

DISCHARGE PLANNING FOR APS WORKERS



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Topics To Be Covered:



- ❧ Discharge Planning Issues Faced By APS Workers and their clients
 - ❧ Hospital
 - ❧ Home Care
 - ❧ Other Settings
- ❧ How the Discharge Process is *Supposed* to Work
- ❧ Strategies Used and Tools Developed by APS and their Community Partners To Seek Safe and Appropriate Discharges



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

Common Discharge Planning Issues Faced By APS



- ❧ “Discharge to APS” without a safe discharge plan, without adequate review of the health/behavioral health and social needs of the individual once discharged. For example:
 - ❧ Hospital discharge of patient who needs nursing home care;
 - ❧ Home care denial of admission or determination to discharge a “difficult to serve” adult;
 - ❧ DD institution discharge of DD client who needs specialized supported residential care

Common Discharge Planning Issues Faced By APS



- ❧ A vulnerable adult who wants (or whose spouse/family want) to return home or to a lower level of care, when APS or others fear the adult or other household members are unable to handle adult's care needs or monitor unstable medical situation. Situation is exacerbated when offered home services are refused, or when living environment is in poor condition or hazardous.
- ❧ The APS client who has been unsuccessful with multiple discharges in the past, resulting in: overuse of the ER, trashing of motels or shelters, noncompliance with residence rules.
- ❧ Assisting residents of licensed residential facilities who become inappropriate for retention due to physical/cognitive impairments.

Issues include: identifying appropriate placements in areas with few vacancies, especially if there are challenging behaviors as well as health/supervision needs; the need to provide for the immediate needs of the resident, which may include having to bring in additional care and/or staffing; legal challenges by licensed operators and/or residents and their families to the request by regulatory authority to relocate.

How is the Discharge Process *Supposed to Work?*



❧ HOSPITALS

Medicare:

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

How is the Discharge Process Supposed to Work?



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).

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 C9-26-05, Baltimore, Maryland 21244-1850.

CMS 10066 (approved 07/10)

Patient Name: _____
Patient ID Number: _____
Physician: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB Approval No. 0938-0602

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 _____

Form CMS-R-133 (approved 03/01)

New York



“Your Rights as a Hospital Patient in New York State”

http://www.health.ny.gov/publications/1449/Section_1.htm

New York



If You Think You Are Being Asked to leave the Hospital Too Soon. . . .

You have the right to appeal decisions made by your doctor, hospital staff or your managed care plan:

- About when you are to leave the hospital;
- If you feel your are being asked to leave the hospital too soon;
- If you believe you have not been given adequate or appropriate plans for your medical care and other services you may need after you leave the hospital; or
- If needed services are not in place.

New York



The law requires that you receive advance notice **in writing** telling you:

- The date the physician and/or hospital plans to discharge you;
- How to appeal if you wish to remain in the hospital; and
- A special number to call with any problems related to leaving the hospital.

New York



For Assistance/Help

There is an Independent Professional Review Agent (IPRA) for your area and your insurance coverage. Should you need assistance/help from the IPRA, the hospital will provide you with a phone number/person to contact.

New York



For Medicare Patients Only

If you feel you are being asked to leave the hospital too soon and have not received advance notice telling you when to leave the hospital, ask for your discharge notice (called “The Important Message from Medicare about Your Rights”). If you are in a Healthcare Maintenance Organization (HMO), you should also request “The Important Message From Medicare About Your Rights.” You must have this written discharge notice in order to appeal the physician’s and hospital’s decision about when you are to leave. See an “Important Message From Medicare About Your Rights” for a complete explanation.

New York



For Managed Care Patients

If you are a patient enrolled in an HMO or managed care plan, first request/submit an expedited appeal to the HMO or plan's utilization review committee if you feel your benefits are unfairly limited or denied, or if you are being asked to leave the hospital too soon, or that medically necessary services are inappropriately excluded from your coverage. If you are not satisfied with the outcome of that appeal request, you may contact the New York State Department of Health by calling: **1-800-206-8125**.

New York



NYS Department of Health Hospital Admission Notice Regarding Discharge Planning Requirements

Before you are discharged, you must receive a written Discharge Notice and Discharge Plan.

You or your representative have the right to be involved in your discharge planning.

You may not be discharged until the services required in your Discharge Plan are secured or determined to be reasonably available.

If you do not agree with the Discharge Plan or believe the services needed are not “reasonably available” you may file a complaint with the NYS Department of Health to investigate your complaint and the safety of your discharge. You may also appeal the written discharge plan or notice you receive from the hospital. The notice will say who to call and how to appeal.

New York



You have the right to:

- Receive all the hospital care that you need for the treatment of your illness or injury – your discharge date is determined only by your health care needs, not by hospital reimbursement or insurance;
- Be fully informed about decisions affecting your care and insurance coverage;
- Designate a representative.

10 NYCRR section 405.9 (b) (14)

New York



Hospital Discharge Planning Protections Do NOT Apply for:

- Patients in “Observation Status” – even if they have been hospitalized for one or more nights! They are not considered “admitted” patients.
- Patients treated in the Emergency Room/Emergency Department

New York



What Patients Need to Do

Patients (or someone on their behalf) need to communicate to hospital 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 initiate the appeal process as soon as possible if they feel the discharge plan is inappropriate.

New York



What Hospital Needs to Do

If such services are needed, include in the Discharge Plan a list of home health agencies, assisted living and skilled nursing facilities that are available to patients in their geographic area.

Before Discharging Patient:

- Check insurance coverage (Medicare, Medicaid, Private Pay, Managed Care)
- Work with plans; use networks and obtain approvals. It is very important that discharge planning begins as soon as possible following the patient's admission.

New York



CERTIFIED HOME HEALTH AGENCIES (CHHA)

CHHAs are a form of home care certified by the New York State Department of Health. They can provide part time intermittent health care and support services to individuals who need intermediate and skilled health care. They can also provide long term nursing and home health care and other services including physical, occupational, and speech therapy, medical supplies and equipment, and social work and nutritional services. CHHA services may be reimbursed by Medicare, Medicaid, private pay and some health insurance.

New York



Admission to home care is based on a comprehensive assessment conducted in the patient's home by a nurse prior to or at the start of care. Needs are identified and a plan of care is developed.

A patient shall be admitted when such assessment indicates the patient's health and supportive needs can be met safely and adequately at home and that the patient's condition requires the agency's services.

New York



Determining whether patient's needs can be met safely at home

Patient must meet at least one of the following criteria:

- Is self-directing
- Is able to call for help
- Can be left alone
- Has informal or other community supports who are willing, able and available to provide care and services for patient in addition to services provided by the agency.

New York



Denial of Admission to a CHHA

The CHHA is not required to admit when:

- Patients who do not meet health and safety criteria
- Conditions exist in or around home that would imminently threaten the safety of personnel
- Agency has valid reason to believe that agency personnel will be subjected to verbal abuse which jeopardizes the agency's ability to secure personnel or provide care to meet patient's needs
- Based on previous experience with the agency, it is known that the patient repeatedly refused to comply with a plan of care or others interfered with patient's ability to comply, and such non-compliance will lead to an immediate deterioration in the patient's condition serious enough so that home care is no longer safe and appropriate or makes attainment of reasonable therapeutic goals impossible and puts patient at risk.

New York



Referral to APS “Difficult to Serve” Patients When CHHA Determines to Deny

At the time determination is made to deny admission based on criteria above, the CHHA must determine whether the patient appears eligible for APS services. If so, CHHA must make referral to APS, indicating patient’s care needs and the reason for the decision not to admit.

If APS accepts the referral, takes action to address the problems preventing admission and notifies the CHHA that such problems have been resolved, the CHHA must reassess the patient to determine whether admission has become appropriate.

10 NYCRR section 763.5 (c)

New York



For patients assessed or reassessed as inappropriate:

Such patients shall be assisted by the CHHA, in collaboration with the discharge planner, the local social services department and other case management providers, as appropriate, with obtaining the services of an alternate provider. If no alternate provider is immediately available, and the local APS, MH or DD agency requests that home care be provided on an interim basis, the agency may provide home care services which minimally address essential patient health and safety needs, for an agreed upon time period.

10 NYCRR section 763.5 (d)

New York



Discharge of CHHA Patients

A discharge plan shall be initiated prior to agency discharge to assure a timely, safe and appropriate transition for the patient.

Patient may be discharged only after consultation, as appropriate, with: the patient, the patient's authorized practitioner, family or informal support, any legally authorized patient representative and any other professional personnel, including any other case manager involved in the plan of care.

New York



Discharge Shall Be Appropriate When:

- Therapeutic goals have been attained;
- Conditions in the home imminently threaten safety of personnel or jeopardize agency's ability to provide care;
- All agency services are terminated by patient;
- The patient, patient's family, patient's informal supports or legally designated representative is non-compliant or interferes with the plan of care, resulting in immediate deterioration in the patient's condition serious enough that home care is no longer safe or appropriate, or has made attainment of reasonable therapeutic goals at home impossible, and the noncompliance/interference continues even after an attempt has been made to explain the likely outcome of such actions.

New York



Referral to APS When CHHA Determines to Discharge Patient

If patient is to be discharged based on criteria above and the agency believes there will continue to be substantial risk to the patient's health and safety subsequent to discharge, a referral must be made to APS or other official agency, as appropriate, at the time discharge determination is made.

If APS or other official agency accepts the referral, takes action to address adequately the problems leading to the discharge determination and notifies the home care agency that such problems have been resolved, the agency shall reassess the patient and determine whether to readmit the patient.

If the agency determines not that the patient's health care needs can no longer be safely met at home, the agency must still continue to provide home care services, but only to the extent necessary to address minimally essential patient health and safety needs until an alternate placement becomes available, and such placement is made or the patient/patient representative made an informed choice to refuse such placement.

10 NYCRR section 763.5(g) (h) (i)

New York



Strategies Used and Tools Developed By APS and Community Partners To Seek Safe and Appropriate Discharges

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 the Discharge Planning Workgroup. They sought to develop tools for discharge planners and consumers addressing:

- Safety
- Discharge Planner Education and
- Consumer Education

New York



Discharge Planning Workgroup

Workgroup participants developed the following tools to assist discharge planners, consumers and service providers:

1. Safety Consideration, including: **“Safety Concerns that Impact an Individual Wishing to Live in the Community”** and **“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_safety.htm

New York



2. **“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
3. **Consumer Information Guide to Discharge Planning, including “What Consumers and Their Families Need to Know Before Being Discharged to Home Care” and “What Consumers Need to Know About Their Abilities and Responsibilities”**
http://www.health.ny.gov/professionals/patients/discharge_planning/discharge_consumer.htm

New York



4. A “**Suggested Model for Transitional Care Planning**” including an Initial Discharge Screen, High Risk Screening Criteria, and criteria for Comprehensive Assessment. A flow chart is included.

[http://www.health.ny.gov/professionals/patients/
discharge_planning/discharge_transition.htm](http://www.health.ny.gov/professionals/patients/discharge_planning/discharge_transition.htm)

New York



Discharge Planning Workgroup

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

New York



NYC APS Standard Letters relating to Discharge Issues:

Hospital Discharge Letter

Letter in response to notification that hospital intends to discharge an APS client back to the community. States that APS believes such a discharge would violate NYS Health regulations because the services necessary to ensure a safe discharge cannot be provided at this time. APS therefore requests that the discharge be postponed until such time as the necessary services are reasonably available. Cites regulation. Lists the services that are necessary to meet patient's continuing health needs and state why these services cannot currently be secured or made available. 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 until such time as the services necessary to ensure a safe discharge are available."

Notice of Unsafe Nursing Home Discharge

Similar to Hospital Discharge letter but citing NY nursing home discharge regulations

Texas



Nursing Home Discharge

Nursing homes must provide the resident, resident's guardian, family representative, or responsible party with a written notice of discharge at least 30 calendar days before discharge, including eviction, unless the health or safety of the resident or other individuals in the facility are endangered and more immediate discharge is necessary.

The discharge notice must include specific information, including:

- reasons for discharge;
- effective date of the discharge;
- the location to which the resident will be discharged; and
- information regarding the resident's right to appeal the discharge.

DADS Rules, 40 TAC [§19.502\(e\),\(f\)](#) [External Link](#)

Texas



❧ Nursing Home planning

As part of the discharge process, the nursing home must also develop a post-discharge plan of care with the participation of the resident, resident's guardian, family member, or responsible party to assist the resident in adjusting to his or her new environment after discharge.

DADS Rules, 40 TAC §19.803(a)(3)[External Link](#)

Texas



APS assists in NH Discharge

- ❧ If we placed them there or convinced them to go as part of service plan.
- ❧ Discharge home is appropriate, but conditions in the home would put them in a state of a/n/e (they need a ramp for example).
- ❧ They have capacity and are choosing to discharge to a state of a/n/e

APS does not assist when

- ❧ Eviction is for non-payment, but they are eligible for a different placement (we are not bill collectors)
- ❧ Individual with capacity refuses discharge planning, but is not returning to a state of a/n/e
- ❧ Nursing home can't find adequate alternative placement.

Texas



Home Health/Provider Care

Due to fierce competition in the supply of services, these are rarely a discharge issue for APS clients in Texas. We simply link the client with an alternate provider.

If all alternatives have been exhausted, this usually results in a placement, either voluntary or involuntary depending upon the individual's capacity and the danger.

Texas



Hospital Discharge

Hospitals are required by law to address any known ongoing needs patients have before discharge.

Such needs include appropriate:

- discharge planning; and
- community referrals.

Texas



APS assists with Hospital discharge

- ❧ We placed them there under a legal order
- ❧ We convinced them to go to hospital in lieu of seeking legal intervention

APS does not assist

- ❧ The only need is long term care placement
 - ❧ Pay source is an issue
 - ❧ Decision making is a barrier
 - ❧ High needs make placement difficult.

Texas







☞ Reality

- ☞ We rely on these partners all the time, sometimes it pays to be helpful.
- ☞ We expend a lot of energy on Community Engagement, educating our partners at NHs, Hospitals, and Home Health agencies.
- ☞ We have a formalized process for making appropriate referrals to licensing and regulatory bodies when we believe discharge requirements are being ignored.
- ☞ At the end of the day, if the client is “on the street”, they belong to us, discharge plan or not.

Oregon



Nursing Facility Discharge

-  Nursing Facilities are required by law to do discharge planning, which includes a post-discharge plan of care. The facility post discharge plan will identify another environment and support available to the resident that is appropriate to meet the resident's needs.
-  Oregon law states that Nursing Facilities give the resident 30 days notice before a move, most of the time. A notice of transfer may be issued at the time of admission or later and must be based upon the projected course of treatment.
-  If a resident does not agree to be discharged, s/he can make a Request for Hearing/Meeting with DHS. The request can be made by filling out a form, or by simply letting a staff member know that they want to have a meeting about the discharge.
-  OAR 411, Division 88

Oregon



❧ Discharge Planners are Mandatory Reporters

1. In Oregon, Discharge Planners must report to APS any concerns regarding the possible abuse, neglect, and self neglect of residents.
ORS 124.050-124.095
2. Discharge Planners must report to APS when a resident leaves the facility against medical advice (AMA) and will be at risk as a result.
3. APS Investigators will respond to concerns about the state of the resident's home conditions after the resident has returned to the home.

Oregon



❧ The Discharge Planner's Toolbox Includes:

- ❧ 1. APS, when the client is being abused, neglected, or possibly self neglecting.
- ❧ 2. Home Health or other visiting health professionals. These visiting professionals are mandatory reporters, and will contact APS if they suspect abuse, neglect, or self neglect.
- ❧ 3. Case Managers – private and Medicaid
- ❧ 4. Multnomah County Transition and Diversion Team
- ❧ 5. Public Guardian's office in Multnomah County
- ❧ 6. ACHP Vacancy Specialist
- ❧ 7. Multnomah County – Risk/Outreach Case Manager- new APS position
- ❧ 8. A number of community partners