Successful Discharge Planning Needs to Occur EARLY and INCLUDE the IDT for ALL Admissions

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ACRONYMS/ABBREVIATIONS USED IN THIS PRESENTATION

Acronyms/ Abbreviations	Definition
ACA	Affordable Care Act
ACO	Accountable Care Organization
ALF	Assisted Living Facility
CMS	Centers for Medicare and Medicare Services
ED	Emergency Department
HHA	Home Health agency
IDT	Interdisciplinary Team
IMPACT	Improving Medicare Post-Acute Care Transformation Act
IRF	Inpatient Rehabilitation Facilities
LOS	Length of Stay
LTCH	Long-Term Care Hospitals
NP	Nurse Practitioner
OIG	Office of Inspector General
PA	Physician Assistant
PAC	Post-Acute Care
PACN	Post-Acute Care Network
PASRR	Pre-Admission Screening and Resident Review
PQRS	Physician Quality Reporting System
SNF	Skilled Nursing Facility
TOC	Transition of Care

OBJECTIVES

- Describe how discharge planning has changed within a SNF
- Describe the reasons to have an IDT participate in discharge planning
- List three benefits to starting discharge planning early and including the IDT

THE HISTORY OF SNF DISCHARGE PLANNING

"Why do we need to do discharge planning in a SNF?
We're a nursing home not a hospital. Our residents come here to stay."

WHAT HAS CHANGED
AND
WHY THE CHANGE?

WHAT HAS CHANGED: IN THE SNF

(CENTERS FOR MEDICARE & MEDICAID SERVICES, 2017)

- Increased number of people using SNFs for short-term care not long-term care
- Aging in place goal, living in the community longer
- Decreased number of people able to use IPR
  - CMS 60% Rule

WHAT HAS CHANGED: US POPULATION

(US CENSUS AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES)

- Per US census shows
  - Number of people aged ≥65 or over increased from 35 million in 2000 to nearly 50 million in 2016; accounting for over 15% of the total population in the US
  - Numbers of individuals ≥ 65 are expected to increase to 75 million by 2030; accounting > 20% of the total population
- Medicare aged enrollment rose from 29.1 million in 2008 to 32.5 million 2017
  - Projected enrollment to exceed 60 million by 2030
- Medicare advantage enrollment rose from 9 million in 2008 to 13.5 million in 2017

WHY THE CHANGE: ACA

(CENTERS FOR MEDICARE & MEDICAID SERVICES, N.D.; THE AFFORDABLE CARE ACT: LOWERING MEDICARE COSTS BY IMPROVING CARE, 2012)

- Enacted March 2010 for comprehensive health reform to
  - Expand healthcare coverage
  - Hold insurance companies accountable
  - Lower health care costs
  - Guarantee more choice
  - Enhance the quality of care for all Americans
    - Preventative care
    - Implementation of public programs
    - Community Services
- Includes
  - Patient Protection and Affordable Care Act
  - Health Care and Education Reconciliation Act of 2010

WHY THE CHANGE: ACA

(CENTERS FOR MEDICARE & MEDICAID SERVICES, N.D.; THE AFFORDABLE CARE ACT: LOWERING MEDICARE COSTS BY IMPROVING CARE, 2012)

- The Patient Protection and Affordable Care Act
  - Quality, affordable health care for all Americans
  - The role of public programs
  - Improving the quality and efficiency of health care
  - Prevention of chronic disease and improving public health
  - Health care workforce
  - Transparency and program integrity
  - Improving access to innovative medical therapies
  - Community living assistance services and supports
  - Revenue provisions

WHY THE CHANGE: ACA

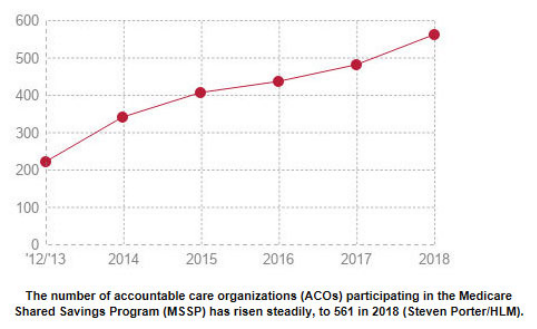
(CENTERS FOR MEDICARE & MEDICAID SERVICES, N.D.; THE AFFORDABLE CARE ACT: LOWERING MEDICARE COSTS BY IMPROVING CARE, 2012)

- ACA marketplace plans 2014
- Healthcare innovations
- Paying for Performance
  - Hospitals: Hospital Value-Based Purchasing Program
  - Physicians: PQRS
    - Some of this data will need to be obtained from SNF medical record
      - Medications and vaccines
      - Verifying diagnoses and specifics related to diagnoses
  - Medicare Advantage Plans: “five-star” plan bonus system
    - Some of this data will need to be obtained from SNF medical record
      - Medication adherence and reconciliation
  - Home Health Agencies: Medicare Home Health Pay for Performance

WHY THE CHANGE: ACA

(CENTERS FOR MEDICARE & MEDICAID SERVICES, N.D.; THE AFFORDABLE CARE ACT: LOWERING MEDICARE COSTS BY IMPROVING CARE, 2012); (PORTER, 2018)

- Bundled Payments started in 2012
- ACOs started in 2012
  - The number of ACOS has increased each year ACOs look at total spend by type i.e. SNF, HHA, hospital
  - Many focus on
    - SNF LOS
    - ED use
    - Hospital readmissions
    - Building high performing PACNs (right level of care & highest quality provider)
    - TOC (appointments & process to prevent gaps in care)
- For both Bundles and ACOs
  - Some have waivers: 3 Day SNF Waiver
  - Should be providing reports/feedback to PACN



The number of accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) has risen steadily, to 561 in 2018 (Steven Porter/HLM).

WHY THE CHANGE: IMPACT ACT OF 2014

(CENTERS FOR MEDICARE & MEDICAID SERVICES, 2016)

- Requires submission of standardized data by LTCHs, SNFs, HHAs, and IRFs to meet the National Quality Strategy of better care, healthy people/communities, and affordable care
- Requires standardized patient assessment data to enable
  - Quality care and improved outcomes
  - Data element uniformity
  - Comparison of quality and data across the post-acute care settings
  - Improve discharge planning
  - Exchange of data
  - Coordinate care
  - Inform payment models

WHY THE CHANGE: SNF EVICTION

(POST ACUTE ADVISOR, 2018; CENTERS FOR MEDICARE & MEDICAID SERVICES, 2017)

- December 2017 CMS memorandum reported that the most common complaint to the Long-Term Care Ombudsman Programs is discharge/eviction
    - Most common reasons listed for resident discharge are behavioral, mental, and/or emotional issues as well payment sources
    - CMS is encouraging states to pursue Civil Money Penalty Reinvestment Projects to help prevent facility initiated discharges that violate federal law

WHY IS THE TEAM APPROACH IMPORTANT?

WHY IS THE TEAM APPROACH IMPORTANT: PATIENT CENTRIC APPROACH

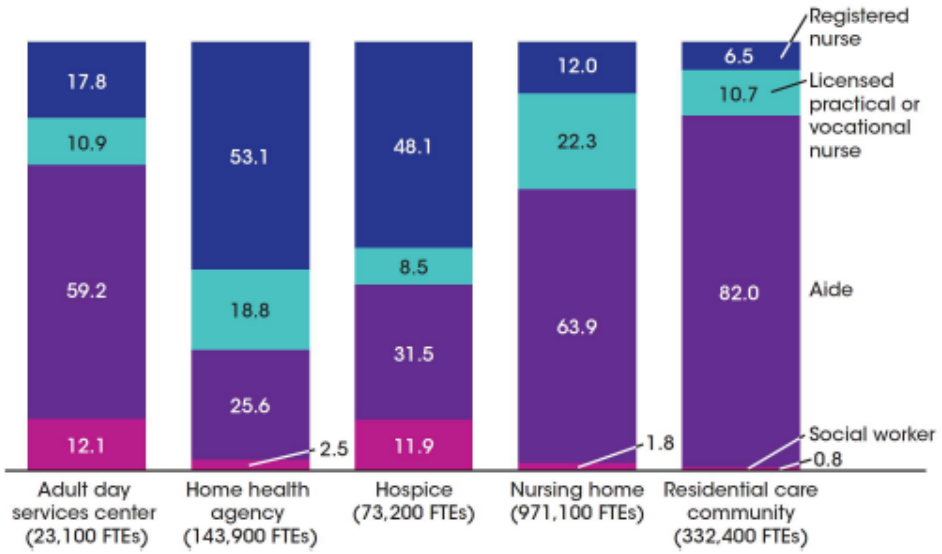
(QUALITY IMPROVEMENT ORGANIZATIONS, 2017; MEDICARE LEARNING NETWORK, 2017)

- Establish or reset communication internally as well as externally
- Individualized, realistic care plans that include the discharge planning needs
  - Functional status
  - Baseline care plan needs to be completed within 48 hours of SNF admission and should include at least orders (dietary, therapy), initial goals, PASARR if needed, social service, etc. but remember this is just the baseline and not the Comprehensive Resident Centered Care Plan
- Not to mention, it is a Regulation!

WHY IS THE TEAM APPROACH IMPORTANT: IT IS MORE THAN JUST SOCIAL SERVICE

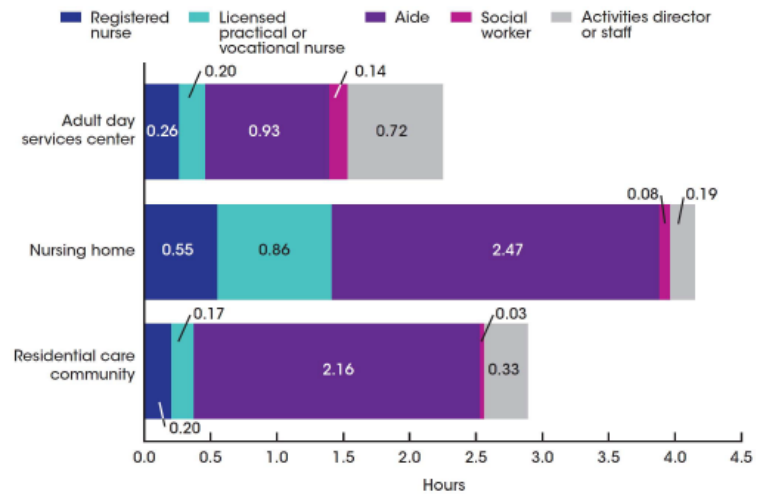
(CENTERS FOR DISEASE CONTROL AND PREVENTION, 2016)

Figure 9. Percent distribution and total number of nursing and social work employee full-time equivalents, by sector and staff type: United States, 2014



NOTES: FTEs are full-time equivalents. Only employees are included for all staff types; contract staff are not included. For adult day services centers and residential care communities, aides refer to certified nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides. For home health agencies and hospices, aides refer to home health aides. For nursing homes, aides refer to certified nurse aides, medication aides, and medication technicians. See Technical Notes for information on how outliers were identified and coded. Percentages may not add to 100 because of rounding. Percentages are based on the unrounded numbers.
SOURCES: CDC/NCHS, National Study of Long-Term Care Providers and Table 2 in Appendix B.

Figure 11. Average hours per resident or participant per day, by sector and staff type: United States, 2014



NOTES: Only employees are included for all staff types; contract staff are not included. For adult day services centers and residential care communities, aides refer to certified nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides. For home health agencies and hospices, aides refer to home health aides. For nursing homes, aides refer to certified nurse aides, medication aides, and medication technicians. Social workers include licensed social workers or persons with a bachelor's or master's degree in social work in adult day services centers and residential care communities; medical social workers in home health agencies and hospices; and qualified social workers in nursing homes. For adult day services centers, average hours per participant per day was computed by multiplying the number of full-time equivalent (FTE) employees for the staff type by 35 hours, divided by the average daily attendance of participants and by 5 days. For nursing homes and residential care communities, average hours per resident per day was computed by multiplying the number of FTE employees for the staff type by 35 hours, divided by the number of current residents and by 7 days. See Technical Notes for information on how outliers were identified and coded. Hours per patient per day could not be provided for home health agencies or hospices, because the administrative data available provided total number of all patients served in a year, not the number served on a given day, which is needed to produce this estimate.
SOURCES: CDC/NCHS, National Study of Long-Term Care Providers and Table 2 in Appendix B.

WHY IS THE TEAM APPROACH IMPORTANT: THE TEAM

- IDT Includes any department that touches the patient
  - Nursing including RNAC/LPNAC and case management
  - Therapy
  - Social Services
  - Dietician
  - Physician/NP/PA
- May also include:
  - Activities
  - Billing office
  - Downstream PAC providers
  - Health system designee
  - Health plan designee
  - Physician practice based care manager

WHAT ARE THE BENEFITS TO EARLY AND INTERDISCIPLARY DISCHARGE PLANNING

WHAT ARE THE BENEFITS: TO STARTING EARLY

- Helps to identify barriers to discharge early
- Notifies families of when a different payment model may start
- Identify the correct downstream partner
- Establish capacity at next level of care if needed
  - HHA
  - ALF
- Starts the conversation of Plan A, Plan B, and Plan C
  - Working to ensure that the person, their family, and the IDT are working together towards the same goals
- Starts the 'Discharge Readiness Summary' or 'SNF Discharge Care Plan Meeting Checklist'
  - This is updated every few days to help to everyone determine which discharge plan is realistic

WHAT ARE THE BENEFITS: TO STARTING EARLY

(LOEFFEL, 2014)

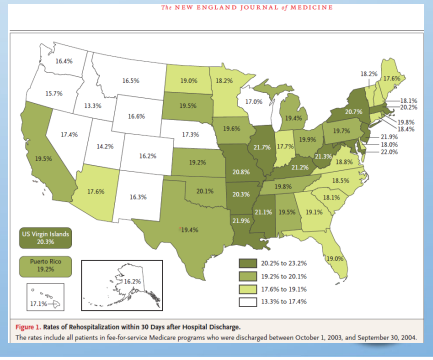
Identification of Expectation Gaps		
Patient	**Task**	**IDT**
3-5 days	**LOS**	14 days
Myself	**Toileting**	Needs assistance intermittingly
Need help	**Bathing**	Unsafe without assistance
Myself	**Dressing**	Needs assistance with lower extremities
Myself	**Meals**	Needs assistance to cook, needs someone to shop for food
Myself	**Medications**	Needs pill box filled then is independent
My kids will take me	**Transportation**	Kids work; may need ride service

- Early and active patient and family engagement
- Identification of expectation gaps
- Assessment of educational needs

WHAT ARE THE BENEFITS: VARIOUS KNOWLEDGE AND EXPERIENCE

(JENCKS, WILLIAMS, & COLEMAN, 2009)

- Each team member has a unique skill set and knowledge
  - Including community, health system, and health plan resources
- Each team member sees different aspects of a person including real and perceived barriers
  - Allows for a more comprehensive assessment of a person's needs and barriers to discharge
- Insures that a person and their family are more likely to have their educational needs met
  - Can lead to development and implementation of facility-wide tools like 'Who to Call, When to Call' educational materials
    - Leading to decrease ED use and readmissions



WHAT ARE THE BENEFITS: PATIENT OUTCOMES

- Improved patient and family satisfaction
  - Establish trust
  - Improved communication
- Improved outcomes
  - Decreased readmissions
  - Decreased ED use

WHAT ARE THE BENEFITS: INTERNALLY AND EXTERNALLY TO THE ORGANIZATION

(OFFICE OF INSPECTOR GENERAL, 2013; CENTER FOR MEDICARE ADVOCACY, INC., 2008)

- Improved communication among the IDT
  - Break down the silos
- Improved relationships with other providers
  - All providers are responsible for some of the same metrics
    - ED use
    - Readmissions
- Meet CMS requirements
  - Provide sufficient preparation and orientation to ensure safe and orderly transfer/discharge from the SNF
  - A 2013 OIG study found that in 2009, 31% of SNF stays did not meet discharge planning requirements
    - 16% did not meet the summary of the stay and discharge status
    - 23.3% did not met the post-discharge plan of care
    - Recommended increased citation

QUESTIONS

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