent Living:

National Council on Aging:
www.longtermcare.gov

State Health Insurance Assistance Programs & State Medical Assistance Office:
www.medicare.gov/contacts

Resources

- Ask Me 3 The National Patient Safety Foundation helps to promote good communication between patients, families, and health care providers with its Ask Me Three program. http://www.npsf.org/askme3/pdfs.php


- Institute for Family-Centered Care By promoting collaborative, empowering relationships among patients, families, and health care professionals, the Institute facilitates patient- and family-centered change in all settings where individuals and families receive care and support. http://www.familycenteredcare.org

- National Transitions of Care Coalition (NTOCC) NTOCC gives healthcare professionals tools, resources, and best practices to enhance transitions of care. http://www.ntocc.org