NAPSA NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

Discharge Planning: Guidance for Adult Protective Services Programs

NAPSA Webinar
May 23, 2018

Presenters

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Topics To Be Covered

- Discharge Planning Defined
- Common Discharge Planning Issues Faced By APS Workers
- How is the Process *Supposed* To Work?
- Suggested APS Best Practices

Discharge Planning Defined

Discharge Planning is a process involving the transition of a patient's care from one level to the next.

Discharge Planning Involves:

- Determining the appropriate post-hospital discharge destination for a patient;
- Identifying what the patient requires for a smooth and safe transition from an acute care hospital/post acute care facility to his or her discharge destination;

Discharge Planning Defined (cont'd)

- Beginning the process of meeting the patient's identified pre-and post-discharge needs.
- The discharge process must be thorough, clear, comprehensive and understood by hospital/facility staff, as well as the patient and/or the patient's representative.

(Federal Center for Medicare & Medicaid Services (CMS) CMS Medicare Learning Network, *Discharge Planning,* Oct 2014)

Common Discharge Planning Issues Faced by APS

- Discharge to the community for a patient that needs assisted living or nursing home care.
- Home care denial of admission or a determination to discharge a “difficult to serve” adult
- Discharge to the community of a person with a developmental disability who needs specialized, supported residential care.

Common Discharge Planning Issues Faced by APS (cont'd)

- A vulnerable adult who wants to (or whose spouse/family wants the adult to) return home or to a lower than needed level of care, i.e.:
  - ✓The home supports are insufficient to meet the needs, address the risks or monitor an unstable medical situation
  - ✓When home services are refused or when the home environment is in poor condition or hazardous

Common Discharge Planning Issues Faced by APS (cont'd)

- An APS client who experiences multiple unsuccessful discharges, resulting in overuse of the ER, trashing of motels or shelters, and non-compliance with residence rules.

How Is the Process *Supposed* To Work?

To better assist their clients to receive the discharge planning services and the appeals rights they are entitled to, APS workers need to know how the discharge planning system is *supposed* to work.

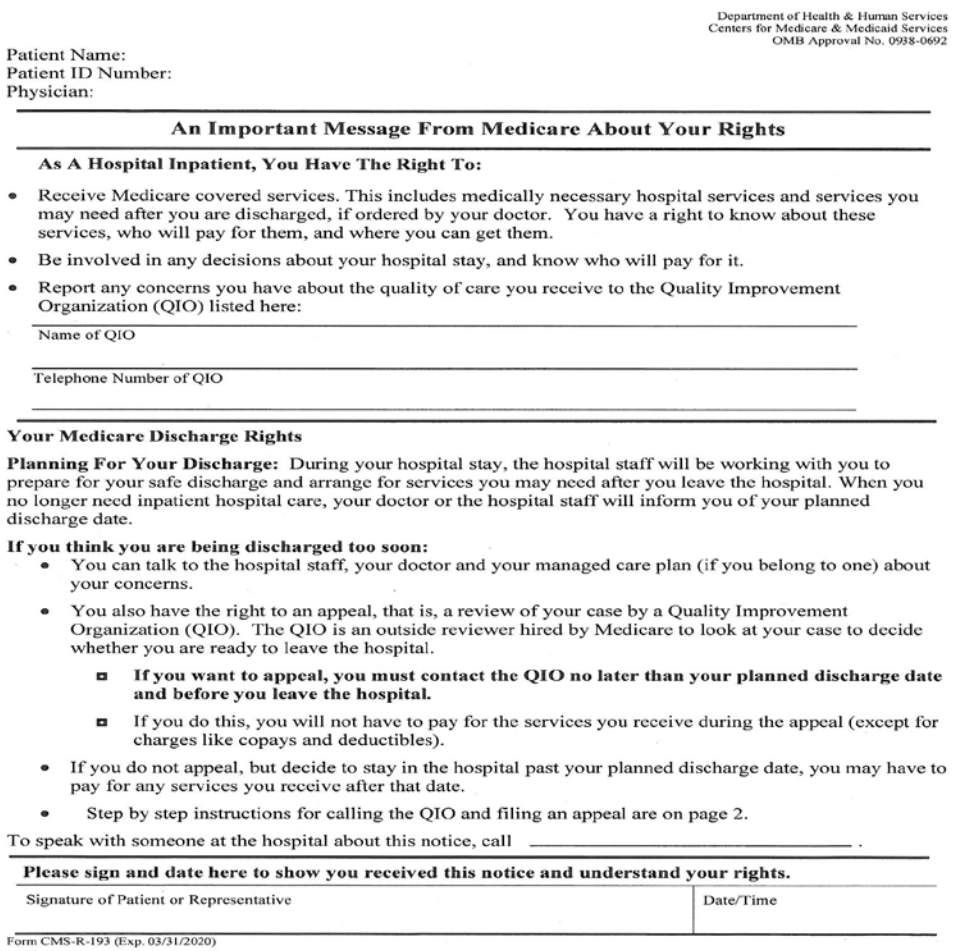
How Is the Process *Supposed* To Work? (cont'd)

HOSPITALS

Medicare:

- Hospital is required to provide on admission, a notice: "An Important Message From Medicare" which informs hospitalized in-patient beneficiaries of their hospital discharge appeal rights.
- Beneficiaries who appeal a discharge decision must receive the "Detailed Notice of Discharge"

How Is the Process *Supposed* To Work? (cont'd)



Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

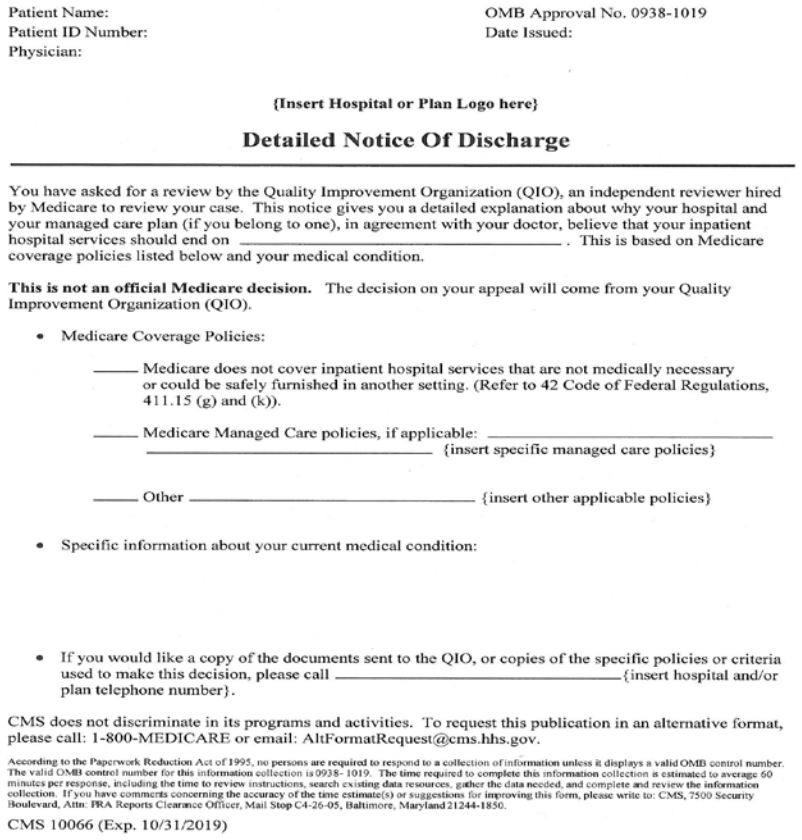
- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call _____ .

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date/Time

Form CMS-R-193 (Exp. 03/31/2020)



Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:

{Insert Hospital or Plan Logo here}

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____ . This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  _____ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  _____ Medicare Managed Care policies, if applicable: _____ _____ {insert specific managed care policies}

  _____ Other _____ {insert other applicable policies}

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call _____ {insert hospital and/or plan telephone number}.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10066 (Exp. 10/31/2019)

How Is the Process *Supposed* To Work? (cont'd)

Federal CMS guidance states the discharge planning process includes:

- Implementing a complete, timely and accurate discharge planning evaluation process, including identification of high risk criteria;
- Maintaining a complete and accurate list of appropriate community-based services, supports, and facilities where the patient can be transferred or referred;

How Is the Process *Supposed* To Work? (cont'd)

- Providing notification to patients that they may request a discharge planning evaluation;
- Completion by appropriate qualified personnel of discharge planning evaluations for every patient identified at potential risk of adverse health consequences without an adequate discharge plan, or if the patient, the patient's representative or attending physician requests such evaluation;

How Is the Process *Supposed* To Work? (cont'd)

- A discharge planning evaluation in the client's medical record. The evaluation considers the patient's care needs immediately upon discharge and whether the needs are expected to remain constant, lessen or worsen over time. It identifies appropriate and available after-acute care services, support and facilities.

How Is the Process *Supposed* To Work? (cont'd)

- Evaluation to include, for persons who may need such services, availability of home health services and of post-hospital extended care/rehabilitation services through participating Medicare providers serving the area in which the patient resides.

How Is the Process *Supposed* To Work? (cont'd)

- Offering the patient a range of realistic options to consider for after-acute care, depending on
  - ✓A pharmacist's assessment of the patient's medication compliance and treatment;
  - ✓The patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he/she entered the hospital;
  - ✓The patient's preferences and goals, as applicable;
  - ✓And the availability, willingness and ability of family/caregivers to provide care.

How Is the Process *Supposed* To Work? (cont'd)

The results of the discharge planning evaluation must be discussed with the patient (or patient's representative)

How Is the Process *Supposed* To Work? (cont'd)

- Providing education to the patient, the patient's family/caregivers and community providers about the patient's post-hospital needs. They must provide information and written and verbal instructions for the patient's care.
- Providing a notice that advises that a patient has a right to request a review of the discharge decision, by asking for an expedited review by a Quality Improvement Organization (QIO) when the hospital determines that in-patient care is no longer necessary.

How Is the Process *Supposed* To Work? (cont'd)

- The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

  45 CFR 482.45 (c) (4)

How Is the Process *Supposed* To Work? (cont'd)

For more information on Medicare appeals rights, visit

https://www.medicare.gov/publications to view **Medicare Appeals**

See Also Your Discharge Planning Checklist: For Patients and Their Caregivers Preparing To Leave A Hospital, Nursing Home or Other Care Setting

https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf

Federal Statute & Regulations on Hospital Discharge Planning for Medicare Beneficiaries

Statute: 42 U.S. Code Section 1395x (ee)

Regulations: Title 42 Code of Federal Regulations (CFR) Section 482.43

Federal Regulations On Skilled Nursing Fcilities (Nursing Homes) Discharge Planning for Medicare Beneficiaries

Title 42 Code of Federal Regulations (CFR) Section 483.15 (Admission, Transfer and Discharge Rights); see also 42 CFR Section 483.21 (c) (Comprehensive person-centered care planning; Discharge planning)

Federal Regulations on Home Health Patient Rights Agencies

Title 42 Code of Federal Regulations (CFR) Section 484.10 (Conditions of Participation: Patient Rights) for Medicare Beneficiaries

Additional State Laws and Policies

It is important to know whether there are additional laws or policies governing discharge in your own State. These could include, among other things, required procedures for hospital/facilities to follow regarding:

- Rights to participate in discharge planning;
- Appeals rights;
- Documentation to be issued/maintained in the client case record.

Suggested APS Best Practices

- Know the rules regarding discharge planning and appeals so you can be in a position to provide support to clients and their families/representatives where appropriate
- Consider issuance of written guidance to APS, shared with hospitals and facilities stating that **discharge to APS, in the absence of other necessary services, does not constitute an acceptable discharge plan.**

Suggested APS Best Practices (cont'd)

PLEASE NOTE: Hospital Discharge Planning Protections Do NOT Apply for:

- Patients in "Observation Status" – even if they have been hospitalized overnight! They are not considered "admitted" patients or in-patients.
- Patients treated only in the Emergency Room/Emergency Department and not admitted as an in-patient.

Suggested APS Best Practices (cont'd)

Things to Consider When A Hospital Or Facility Refers a Patient/Resident to APS:

- The hospital/facility must provide information to APS, which leads APS to conclude the client will be returning to the community upon discharge and that the client may be eligible for APS upon such return to the community.
  - ✓To determine this, APS needs to receive all pertinent information regarding the patient's medical, cognitive and social condition.

Suggested APS Best Practices (cont'd)

- An APS assessment of a patient in a hospital/facility should be conducted in close cooperation with discharge planning staff. The APS assessment should place special emphasis on the client's physical environment and the degree to which client's support systems will be able to meet client's needs upon discharge.
- Even though APS may conduct assessment, nothing diminishes the hospital/facility's primary responsibility for discharge planning set forth in federal and state laws.

Suggested APS Best Practices (cont'd)

- The hospital/facility retains responsibility for accessing all necessary post hospital/facility services, such as personal and home health services, prior to the patient's discharge.
- APS does not accept primary case management responsibility for the patient/resident until discharge and return to community.
- Remember: Patients/residents have a right to self-determination in choosing or agreeing to a discharge plan. A person who insists on returning to a dangerous home environment upon discharge is free to do so unless it is determined that the person lacks capacity to make and understand decisions related to his/her care.

Suggested APS Best Practices (cont'd)

- If capacity is in question, seek a psychiatric evaluation before the person is discharged, focusing on:
  - ✓Ability to make and express choices about decisions
  - ✓Ability to provide reasons for these choices
  - ✓Ability to make choices based in reality
  - ✓Ability to understand/appreciate the potentially harmful consequences of his/her course of action
- If a determination is made that patient/resident is not presently able to make care-related decisions and that patient/resident will be at risk of harm upon discharge, the hospital/facility must act to prevent or delay the discharge, in accordance with law.

Suggested APS Best Practices (cont'd)

- If determination is made that the patient/resident does have decision-making capacity, the hospital/facility and APS have no choice but to allow the person to return to the community.
- It is good practice to enter into agreements with hospitals/facilities setting forth respective roles and responsibilities of APS and hospital/facilities for persons facing discharge, some states have provided APS with models of such agreements.

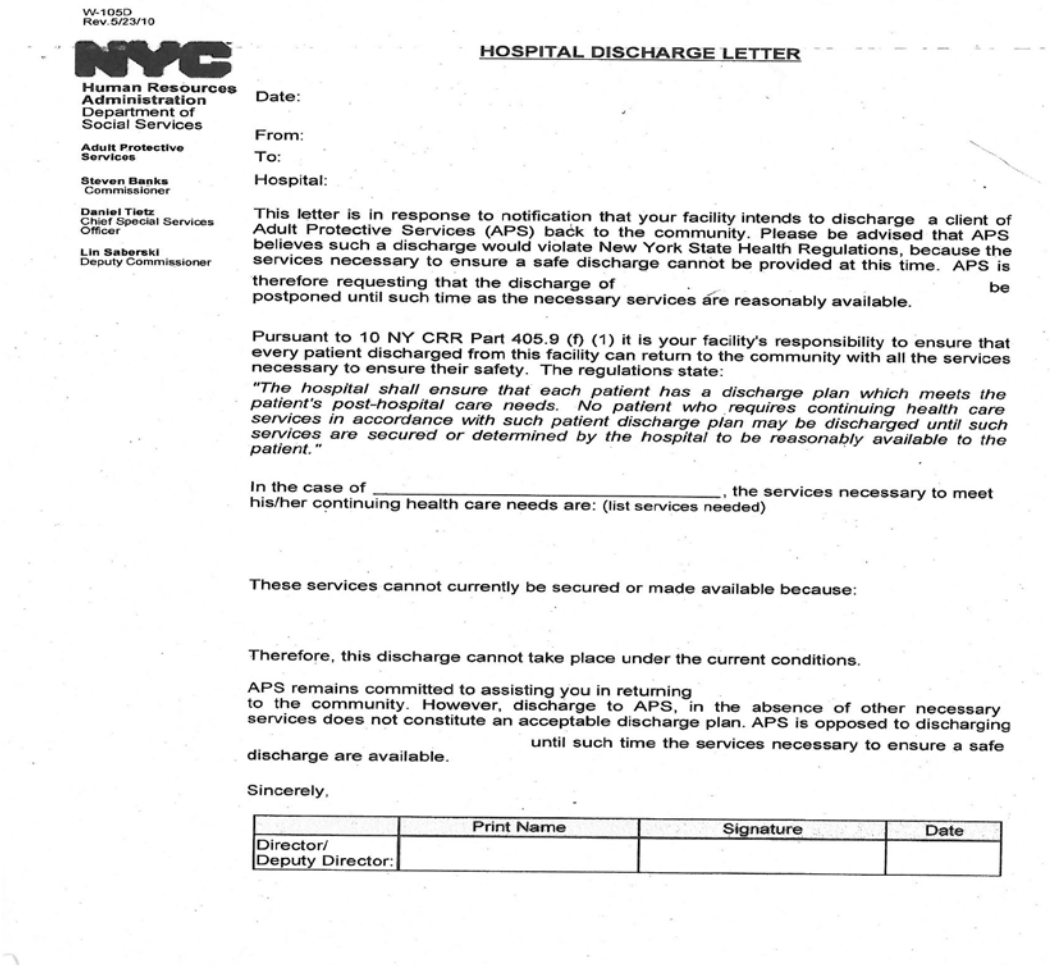
Suggested APS Best Practices (cont'd)

- Some APS units (e.g. New York City APS) have developed **standard letters** to send to hospitals or facilities in cases where APS clients receive notification that they will soon be discharged and where APS believes that discharge would not be safe and would not conform to applicable law.
  - ✓In appropriate cases, APS sends a letter to the hospital/facility requesting discharge be postponed until such time necessary services are reasonably available.
  - ✓Cites applicable discharge regulations.

Suggested APS Best Practices (cont'd)

- ✓Lists services necessary to meet continuing health needs, and states that these services have not been made available.
- ✓Also states: "Discharge to APS, in the absence of other necessary services, does not constitute an acceptable discharge plan. APS is opposed to discharging the patient/resident at this time, until such time as the services necessary to ensure a safe discharge plan are available."

Suggested APS Best Practices (cont'd)



W-105D
Rev.5/23/10

NYC

Human Resources Administration
Department of Social Services

Adult Protective Services

Steven Banks
Commissioner

Daniel Tietz
Chief Special Services Officer

Lin Saberski
Deputy Commissioner

HOSPITAL DISCHARGE LETTER

Date:

From:

To:

Hospital:

This letter is in response to notification that your facility intends to discharge a client of Adult Protective Services (APS) back to the community. Please be advised that APS believes such a discharge would violate New York State Health Regulations, because the services necessary to ensure a safe discharge cannot be provided at this time. APS is therefore requesting that the discharge of be postponed until such time as the necessary services are reasonably available.

Pursuant to 10 NY CRR Part 405.9 (f) (1) it is your facility's responsibility to ensure that every patient discharged from this facility can return to the community with all the services necessary to ensure their safety. The regulations state:

"The hospital shall ensure that each patient has a discharge plan which meets the patient's post-hospital care needs. No patient who requires continuing health care services in accordance with such patient discharge plan may be discharged until such services are secured or determined by the hospital to be reasonably available to the patient."

In the case of _____, the services necessary to meet his/her continuing health care needs are: (list services needed)

These services cannot currently be secured or made available because:

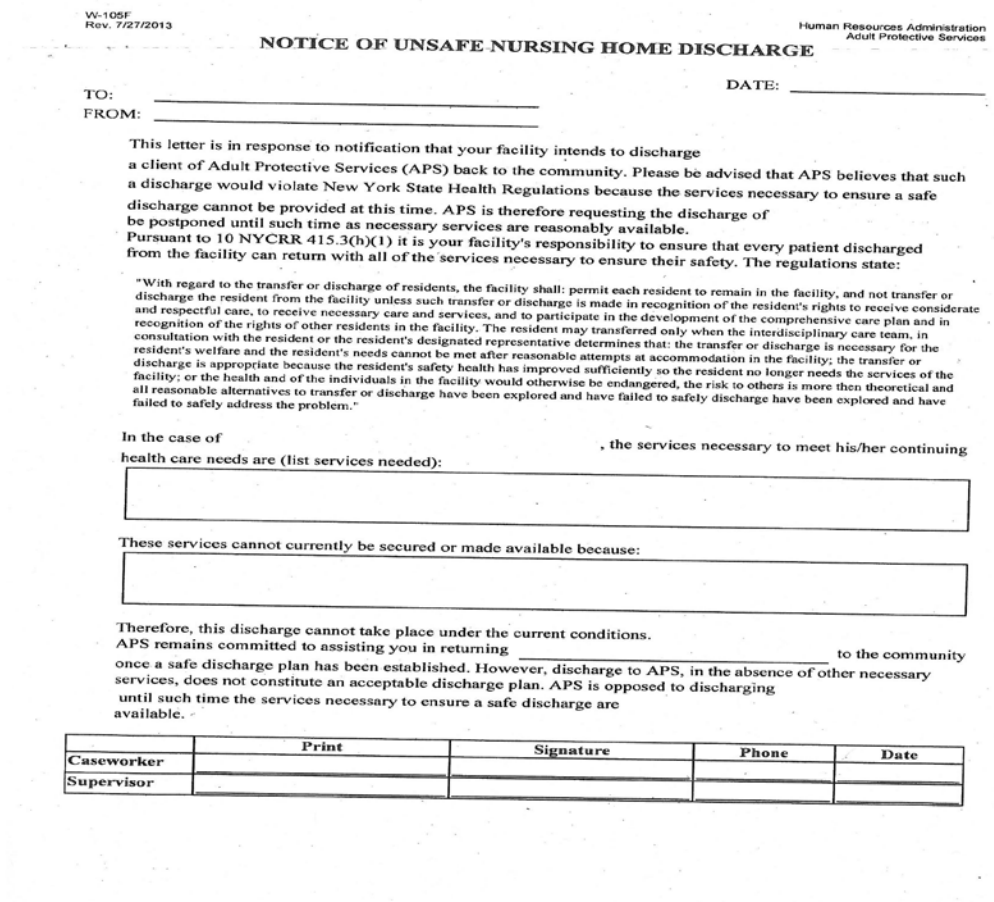
Therefore, this discharge cannot take place under the current conditions.

APS remains committed to assisting you in returning to the community. However, discharge to APS, in the absence of other necessary services does not constitute an acceptable discharge plan. APS is opposed to discharging until such time the services necessary to ensure a safe discharge are available.

Sincerely,

	Print Name	Signature	Date
Director/ Deputy Director:			

Suggested APS Best Practices (cont'd)



W-105F
Rev. 7/27/2013

Human Resources Administration
Adult Protective Services

NOTICE OF UNSAFE NURSING HOME DISCHARGE

DATE: _____

TO: _____

FROM: _____

This letter is in response to notification that your facility intends to discharge a client of Adult Protective Services (APS) back to the community. Please be advised that APS believes that such a discharge would violate New York State Health Regulations because the services necessary to ensure a safe discharge cannot be provided at this time. APS is therefore requesting the discharge of _____ be postponed until such time as necessary services are reasonably available.

Pursuant to 10 NYCRR 415.3(h)(1) it is your facility's responsibility to ensure that every patient discharged from the facility can return with all of the services necessary to ensure their safety. The regulations state:

"With regard to the transfer or discharge of residents, the facility shall: permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless such transfer or discharge is made in recognition of the resident's rights to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility. The resident may transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative determines that: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation in the facility; the transfer or discharge is appropriate because the resident's safety health has improved sufficiently so the resident no longer needs the services of the facility; or the health and of the individuals in the facility would otherwise be endangered, the risk to others is more then theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely discharge have been explored and have failed to safely address the problem."

In the case of _____, the services necessary to meet his/her continuing health care needs are (list services needed):

These services cannot currently be secured or made available because:

Therefore, this discharge cannot take place under the current conditions. APS remains committed to assisting you in returning _____ to the community once a safe discharge plan has been established. However, discharge to APS, in the absence of other necessary services, does not constitute an acceptable discharge plan. APS is opposed to discharging _____ until such time the services necessary to ensure a safe discharge are available.

	Print	Signature	Phone	Date
Caseworker				
Supervisor				

Suggested APS Best Practices (cont'd)

See sample NYC letters at: http://www.napsa-now.org/SAMPLEDischargeLetter

Suggested APS Best Practices (cont'd)

- Patients or someone on their behalf need to communicate to hospital/facility what resources they have at home.
  - ✓Type of housing
  - ✓Transportation needs
  - ✓Assistance with activities of daily living
  - ✓Social supports available

It is extremely important that patients or someone on their behalf communicate with the physicians, nurses and discharge staff about concerns about inappropriate discharge.

New York: Discharge Planning Workgroup

Our State agency, NYS Office of Children & Family Services, together with several local APS units, the NYS Department of Health and several other state, local, public and private providers, and consumer advocates, participated in this workgroup.

The workgroup sought to develop tools for discharge planners and consumers addressing:

- Safety
- Discharge Planner Education and
- Consumer Education

New York: Discharge Planning Workgroup (cont'd)

"Safety Concerns That Impact An Individual Wishing to Live in the Community"

"Key Elements for Effective and Safe Discharge Planning to Facilitate An Individual's Right to Choose"

http://www.health.ny.gov/professionals/patients/discharge_planning/discharge/discharge_safety.htm

New York: Discharge Planning Workgroup (cont'd)

"What the Discharge Planner Needs to Know in Order to Effect a Safe and Efficient Transition"

http://www.health.ny.gov/professionals/patients/discharge_planning/discharge_checklist.htm

New York: Discharge Planning Workgroup (cont'd)

"What Consumers and Their Families Need to Know Before Being Discharged to Home Care"

"What Consumers Need to Know About Their Abilities and Responsibilities"

http://www.health.nygov/professionals/patients/discharge_planning/discharge_consumter.htm

New York: Discharge Planning Workgroup (cont'd)

A subcommittee of the Workgroup was created for discussion of actual Complex Cases involving discharge/transition issues involving multiple systems of care.

Questions???? Comments???

Thank you!

Alan.Lawitz@ocfs.ny.gov

Deborah.Greenfield@ocfs.ny.gov