LTC Discharge and Transfer Requirements
OUTLINE

- Transitions of Care
- LTC Discharge and Transfer Documentation Requirements
- Intent of the Regulations
Understanding the Breakdowns and Impact of Ineffective Care Transitions
“Transitions of care” refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change. For example, a patient might receive care from a primary care physician or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she may receive care from a visiting nurse or support from a family member or friend.

However, these transitions are often complicated and result in negative outcomes for patients.
Breakdowns in Transitions of Care

• Communication Breakdowns. Care providers do not effectively or completely communicate important information among themselves, to the patient, or to those taking care of the patient at home in a timely fashion. The communication method – whether verbal, recorded, or written – is ineffective.
  • **Expectations** differ between senders and receivers of patients in transition
  • **Culture** does not promote successful hand-off (e.g., lack of teamwork and respect)
  • Inadequate amount of **time** provided for successful hand-off
  • Lack of **standardized procedures** in conducting successful hand-off, (e.g. use of SBAR)
Breakdowns in Transitions of Care

- **Patient Education Breakdowns.** Patients or family/friend caregivers sometimes receive conflicting recommendations, confusing medication regimens, and *unclear instructions* about follow-up care. Patients and caregivers are sometimes excluded from the planning related to the transition process. Patients may *lack a sufficient understanding of the medical condition or the plan or care*. As a result, they do not buy into the importance of following the care plan, or lack the knowledge or skills to do so.
Breakdowns in Transitions of Care

- Accountability Breakdowns. In many cases, there is no physician or clinical entity that takes responsibility to assure that the patient’s health care is coordinated across various settings and among different providers. Providers – especially when multiple specialists are involved – often fail to coordinate care or communicate effectively, which creates confusion for the patient and those responsible for transitioning the care of the patient to the next setting or provider. Primary care providers are sometimes not identified by name, and there is limited discharge planning and risk assessment. Steps are not taken to assure that sufficient knowledge and resources will be available – either at home or at the next setting – to the patient upon discharge.
Prevalence of Adverse Events

**22%** of Medicare Beneficiaries Experienced Adverse Events During a Post-Hospitalization SNF Stay in 2011

**11%** of Medicare Beneficiaries Experienced a Temporary Harm Event During a Post-Hospitalization SNF Stay in 2011

**60%** of These Events Were Likely Preventable
TRANSITIONS OF CARE

The Cost to Medicare

$28.4 Billion Total Medicare Payments Paid to SNFs in 2011 for Services Provided to 1.8 million beneficiaries

$4.4 Billion Yearly Cost of Adverse Events to the Medicare Program

15% of Medicare Costs are Associated with Adverse Events
Elements Recommended by The Joint Commission to Improve Care Transitions:

- Multidisciplinary Communication, Collaboration and Coordination from Admission through Transfer – Including Patient/Family Education
- Clinician Involvement and Shared Accountability During Transition
- Comprehensive Care Planning and Risk Assessment – Including Medication Reconciliation
- **Standardized Transition Plans, Procedures and Forms**
- Standardized Training for Clinical Staff
- Timely Follow-Up, Support and Coordination Post-Transition
- Root Cause Analysis When a Readmission Occurs
- Evaluation Compliance with Transition Process
DISCHARGE/TRANSFER DOCUMENTATION REQUIREMENTS

42 CFR 483.15.(c)(2)
When the facility transfers or discharges a resident under any permitted circumstance, the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider.

Documentation in the resident’s medical record must include the basis for the transfer/discharge:

• Documentation by the attending physician if the resident’s health status has improved or the resident is a danger to self
• Documentation by an affiliated physician if the resident is a danger to others
• If applicable – The specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)
Information provided to the receiving provider must include a minimum of the following:

- **Contact information** of the practitioner responsible for the care of the resident.
- Resident representative information including contact information, if applicable.
- All special instructions or precautions for ongoing care, as appropriate.
- Comprehensive care plan goals.
- All other necessary information, including a copy of the resident’s discharge summary (if return is not anticipated), and any other documentation, as applicable, to ensure a safe and effective transition of care.
DISCHARGE/TRANSFER DOCUMENTATION

REQUIREMENTS

Special Instructions may include:
• Treatments and devices (oxygen, implants, IVs, tubes/catheters)
• Precautions such as isolation or contact
• Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions

Other Necessary Information may include:
• Resident status, including baseline and current mental, behavioral, and functional status
• Reason for transfer
• Recent vital signs
• Diagnoses and allergies
• Medications (including when last received)
• Most recent relevant labs, other diagnostic tests, and recent immunizations
When return is not anticipated, the Discharge Summary must include:

- The resident’s disease diagnoses and health conditions
- Course of illness/treatment or therapy
- Medications
- Pertinent lab, radiology, consultation results
- Instructions or precautions for ongoing care
INTENT OF THE REGULATIONS

Surveyor Guidance
Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements. The transferring or discharging facility may transmit the information electronically in a secure manner which protects the resident’s privacy, as long as the receiving facility has the capacity to receive and use the information. Communication of this required information should occur as close as possible to the time of transfer or discharge.
INTENT OF THE REGULATIONS

Hospitalization Critical Element Pathway

Use this pathway for a resident who was hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.

Review the following in Advance to Guide Observations and Interviews:
- Review the most current comprehensive MDS/CAAs for Sections B – Hearing, Speech, and Functional Status, I – Active Diagnoses, J – Health Conditions-Pain, Falls, N – Medications, Programs.
- Physician’s orders (e.g., treatment prior to being hospitalized, meds, labs and other diagnostic current orders).
- Pertinent diagnoses.
- Relevant progress notes (e.g., physician, non-physician practitioner, and/or nursing notes) from the hospital, or request the previous medical record to review circumstances surrounding discharge.
- Care plan (e.g., symptom management and interventions to prevent re-hospitalization based assessment).

Observations:
- Is the resident exhibiting the same symptoms that sent the resident to the hospital? Is the resident displaying:
  - Physical distress;
  - Mental status changes;
  - A change in condition; and/or
  - Pain?
- Are care plans (e.g., hospitalization monitoring)?

Resident, Representative Interview, or Family Interview:
- Why were you sent to the hospital? Has your condition improved? If not, do you know why it’s not getting better?
- When did you start to feel different, sick, or have a change in condition?
- Do you feel staff responded as quickly as they could have when you had a change in condition?
- Has staff talked to family about your hospitalization?
- Has your health care team discussed this with your family?
- What things are specific to an individual’s condition?

Discharge Critical Element Pathway

Use this pathway for a resident that has been or is planning to be discharged to determine if facility practices are in place to ensure the resident’s discharge plan meets the needs of the resident.

Review the Following in Advance to Guide Observations and Interviews:
- Review the most current comprehensive and most recent quarterly (if the comprehensive isn’t the most recent) MDS/CAAs for Sections A – Discharge Status (A2100), C – Cognitive Patterns, G – Functional Status, and Q – Participation in Assessment and Goal Setting.
- Physician’s orders (e.g., medications, treatments, labs or other diagnostics, and the discharge order – planned or emergent).
- Pertinent diagnoses.
- Care plan (high-risk diagnoses, behavioral concerns, history of falls, injuries, medical errors, discharge planning to meet the resident’s needs including but not limited to resident education and rehabilitation, and caregiver support and education).

Observations:
- Does staff provide care for the resident as listed in the discharge plan? If not, what is different?
- How are staff providing education regarding care and treatments in the care plan?
- How does the resident perform tasks or demonstrate understanding after staff provides education?

Resident, Resident Representative, or Family Interview:
- What are your discharge plans?
- What has the facility discussed with you about returning to the community or transitioning to another care setting?
- Were you asked about your interest in receiving information regarding returning to the community? If not, are you interested in receiving information?
- What was your involvement in the development of your discharge plan?
- What has the facility talked to you about regarding post-discharge care?
- What was your overall experience with discharge planning?
- If discharge is planned:
  - How did the facility involve you in selecting the new location?
  - Did you have a trial visit, if feasible? How did it go?
  - How were your goals, choices, and treatment preferences taken into consideration?
  - What are your plans for post-discharge care (e.g., self-care, caregiver assistance)?
  - What information did the facility give you regarding your discharge (e.g., notice, final discharge plan)? Was it given? Was the information understandable; and
  - What discharge instructions (e.g., medications, rehab, durable medical equipment) were discussed?
QUESTIONS?

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