Care Transition from Hospital to Long Term Care: Why Advocacy is Critical

NCCNHR Annual Meeting

Friday, October 23, 2009

Hospital Discharge Planning

- Legal and Regulatory Requirements
- Joint Commission Requirements
- Interesting Cases—Simon Ben-Shlush

Hospital Conditions of Participation

- **“The written discharge planning process must reveal a thorough, clear, comprehensive process that is understood by the hospital staff.**
- **Adequate discharge planning is essential to the health and safety of all patients. Patients may suffer adverse health consequences upon discharge without benefit of appropriate planning. Such planning is vital to mapping a course of treatment aimed at minimizing the likelihood of having any patient rehospitalized for reasons that could have been prevented.”**
- **Next, “hospital must identify at an early stage all patients who are likely to suffer adverse consequences upon discharge if there is no adequate discharge planning”.**

Hospital Conditions of Participation

- **"The needs assessment can be formal or informal. A needs assessment generally includes an assessment of factors that impact on a patient's needs for care after discharge from the acute care setting. These may include assessment of biopsychosocial needs, the patient's and caregiver's understanding of discharge needs, and identification of post-hospital care resources.**
- **At the present time, there is no nationally accepted standard for the evaluation. The purpose of a discharge planning evaluation is to determine continuing care needs after the patient leaves the hospital setting. It is not intended to be a care-planning document. The hospital may develop an evaluation tool or protocol."**

Hospital Conditions of Participation

- **§482.43(b)(2) - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.**

Interpretive Guidelines §482.43(b)(2)

- The responsibility for discharge planning is often multidisciplinary. It is not restricted to a particular discipline. The hospital has flexibility in designating the responsibilities of the registered nurse, social worker, or other appropriate qualified personnel for discharge planning. The responsible personnel should have experience in discharge planning, knowledge of social and physical factors that affect functional status at discharge, and knowledge of community resources to meet post-discharge clinical and social needs.

Hospital Conditions of Participation

- **§482.43(b)(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.**

Interpretive Guidelines §482.43(b)(3)

- The hospital is responsible for developing the discharge plan for patients who need a plan and for arranging its initial implementation. The hospital's ability to meet discharge planning requirements is based on the following:
- Implementation of a needs assessment process with identified high risk criteria;
- Evidence of a complete, timely, and accurate assessment;
- Maintenance of a complete and accurate file on community-based services and facilities including long term care, sub acute care, home care or other appropriate levels of care to which patients can be referred; and
- Coordination of the discharge planning evaluation among various disciplines responsible for patient care.

Hospital Conditions of Participation

- **§482.43(b)(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.**

  Interpretive Guidelines §482.43(b)(4)
- The capacity for self-care includes the ability and willingness for such care. The choice of a continuing care provider depends on the self-care components, as well as, availability, willingness, and ability of family/caregivers and the availability of resources.
- The hospital must inform the patient or family as to their freedom to choose among providers of post-hospital care. Patient preferences should also be considered; however, preferences are not necessarily congruent with the capacity for self- care.
- Patients should be evaluated for return to the pre-hospital environment, but also should be offered a range of realistic options to consider for post-hospital care. This includes patients admitted to a hospital from a SNF, who should be evaluated to determine an appropriate discharge site.
- Hospital staff should incorporate information provided by the patient and/or caregivers to implement the process.

Hospital Conditions of Participation

- **§482.43(b)(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.**

Interpretive Guidelines §482.43(b)(6)

- The hospital must demonstrate its development of discharge plan evaluation for patients in need and then must discuss the results of the evaluation with the patient or individual acting on his/her behalf. Documentation of these activities is expected.
- The discharge plan evaluation is generally found in the clinical notes if there is no dedicated form. The hospital will be expected to document its decision about the need for a plan, document the existence of plans when needed, and indicate what steps were taken to implement the plans initially. Evidence of an ongoing evaluation of the discharge planning needs of the patient is the important factor.
- Documented evidence of discussion of the discharge planning evaluation with the patient, if possible, and interested persons should exist in the medical record. Although not mandated by this CoP, it is preferable that the hospital staff seek information from the patient and family to make the discharge planning evaluation as realistic and viable as possible.
- **The Patients' Rights CoP (§482.13) does provide the patient the right to participate in the development of their plan of care. Discharge planning is considered a part of the plan of care.**

Inadequate Discharge Planning and Patient Harm

- Medication Issues
- Patient Education
- Lack of Coordination in the Transition Process—community and institutional settings

Hospital Discharge Advocacy Demonstration Project

- Grant from PA Department of Aging
- Role of Advocate
- Coordination with LTC Ombudsman

Essential Elements of Discharge Process

- Education
- Advocacy
- Informed Consent
- Follow-up on pending results and scheduling of visits
- Communication

What is Neglectful Conduct?

- Neglect defined in civil context
- Discharge planning process

Goals of the Project

- To assist families and patients in their transition from the hospital to LTC setting
- To equip residents and family members with the tools to advocate for quality care
- To provide discharge planners with current “real-time” information pertaining to LTC settings
- To increase awareness of the LTC Ombudsman Program

Protocol:

- At the time of admission to LTC, social worker notifies Care Transition representative via telephone or email
- Care Transition representative contacts patient and or family to further explain role and function prior to discharge or after admission to a new care setting.

Role of Care Transition Representative:

- Advocate on behalf of elderly patients being discharged from hospital setting to long term care settings

Protocol:

- Establish rapport with consumer ASAP (via telephone contact and possibly hospital visit)
- Visit resident at new care setting
  - discuss care plan
  - provide educational counseling regarding advocacy around care plan and resident needs
  - provide information about the LTC Ombudsman program to ensure greater understanding of resident rights

Expected outcomes:

- Increased follow up during and after discharge to new care setting
- Enhanced information provided to consumers and their families
- Increased resident awareness of Ombudsman Program

Themes:

- Family/Patient Concerns
  - Swiftness of discharge
  - Lack of involvement in LOC decision
  - Pressure to agree to discharge plan
  - Lack of time to tour facilities

From our files:

- JR admitted to hospital for CP NH
  - JR's family did not want him to return to CP
  - JR was nevertheless discharged to CP pending family's ability to find a new place
- Issues at CP
  - No escort provided, as promised, to dialysis
  - Personal items stolen
  - Too many Nitro patches on at one time

From our files:

- Philadelphia man in his 60's with AIDS discharged from hospital to suburban nursing home
  - After 6 weeks sent to an unlicensed facility in Philadelphia to live in squalor
  - Two others were found at the home to have been discharged from the same nursing home

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