Q0400: Discharge Plan

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?

0. **No**
1. **Yes** → Skip to Q0610, Referral

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to a resident's health and quality of life.
- For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with LCA experts about returning to the community. Community resources and supports exist that may benefit these residents and allow them to return to a community setting.
- Being discharged from the nursing home without adequate discharge planning occurring (planning and implementation of a plan before discharge) could result in the resident's decline and increase the chances for re-hospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.

Q0400: Discharge Plan (cont.)

Planning for Care

- Many nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to community resources.
- The care plan should include the name and contact information of a primary care provider chosen by the resident, family, significant other, guardian or legally authorized representative, arrangements for durable medical equipment (if needed), formal and informal supports that will be available, the person*(*s*)* and provider(s) in the community who will meet the resident's needs, and the place the resident is going to be living.
- Each situation is unique to the resident, *their* family, and/or guardian/legally authorized representative. A referral to the LCA may be appropriate for many individuals, who could be maintained in the community homes of their choice for long periods of time, depending on the residential setting and support services available. For example, a referral to the LCA may be appropriate for some individuals with Alzheimer's disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The interdisciplinary team should not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available.
- Discharge instructions should include at a minimum:
  - the individuals preferences and needs for care and supports;
    - personal identification and contact information, including Advance Directives;
    - contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;
    - brief medical history;
    - current medications, treatments, therapies, and allergies;
    - arrangements for durable medical equipment;
    - arrangements for housing;
    - arrangements for transportation to follow-up appointments; and
    - contact information at the nursing home if a problem arises during discharge
  - A follow-up appointment with the designated primary care provider in the community and other specialists (as appropriate).
  - Medication education.
  - Prevention and disease management education, focusing especially on warning symptoms for when to call the doctor.
  - Who to call in case of an emergency or if symptoms of decline occur.
  - Nursing *home (NH)* procedures and discharge planning for sub-acute and rehabilitation community discharges are most often well-defined and efficient.

Q0400: Discharge Plan (cont.)

— Section Q has broadened the scope of the traditional boundary of discharge planning for sub-acute residents to encompass long stay residents. In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, transportation, employment if desired, and social engagement opportunities.

- Asking the resident and family about whether they want to talk to someone about a return to the community gives the resident voice and respects *their* wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts.
- The *NH* is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with providing information regarding community-based services and, when appropriate, transition services planning. The nursing facility interdisciplinary team and the LCA should work closely together. The LCA is the entity that does the community support planning, (e.g., housing, home modification, setting up a household, transportation, community inclusion planning, etc.). A referral to the LCA may come from the nursing facility by phone, by e-mails or by a state's on-line/website or by other state-approved processes. Each state has a process for referral to an LCA, and it is vital to know the process in your state and for your facility. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process.
- Each NH needs to develop relationships with their LCAs to work with them to contact the resident and their family, guardian or significant others concerning a potential return to the community. A thorough review of medical, psychological, functional, and financial information is necessary in order to assess what each individual resident needs and whether or not there are sufficient community resources and finances to support a transition to the community.
- Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are more readily available *than in the recent past*. Resource availability and eligibility coverage varies across States and local communities.
- Should a planned relocation not occur, it might create stress and disappointment for the resident and family that will require support and nursing home care planning interventions. However, a referral should not be avoided based upon facility staff judgment of potential discharge success or failure. It is the resident's right to be provided information if requested and to receive care in the most integrated setting.

Q0400: Discharge Plan (cont.)

- Involve community mental health resources (as appropriate) to ensure that the resident has support and active coping skills that will help *them* to readjust to community living.
- Use teach-back methods to ensure that the resident understands all of the factors associated with *their* discharge.
- For additional guidance, see CMS' **Your Discharge *Planning C*hecklist*: F*or patients and *their* caregivers preparing to leave a hospital, nursing home, or other care setting**. Available at https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf.

Steps for Assessment

1. A review should be conducted of the care plan, the *clinical* record, and clinician progress notes, including but not limited to nursing, physician, social services, and therapy to consider the resident's discharge planning needs.
2. If the resident is unable to communicate *their* preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other or guardian, as designated by the individual.
3. Record the resident's expectations as expressed/communicated, whether *NH staff believe* that they are realistic or not realistic.
4. The resident, *their* interdisciplinary team, and LCA (when a referral has been made) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance).
5. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes).
6. A determination of family involvement, capability and support after discharge should also be made. However, support from the family is not always necessary for a discharge to take place.

DEFINITION

ACTIVE DISCHARGE PLANNING

*An **active** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future.*

*If there is not an **active** discharge plan, residents should be asked if they want to talk to someone about community living (Q0500B) and then referred to the LCA accordingly. Furthermore, referrals to the LCA are recommended as part of many residents' discharge plans. Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.*

Q0400: Discharge Plan (cont.)

Coding Instructions for Q0400A, Is *a*ctive *d*ischarge planning already occurring for the *r*esident to *r*eturn to the *c*ommunity?

- **Code 0, No:** if there is not active discharge planning already occurring for the resident to return to the community.
- **Code 1, Yes:** if there is active discharge planning already occurring for the resident to return to the community.