Setting the Stage:
Requirements and Need for NF Discharge Planning

Robin Wagner, Deputy Assistant Secretary
Office of Aging and Adult Services
Why this training....

• Discharge planning is required under state and federal law and regulation

• There is increased emphasis from the federal level on identifying and addressing resident need and desire for discharge

• More resources are becoming available, especially for people with mental illness
Discharge planning is important because...

- NF stays are shorter. More and more admits to NFs are being discharged -- and discharged sooner -- than before.

- Effective planning gives residents their best chance for successfully returning to the community.
What the data tells us...

62% of NH admits to Louisiana nursing homes discharge within 90 days

Of those who discharge within 90 days:
– 47% discharge back to the community
– 43% discharge to an acute care hospital
What the data tells us...(Cont’d)

• Individuals coming into nursing homes are younger than before
Age Distribution of Medicaid Nursing Home Residents (1999 vs 2013)
What the data tells us...(Cont’d)

Individuals are not being identified for discharge planning when they should be.

– Since 2010, when Section Q went into effect, we have had referrals from only 129 nursing homes – fewer than 50%.

– Fifty of the 129 have referred only one (1) person since 2010; 83 have referred 3 or less.
DHHS Office of Inspector General


• 31% of Medicare stays did not meet discharge planning requirements
  – 16% - no summary of stay and status at time of discharge
  – 23.3% - no post-discharge plan of care

Recommendation:

• Increase surveyor efforts to cite & sanction
Discharge Planning and the Survey Process

Cecile Castello, RN
DHH-Health Standards Section Director
What the Department expects...

• The Department’s expectations are set forth in regulatory requirements.

• The Department expects that staff will follow their professional and ethical standards.

• The Department expects that staff will provide needed assistance to adequately plan and prepare.
When do we check...

- Complaint investigations
- Standard surveys where evidence indicates that residents who should have been assisted to transition have not been assisted.
Regulatory Language Regarding Discharge Planning

Evelyn Frye, RN, BSN
DHH- Health Standards Section
Nursing Home Program Manager
F250 - Social Services

• The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

• INTENT of REQUIREMENT
  – To assure that sufficient and appropriate social services are provided to meet the resident’s needs.

Louisiana Department of Health and Hospitals
Discharge Planning Services

• Maintaining contact with family (with resident’s permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;

• Helping with arrangements
  o (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);
F204
Orientation for Transfer or Discharge

• A facility must provide
  – SUFFICIENT PREPARATION and
  – ORIENTATION
to residents to ensure safe and orderly transfer or discharge from the facility.
F204 – Sufficient Preparation

– “SUFFICIENT PREPARATION” means the facility:
  • informs the resident where he or she is going and takes steps under its control to assure safe transportation.
  • should actively involve, to the extent possible, the resident and the resident’s family in selecting the new residence.
EXAMPLES OF ORIENTATION:

• trial visits, if possible, by the resident to a new location;

• working with family to ask their assistance in assuring the resident that valued possessions are not left behind or lost;

• orienting staff in the receiving facility to resident’s daily patterns; and

• reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan.
F272 - Resident Assessment

– A facility must make a comprehensive assessment of a resident’s needs, using the *resident assessment instrument (RAI)* specified by the State. The assessment must include at least the following:
  • (xvi) Discharge potential.

“Discharge potential” refers to the facility’s expectation of discharging the resident from the facility within the next 3 months.
F283 - Requirement Discharge Summary

When the facility anticipates discharge a resident must have a discharge summary that includes:

(1) A recapitulation of the resident’s stay;

(2) A final summary of the resident’s status to include:

Medical history, current diagnosis/condition, medical status measurements, functional status, cognitive status, any impairments, nutritional status/requirements, drug therapy, special treatment, procedures, psychosocial status and rehabilitation potential at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

Louisiana Department of Health and Hospitals
Discharge Summary

• The Intent:
  – To ensure appropriate discharge planning and communication of necessary information to the continuing care provider.
F284 - Post-Discharge Plan of Care

• A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.
Post-Discharge Plan of Care

A “post-discharge plan of care” means the discharge planning process which includes:

• assessing continuing care needs and
• developing a plan designed to ensure the individual’s needs will be met after discharge from the facility into the community.

Applies to resident whom the facility discharges to a private residence, to another NF/SNF, or to another type of residential facility.
Involuntary Discharge Planning

• An involuntary discharge should be handled in the same manner as a routine discharge. It MUST be a planned process to assure that it is done in a safe & orderly manner.

• This type of discharge MUST be done in accordance with the established Federal & State Regulations. (See the requirements in the Standards for Payment.)
Health Standards Website

• Accessing the links for the Regulatory Guidelines i.e., Federal Regulations, Standards for Payment, Licensing Standards: GO to
Best Practices to Ensure a “Safe and Orderly” Discharge

Linda Sadden
DHH, OAAS
Question

When should you start discharge planning?

– A. Before the resident moves in
– B. The day the resident moves in
– C. After the 7 day assessment is complete
– D. After the care plan is complete
Answer

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What makes a plan a good plan?

• A good plan starts with a good assessment.
  – Evaluates strengths and needs
  – Multi-disciplinary
  – 24-hour routines

• A good assessment starts on Day 1 (or maybe before).

• A good plan is built around the resident’s goals and preferences.

• A good plan incorporates local resources.
Day 1 Questions

• Where did the resident live before they came to live with you?

• Who lived with them and why?

• Where will they live when they leave you?

• Who will live with them when they leave you?
Essential Areas

- Medical and Behavioral Health Needs
- Social Program Supports
What are the medical needs?

• Do they need disease management education?
  — Red flags
  — Health literacy of resident or caregiver
  — Competency checks

• Do they need help in knowing how to take their medication?

• Do they have a physician and an appointment for follow-up?

• Do they have a regular pharmacy?

• Do they need DMEs/assistive devices (e.g., pill minders)/personal emergency response systems?
What are the behavioral health needs?

• Is there a history of behavioral health issues?

• What is the source of that history?

• What does the resident need going forward?

NOTE: Documenting history including diagnosis and sources of diagnosis will be critical.
What social program & supports do they need?

• Are they Medicare or Medicaid eligible?

• Are they eligible for Veteran’s Administration Services?

• Are they SSI or SSDI eligible?

• Will they need food stamps? Utility assistance? Help with paying for medications?
What documents do they need?

• SS letter establishing income

• Picture ID

• Birth certificate
Follow-up!

• Have they bee in contact with new care provider?

• Have they experienced a decline?
Discharge planning is mostly easy!

Most residents will be going home and/or with family and need only basic discharge planning. In general, these residents/caregivers need to know:

• How to take their medications
• Who their new care provider will be
• How to get medical help if needed
Discharge planning for some is a little harder…

• Will they need help connecting to:
  – Social services?
  – Veterans services?
  – Older Americans Act Programs?

• Will they need help finding resources for home modifications or DME (e.g., ramps, grab bars)?
Special Needs of Renters

• Who is the landlord?

• What does the landlord need to keep the space available?

• Are there charitable organizations that can help?

• What about their belongings?
Aging and Disability Resource Centers (ADRCs)

ADRCs—a vital function of the Governor’s Office of Elderly Affairs—are a single point of access for information and assistance with unmet and long-term care needs for members of our community including:

• Older Adults - defined as 60 or older
• Adults who have adult-onset disabilities
• Families / friends / professionals seeking information on long term support services
Aging and Disability Resource Centers

For more information

Governor’s Office of Elderly Affairs
225-342-0171

www.louisianaanswers.com
Residents with Unsafe Situations

- Financial exploitation
- Caregiver neglect or abuse
- Self-neglect
Protective Services

• NH staff are mandated reporters.

• Seek confidentiality rather than anonymity.

• Err on the side of over-reporting.

• Call as soon as you suspect (vs. have proof of) abuse, neglect or exploitation.
Other Challenges

• Residents with a history of behavioral health issues

• Residents without stable housing
  – Individuals whose needs and/or caregiver situations have changed
  – Individuals with a history of homelessness
Discharge Planning & Behavioral Health Clients

Tara R. DeLee, LCSW
Louisiana Behavioral Health Partnership (LBHP)

A new way of delivering behavioral health services in Louisiana that increases access & coordination of services to Medicaid-funding for behavioral healthcare

• Basic package of behavioral health services for most Medicaid recipients
• Enhanced package of services for eligible recipients with Serious Mental Illness
• Uses Magellan at Statewide Management Organization (SMO) and point of access
Basic Package

Benefits for all LBHP members *including NF residents*

- **Mental Health**
  - Inpatient psychiatric hospitalization
  - Physician services (Medication Management visits with a Psychiatrist)
  - Outpatient therapy or counseling appointments

- **Substance abuse**
  - Intensive outpatient treatment programs
  - Individual Counseling and Group therapy
  - Detoxification services
  - Residential treatment services
Additional Services for SMI in the community

• State plan services often referred to as “1915i” or “1915i waiver”

• Requires an Independent Assessment (IA) to determine eligibility *(30 days prior to discharge)*

• Services:
  – Community Psychiatric Supports & Treatment (CPST)
  – Psychosocial Rehabilitation (PSR)
  – Assertive Community Treatment (ACT)
  – Crisis Intervention Services
For Dual Eligibles

- Dual-eligibles are also eligible for Mental Health Intensive Outpatient (IOP) services and Partial Hospitalization. This is not managed by Magellan, but Medicare pays the bulk and Magellan covers the co-payment after Medicare.
Accessing Services

• Accessing services
  – Go to www.magellanoflouisiana.com
  – Call Magellan at 1-800-424-4399 and talk to a member service representative
  – Discuss available options with an outpatient support specialist to find and make an appointment with a provider that is right for the resident.
Magellan Provider Search


Enter zip code to locate providers in your area.
Housing Resources

Tammy LeBlanc
Executive Management Officer
DHH, Office of Aging and Adult Services
Housing Resources

- **Louisiana Housing Search**: [http://www.lahousingsearch.org/](http://www.lahousingsearch.org/)
- **Permanent Supportive Housing**: 1-800-424-4461
- **Louisiana Governor’s Office of Elderly Affairs: Aging and Disability Resource Centers**
  - Louisiana Answers: [www.louisianaanswers.com](http://www.louisianaanswers.com)
A Homeless Coalition is a group of organizations committed to ending homelessness. They provide a variety of homeless services such as:

- Emergency Shelters
- Transitional Housing
- Housing Vouchers
- Behavioral Health Housing
How do I know what homeless services are offered in my region?

It is important to establish relationships with the local homeless coalition and the homeless agencies.

The best way is to join your local homeless coalition and attend meetings.
A Case Study: Mr. H

The nursing home was not prepared for discharge at 2pm when his transportation arrived. He (and his transportation) had to wait for the nurse on duty to give his meds at the 4 pm shift change. The SSD at the nursing home was not present. He did not have a wheelchair or walker. He had been trained on how to do insulin and glucose checks. There were no discharge orders for home health to aid in his diabetic care. Mr. H was sent home dirty and in torn pajamas to his new apartment.