9-29-2015 Weekly Clinical Update

Again, based on survey results, let's talk Discharge Planning this week. It's more than a regulatory requirement, but rather it is vital to the residents' care processes. It requires precision, empathy, and coordination (a LOT of coordination) …even if the resident doesn't intend to leave the facility. It must include safety, continuity, and especially dignity, BUT it also has to meet regulatory requirements including "person-centered" locus of care principles. Discharge planning is a continuous process that reflects the facility's commitment to quality, compliance and compassion. It should reflect strength to the residents and caregivers rather than stress! Feel free to use this document as a checklist for discharge planning to ensure all components are covered in each resident's care plan.

Starting with the regulatory requirements, CMS mandates that discharge planning is included in both the 48-hour baseline care plan and the comprehensive care plan. Requirements include:

- Resident and family involvement in decisions about discharges…in fact, the care plan should include, "Resident's stated plan for discharge is _____." After all, it IS the resident's discharge plan, not the facility's. There are times when the resident's desires for discharge aren't based in "reality", but it is still VITAL to include what the resident's goals for discharge are. Then include the feasibility of that plan and interventions to assist the resident and family to adjust to the reality of needed cares/services.
- The Discharge Plan must include an assessment of post-discharge needs including:
    - Medical
    - Behavioral
    - Social supports
    - Health equity and trauma-informed transitions
        - Screening for housing instability, food insecurity, caregiver support and possible burnout
        - Offer culturally responsive materials and translation services as needed
        - Avoid abrupt or punitive discharges that could re-traumatize residents
- Coordination with receiving providers to ensure a seamless transition, even if the resident is continuing care in the facility on a permanent basis but on a different unit or with a different payor source.

- Documentation of identified risks and mitigation strategies including and especially for “involuntary”, or “facility-initiated” discharges

So, what is included in a comprehensive & effective discharge plan?:

- Pre-discharge assessment including but not limited to:
  - Physical, cognitive, and psychosocial status
  - Durable Medical Equipment, meds, and follow-up care identified:
    - Specific needs
    - By whom
    - When provided
    - Where provided
  - Screen for behavioral health needs and trauma-informed supports identified
- Resident and family engagement and active participation
  - Use AND DOCUMENT teach-back methods to confirm understanding
  - Offer visual aids or QR-coded video summaries of care routines
  - Provide contact sheets for emergency, community resources, and advocacy
    - Include name, phone number, email addresses, & what services provided by each contact
    - Follow up in 1 week to ensure understanding and determine additional assistance needed
- Interdisciplinary Collaboration
  - Departments involved should include:
    - Physician
    - Pharmacy
    - Lab/Radiology
    - Nursing
    - Social Services
    - Therapy
    - Dietary
    - Transportation services
  - Consider tools to capture preferences and care instructions
  - Document discharge readiness in documentation and care conference notes
- Post-Discharge Coordination
  - Confirm appointments, transportation & medication access
  - Share Discharge Summary with receiving providers

- Follow up within 72 hours to assess adjustment and prevent rehospitalization