MDS Alert

MDS 3.0: Ready to Ramp Up Discharge Planning Under Section Q?

This one simple strategy can help reduce rehospitalization.

The MDS 3.0's Section Q spells out more in-depth discharge planning requirements than the MDS 2.0 version. And now's the time to think through how your facility is going to meet those demands.

The regulatory reality: "The discharge planning and documentation requirements have always been in the survey process" as part of the State Operations Manual, Appendix PP, observes **Rena Shephard, MHA, RN, RAC-MT, C-NE.** The requirements just haven't "been connected like this to the RAI manual before," says Shephard, president and CEO of RRS Healthcare Consulting Services in San Diego.

Section Q will be a change for nursing facilities, predicts **Marilyn Mines, RN, RAC-CT, BC.** She sees many interim care plans relating to discharge, "but they don't indicate the specifics" spelled out in the MDS 3.0, says Mines, manager of clinical services for FR&R HealthcareConsulting in Deerfield, Ill.

Follow This 3-Pronged Plan

You can make considerable headway in meeting the discharge planning requirements by focusing on these key strategies:

1: Nail down the Key Elements of the Discharge Process. As part of the assessment process for discharge,the facility should evaluate the site to determine "the safety of the resident's surroundings and the need for assistive/adaptive devices, medical supplies, and equipment," advises the MDS 3.0 RAI User's Manual.

"The resident, interdisciplinary team, and local community agency(when a referral has been made to a local community contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker,meal preparation, ADL assistance, transportation, prescription assistance) and make appropriate referrals,"advises the manual. (For more information about making a referral to a local community contact agency when the Return to Community Referral Care Area Assessment (CAA) triggers, see MDS Alert, Vol. 8, No. 6.)

Also assess the resident's eligibility for financial assistance. Look at various funding sources, advises the manual, "e.g., private funds, family assistance, Medicaid, long-term care insurance, prior to discharge to determine where the resident will go (home, assisted living, board and care, group living)." In addition, determine if the resident will have family involvement and support after she is discharged.

Don't miss: The manual alsooutlines what discharge instructions should include (see the next page).

2. Assess Home Setup. Doing pre-discharge home visits can help you identify scenarios where a resident may not be safe in the home and what he needs in order to function there. Rehab therapists can, for example, make home visits reimbursable under Part A and Part B, notes **Elisa Bovee, MS, OTR/L,**director of education and training for Harmony Healthcare International in Topsfield, Mass. (for more information on this approach, see the article on page 42).

Example: Christine Twombly, RNC, once insisted on physical therapy doing a home evaluation for a nursing home resident. She went along, as well. "The family said they had [accommodations set up for the resident], but what they had was a shed with a bed and commode" and no heat. "That's where the resident was going to live," says Twombly, with Reingruber & Co. in St. Petersburg, Fla.

Use a triage approach: Most facilities aren't going to have the resources to do non-reimbursable home visits on all residents. You can, however, make visits to the homes of higher risk residents, says **David Farrell, a** long-term-care

CPT® 2023 American Medical Association. All rights reserved.

administrator for California-based SNF Management. Examples include "a resident who doesn't have anyone or a caregiver who seems frail or may be contributing to the person's alcoholism," says Farrell. "Or you see the resident has a history of having Adult Protective Services involved." In such cases, "we'd have a [facility] social worker do a home visit."

What if the caregiver, such as a spouse, appears incapable of taking on the caregiving task? "You have to be realistic and tell them how at risk they may be," Farrell advises.

Tips: Farrell's facility has the social worker call discharged residents 24 hours after discharge to see how they are doing. "We make sure the person is safe, has his/her meds, and home health showed up, etc." The calls not only prove to be "an excellent customer service strategy," but they also reduce hospital readmissions. "If the person does have a problem, oftentimes it's minor and something you can handle over the phone," says Farrell. The discharge process happens so quickly, residents or their caregivers sometimes don't capture all of the information. "Within 24 hours, however, they may have more questions, usually about their medications," Farrell observes.

"Community volunteers could help make minor alterations to help people function better in their homes," says **Barbara Frank,** a consultant in Warren, R.I. Examples include "changing the height of counters or shelves so that people can reach what they need," she adds.

"If a church, for example, were to adopt a nursing home and send volunteers into a person's home to identify how to help people function better -- that would probably help prevent a lot of returns to the hospital," Frank advises.

3. Document What You've Done to Facilitate a Safe Discharge. "Document the discussions you've had with the resident/family [about discharge planning] and the services in place," advises attorney **Meg Pekarske**, with Reinhart Boerner Van Deuren in Madison, Wis. In some cases, you may have to look at competency issues in terms of whether the person is capable of making a choice to go home, Pekarske adds.

"States have made changes to elderly abuse laws so that some laws include self-neglect." If the person isn't competent to make a choice to return home, "activate the power of attorney document or, if none exists, have the family pursue guardianship," Pekarske advises.

CPT® 2023 American Medical Association. All rights reserved.