Discharge Planning/
Transition of Care:
What’s Hot in the 20-teens
CMSANJ - July 24, 2014

Jackie Birmingham, RN, BSN, MS
VP, Emerita, Clinical Leadership
Curaspan Health Group
jbirmingham@curaspan.com
http://connect.curaspan.com
Introduction & Agenda

• Discharge planning was hot, then cool, now hot –
  • with a new name and closer alignment with other case management functions!

• Agenda:
  • What is still hot
  • Four Phases of Transition of Care
  • What CMs do in each phase

• Please note: This is not legal advice. It is current at the time of writing – and may/will change.
• Please work with your organization on any changes in practice
What is still HOT......Regulations

- **The Federal Rules & Statues ‘The Act’ (Social Security Act) (Congress)**
  - “Act of Congress’ (§482- Public Health)
- **The Conditions of Participation ‘COPs ‘ (CMS)**
  - Utilization Review
  - Discharge Planning
- **The Interpretive Guidelines ‘Igs’ (CMS Survey and Certification Group)**
  - Major revision 2013
  - Surveyor’s guide ‘rearranged’ (14 vs 24 sections)
  - More focus on ‘transition’
  - Blue Boxes- advisory
- **Latest (Rev. 116, 06-06-14)**
Transition Phases

1. Admission (UR)
2. Continued Stay (UR)
3. Discharge Planning (DP)
4. Post-Discharge-Phase (QA)
Transition: examples of topics for each phase

1. **Admission**
   a) Pre-admission (3 days)
   b) Admission (which level)
   c) 2 MN rule – going to be the 20 MN rule

2. **Continued stay**
   a) UR Conditions of Participation (Long Stay)
   b) Outlier status (Long Stay)

3. **Discharge**
   a) Conditions of Participation (Blue Boxes)
   b) 3 MN rule for Extended care benefits
   c) “No-bed available”
   d) Patient Choice
   e) Appeal process (IM)

4. **Post-Acute-Period**
   a) Collaboration with Providers across levels
   b) More blue boxes
   c) Readmission
1. Transition Phase: Admission

1. Admission (UR)
Pre-ADMISSION

- Pre-Admission – 3 days prior combined $$$$$
- What happens to the patient before admission
  - Combined costs with hospital charges
    - And 30 days after discharge
- How can you manage ‘pre-admission’
  - Make the correct ‘admission decision’
- Work with organizations that provide non-acute care
  - Who was (or was not) providing care prior?
• 2 MN rule = CHANGED/Changing

• ‘Certification’ now only applies to long stay (20 days)
  • “Hospital Outpatient Prospective Payment - Proposed Rule” –
    • CMS 1613-P (July 14, 2014)

• Changes to the physician certification requirements for hospital inpatient admissions:
  • the estimated time the patient will need to remain in the hospital,
  • and the plan of posthospital care (if applicable),
• Certification applicable to long-stay cases and outlier cases
BUT Hospitals **Must continue to** …

- Justify medically necessary admission
- Have a valid ‘admission order’
- Choose appropriate level of care
  - Inpatient
  - Observation
- Or ‘another level of care’ (Discharge)
- Follow EMTALA rules on “Patient Dumping”
  - Emergency Medical Treatment and Active Labor Act
Five ‘Other’ Reasons to watch the clock

- SNF- CB
- 3 Midnight Rule
- Hospital Census reporting
- Admission Rates
- Midnight not the time to Discharge
2. Transition Phase: **Continued Stay**

2. Continued Stay
   (Utilization Review)
Admission Decisions – Accountability - UR

- Ultimate accountability – Utilization Review Committee
  - The decision will follow the patient for the entire episode of care (aka ‘spell of illness’)
- Hospitals primarily engaged in providing, by or under the supervision of physicians, to inpatients
  - (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or
  - (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

Continued Stay *(after admission to inpatient)*

- Conditions of Participation (COP): Utilization Review –
  - The Committee
- The minutes of meetings
- The defense of decisions –
  - Criteria- InterQual, MCG, Legacy (home grown)
  - NCD- National Coverage Determination
- Parallel function with Discharge Planning
  - When continued stay no longer justified,
  - A discharge plan must be ready to be implemented
Utilization Review - Committee – Long Stays

• SOM Appendix A 06/06/2014 (page 320)
  • UR PLAN... “should also establish procedures for the review of the medical necessity of admissions, the appropriateness of the setting, the medical necessity of extended stays,”
  • “Review the minutes of the UR committee to verify that they include dates, members in attendance, extended stay reviews with approval or disapproval noted in a status report of any actions taken”.

§ 424.13 Requirements for inpatient services of hospitals other than psychiatric hospitals.
(a) Content of certification and recertification. Medicare Part A pays for inpatient hospital services of hospitals other than psychiatric hospitals only if a physician certifies and recertifies the following:
(1) The reasons for either—
   (i) Continued hospitalization of the patient for medical treatment or medically required inpatient diagnostic study; or
   (ii) Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of part 412 of this chapter).
(2) The estimated time the patient will need to remain in the hospital.
(3) The plans for posthospital care, if appropriate.

(b) Certification of need for hospitalization when a SNF bed is not available.
(1) A physician may certify or recertify need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF but no bed is available in a participating SNF.
(2) If this is the basis for the physician’s certification or recertification, the required statement must so indicate; and the physician is expected to continue efforts to place the patient in a participating SNF as soon as a bed becomes available.
3. Transition Phase: **Discharge Planning**
1. Screen All Patients
2. Evaluate for post-discharge needs
3. Develop a discharge plan
4. Initiate implementation of the plan
Step 1: Screen all patients

- **Policy** – plan screening for all patients
  - Surveyor will interview **Staff** and patients
- Not just ‘high risk’
  - If using high risk – how are others screened?
- If from ‘other’ level of care – prior to admission
  - Especially 3 days prior
- What went wrong?
  - SNF readmission? – could that have been avoided
  - HHA readmission? – was that the correct level of care
- Admission Assessment done by nurses is critical
Step 2: Evaluate for post discharge needs

- Not ‘continued stay review’-
- Predict functional needs-
- Patient’s capacity for self care
- Return to same environment
  - If not – why not?
- Short term
- Patient history
  - of readmission
  - return to ED without admission
Step 3: Develop a discharge plan

- Plan based on medical and social needs of the patient
- Multidisciplinary team
  - Discharge COP assigned to the Hospital
  - Not to one department
  - Not to the physician writing the order
- Right to appeal or refuse
Work with Post-Acute-Providers

Never been more important to collaborate

• The plan for post-acute care is ‘complex’

• Work with Liaison staff
  • But have a policy

• Send appropriate information – ahead of time
  • Meaningful Use of medical information

• Don’t need consent to send information!
  • HIPPA Title II: Discharge Planning is a ‘treatment’
  • Unless your hospital policy so states
Patient Choice

• You may be the ‘messenger’ – but it is a real message
  • Accountable Care Organizations, Patient Centered Medical Homes
  • Waived programs to support community discharge
• Choice: Among appropriate and available post-acute providers
• Limit choice to ‘real options’: Available, appropriate, timing
  • August 11, 2004 Federal Register page 49227

“Our intent is to provide patients with real options. We would not expect that the patient be given an exhaustive list of SNFs with no available beds. The intent is to provide patients and their families with information in order to make informed decisions.”
“Plans for Posthospital care”

• The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.
  • (b) Certification of need for hospitalization when a SNF bed is not available.

• the physician is expected to continue efforts to place the patient in a participating SNF as soon as a bed becomes available.

• BUT – the hospital is responsible for ‘discharge planning’

3 MN Rule for SNF

• In order to qualify for post-hospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days.

• In addition, effective December 5, 1980, the individual must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in §20.2 applies.

➤ 20.1 - Three-Day Prior Hospitalization: (Rev. 183, 04-04-14)

• The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, **but not the day of discharge**, is counted as a hospital inpatient day.

No bed available: References


- http://www.ecfr.gov/cgi-bin/text-idx?SID=2ca82308b2479d75a86dde8b08446b03&node=42:3.0.1.1.11.2.5.3&rgn=div8
• Surveyor's Work Sheets: Advice –
  • In the document – in Blue Boxes
• “Not Required/Not to be Cited”

1. Do discharge planning for ‘outpatients’ (observation), emergency department;
2. Develop discharge policies with input from Medical staff & facilities that provide after-care;
3. If patient refuses discharge planning – document;
Step 4: Initiate implementation of the plan

1. Plan reasonable, attainable;
2. patient choice -preference when possible;
3. No delay in discharge due to discharge planning;
4. Do not refer to a SNF because it is easier.
Appeal Discharge: The ‘IM’

A revision (not new!) 2007
Part of Financial Liability Protections
- In same chapter as Beneficiary Notice Initiative
  - HINNs (Hospital Issue Notices of Non-coverage)
- Patient’s rights to be notified of their discharge and a right to appeal the discharge.
- The delivery of the follow-up copy is still being monitored
Change in QIO 11th SOW (splitting functions)

- CMS is changing the way it contracts with Quality Improvement Organizations (QIO) August 1, 2014
- Intro of QIN (Quality Innovation Network)
- BFCC QIO (Beneficiary and Family Centered Care)
  - all beneficiary complaints and quality of care reviews
- Contracts known as – SOW (Scope of Work)
  - Bases of the change: COI ‘conflict of interest’
  - SOW x 3 years = in place 30 years
  - 11th SOW -
Now two distinct sections of the QIO

1. **“QIN”** Quality Innovation Network
   - will conduct ‘traditional quality improvement projects.

2. **BFCC/QIO** (Beneficiary and Family Centered Care QIO).
   - “Case review and monitoring activities separate from the traditional quality improvement activities of the QIOs.”
   - “They will be responsible for ensuring consistency in the review process with consideration of local factors important to beneficiaries.”

http://www.hqsi.org/index/QIO-Transition.html
What isn’t changing: The “IM”

- “The Important Message” or the Detailed Message Form.
- These notices remain unchanged from the 07/10 approved versions and are effective until 7/31/2016
4. Transition Phase:

Post Discharge Period
More Advisory Boxes – Interpretive Guidelines

• **The discharge plan does not stop at discharge**
  • Schedule follow-up appointments
    • Who, with whom, when, how?
  • Filling prescriptions prior to discharge
    • Who pays, renewals?
• Arrange remote monitoring technologies
  • Telemedicine, specialty systems
• Follow-up phone calls
  • Who, how does this fit with others?
  • How do you find time?
  • WHAT do you do with the information?
Post-Discharge Period

- Hospitals have a strong interest in what happens to patients after discharge
  - Outreach – call after discharge
  - Readmission
  - Patient Experience of Care
  - Efficiency Score (MSPB) VBP
  - Collaboration with PAPs the most important factor in a successful transition
Birds-eye view: Transition Phases

1. Admission (UR)
   - What level for admission?
   - Can patient be discharged?

2. Continued Stay (UR)
   - No bed available?
   - Prove it!!!! Did patient appeal?

3. Discharge Planning (DP)
   - Is the patient referred or transferred to the ‘best’ match?
   - Is the next provider getting meaningful info?
   - “MU2”-

4. Post-Discharge Period (QA)
   - Did the patient get a call after discharge?
   - “Is plan working”?
Summary..... THANK YOU!

1. What you do in one setting follows the patient and family to other settings!
2. Discharge Planning and Utilization Review are ‘logical’: They are based on what Case Managers do.
3. The hospital revenue cycle is dependent on what you do to facilitate a safe, effective transition of patients.
4. You must find a way to monitor changes in rules since this also changes how your organization is paid.
5. YOU make a difference in how transition happens!!! Transition of care is important to patients and their families!!!!