THE 5 THINGS EVERY SNF SHOULD KNOW ABOUT DISCHARGE PLANNING.
The 5 things every SNF should know about discharge planning.

The walls between the worlds of acute and post-acute care can alternately be viewed as thin as tissue or thick as reinforced concrete. Until recently, precious little attention has been paid to that narrow window of time when people move from hospital to nursing home. In so many cases, it is as critical a time as any human can experience in their often difficult passage from one level of care to another.

For one brief moment in time, this patient is the center of the universe to scores of professionals whose jobs intersect with them all too briefly and in literally hundreds of equally impersonal and intimate ways.

For most, it is a 24-72-hour period of utter chaos, disorientation and confusion. And that's just the patients' view.

But for skilled nursing facilities, whose roles during these handoffs are coming under exponentially greater scrutiny than ever before, understanding the discharge planning process on the front end can make a world of difference in the middle and back end of their time with these charges.

In so doing, nursing homes and other post-acute settings can avoid costly adverse medical events and unanticipated rehospitalizations, which now threaten to hurt their Five Star ratings and level of reimbursement because of new purchasing models and regulatory changes.

Here are five important things every skilled nursing facility needs to know about the hospital discharge planning process.

1. Critical patient information is often missing or incomplete.

According to the Institute for the Advancement of Senior Care, be prepared to be at a communication disadvantage from the start. SNFs must often accept patients with diagnoses that are incomplete or missing (often for days and even weeks). They also have virtually no control on deciding what information is shared and often find themselves admitting patients lacking key information, hindering their ability to fully understand their status, needed supplies, or how to even conduct meaningful conversations with other key providers.

“Timeliness and accuracy of information are what concerns me the most,” says Suresh Vishnubhatla, executive vice president of long-term care operations at PharMerica, a leading long-term care pharmacy services provider that recently conducted a study of patient discharges between hospitals and nursing homes. “Someone shows up at 8 o'clock at night and by the time the nurse is done with initial logistics issues like getting the patient settled and sending the pharmacy orders, it might be 10 PM. By the time you get the orders, dispense and have a driver deliver the medications to the facility, it could be 2 in the morning.”

As difficult as it is for caregivers, it’s even worse for patients and families. “What if that patient is a heart patient?” he adds. “There are medications they have to take and protocols to be followed and when there are delays in that, are you compromising care? The answer is yes.”
Nursing homes are left asking themselves if they used the right information to make critical decisions, or provided it in a timely and accurate way to downstream providers like their pharmacy, lab, and the patient’s physician, he adds.

Improvements can be achieved through interoperability.

“Systems in the SNF and the hospital are not tied together, but they need to be so we can move this information from one place to another without having to rely on faxes and phone calls and emails going back and forth,” adds Vishnubhatla. And an offsite pharmacist or doctor shouldn’t be surprised to find the referring hospital never closed out records on their end, leaving them to wonder if the patient ever made it to the nursing home in the first place. “So the triggers that will let the technology push the information to the appropriate sources are not pulled in a timely fashion,” he says. “You have no idea how much time it can take to tap into this spigot of information. It takes forever in technology speak. It’s not because of the challenges of technology. It’s just the bureaucracy. “

2. Communication is most critical during the first 24–48 hours.

“Poor communication during transitions from one care setting to another can lead to confusion about the patient’s condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis, and lack of follow through on referrals,” notes Stratis Health in a transitions success report it issued in April 2015. (Stratis Health is a Bloomington, MN-based nonprofit organization that leads collaboration and innovation in health care quality and safety.)

Nowhere is that confusion felt more acutely than among friends and relatives.

“There’s a behavioral aspect here we should not ignore,” observes Vishnubhatla. “Admitting patients can be a stressful thing for nursing staff. They’re trying to get them situated in their room, making them comfortable, arranging for something to eat, all the while telling anxious family members they don’t yet have the medications the new patient needs. The family gets upset at the nursing staff, causing them to get more flustered and more frustrated. You can’t ignore that. What do nurses like to do most? Take care of their patients. How can we best enable them?

By communicating effectively and ensuring their new patients have the medications they need in a timely manner.”

When he worked as director of nursing years ago for Promontory Healthcare Companies, Chukk Nielson, BSN, bore witness to the impact poor communication wreaked on confused and worried family members after following the ambulance that took their parent or loved one to a nursing home in the middle of the night. Promontory is a network of short term rehab and sub acute care skilled nursing facilities, home health operations, and acute care and psychiatric hospitals.

“The geriatric population tends to be one end of the spectrum or the other when it comes to the level of involvement from loved ones,” says Nielson, a PharMerica client who now serves as clinical operations manager for Promontory Healthcare. “A lot of family involvement can be very difficult or very good. And no family involvement can be devastating,” he says. “It’s really unfortunate, especially for patients who are not alert and oriented, or they have some sort of dementia process. And yes, it does become difficult, especially when you do have just enough family involvement to be dangerous.”

Nielson says Promontory has seen discharge planning from both the hospital and sub-acute side, and has learned the value of timely communication and sharing relevant information. “When we are discharging folks to a home health organization, we ensure that the patients and their family are made very aware of what that discharge plan looks like while taking into account the expectations of the client, the providers and the clinicians,” he adds.
3. Documentation can either save you or doom you.

The old adage, “If it’s not documented, it never happened,” rings hollow when it comes to transitions from hospitals to nursing homes. And just because a referring partner sends a patient to a SNF with swiss cheese doesn’t relieve the nursing facility of its duty to demand information and document thoroughly.

What should SNFs look for in terms of information? Plenty, according to Holly Harmon, senior director of clinical services at the American Health Care Association. One key piece, of course, is the discharge documentation. “Is there a complete story for the person prior to their hospital admit, during their hospital stay and goals for after hospital stay care?” she says.

Vishnubhatla agrees. “The key piece of information nobody gives us yet we would love to have is what meds was the patient on before they went to the hospital?” he says. “We really have no idea what these patients were on before they were hospitalized. Looking at someone from a care transitions standpoint, wouldn’t that be useful to have? All too often, this information isn’t provided.”

Other key pieces of information SNFs should have and seek out, according to Harmon, include the patient’s complete medical history, assessments, and medication treatment history and reconciliation. As if that weren’t enough, Harmon urges providers to “look for any possible information gaps – where the ‘rest of the story’ usually resides,” she adds.

“Nursing homes often find themselves looking for two paragraphs in a 25-page document and when you have staff running around trying to get things done, it’s easy to miss them, or misinterpret,” says Vishnubhatla. “Mistakes can happen.”

The exercise doesn’t end after the first 48 hours.

“Here’s why I’m a proponent of positive charting,” says Nielson. “Because I know that my patient is being taken care of. I can follow that chart, those nursing notes, that medication administration record and it tells me a story. It tells me a story of what it looked like when my patient woke up to the time they went to bed and then observations made throughout the night.”

4. A botched discharge can lead to problems down the road.

The role skilled nursing facilities play in accepting discharged hospital patients cannot be overstated. By remaining vigilant during the hand-off and asking for information when there is none to be found, SNFs can save themselves a great deal of misery months later.

An admitted patient who goes without needed medications in a timely fashion, or has health issues that an incomplete discharge summary or continuity of care document failed to mention could suffer a cascading series of adverse events that could lead to rehospitalization before or after discharge on the other end. The cost to the admitting facility could be dear.

“The average total time it takes from hospital discharge to the time meds are available could be almost 10 hours – five hours for patients to get there, three hours to get the orders and two hours to get it done,” says Vishnubhatla, noting that PharMerica’s TransitionRx® program has literally shaved off six hours from the process.

“Most of the time I’m told hospital caregivers don’t do a thorough job tracking down a patient’s medication history prior to discharge,” adds Vishnubhatla, who urges SNFs to avoid complacency at a time when rehospitalization penalties for them are slight.

But that’s about to change in short order. “The foundational components of the recent Reform of Requirements of
Participation and the Impact Act of 2014 – person centered care and safe transitions of care – are fundamental expectations for the healthcare continuum and will not lose traction,” warns Harmon. “SNFs are increasingly accountable for outcomes after they themselves discharge a patient.”

Promontory follows a 60-day course of comprehensive followup once it discharges patients, according to Nielson. This includes an initial followup within 24 hours of discharge to home health (72 for discharges to non-healthcare settings), followed by weekly and later biweekly calls to ensure the patient is taking their medications, making doctor appointments, and to field concerns or questions. “The process has paid off in spades, leading to a 60% drop in rehospitalizations,” Nielson says.

5. Engaging with discharge planners requires skill and knowing the rules.

For obvious reasons, skilled nursing facilities need to respect that “wall” referenced at the beginning of this story – regardless of how thin or thick it is. Engaging with discharge planners is a vital and necessary task not only for the sake of patients in transition, but also ensuring a healthy referral base.

Doing so requires a keen understanding of the rules, some of which can seem like shifting sand, a dose of business acumen, and a keen respect for the role discharge planners have in the transitions of care process according to AHCA’s Holly Harmon. She advises facilities to showcase what they do well, identify a hospital’s greatest needs with tangible ways to address them, seek relationships built on positive collaboration, and form hospital/SNF teams to jointly work on process improvements around care transition.

What’s permissible and necessary includes:

- Knowing your center’s capabilities for providing care and services;
- Clearly communicating your center’s capabilities and unique offerings;
- Showcasing your performance based on outcome and experience data of your customers;
- Seeking to understand the needs of the individuals being referred and objectively determine if your center can meet their needs;
- Centering your communication and decisions around doing the right things for the people you serve;
- Inviting them for a visit and tour;
- Maintaining open dialogue and determining the process for addressing issues as they arise; and
- Staying abreast of your state regulations and requirements.

As for what’s not acceptable, Harmon has one simple yet profound piece of advice: “Don’t promise care you cannot provide.”

Conclusion

It’s painfully obvious that the transition from hospital to skilled nursing is a process that is as complex as it is chaotic. Skilled nursing facilities that rise to the challenge of doing all they
can to ensure and even facilitate the flow of information and communication will be the best practice leaders in the near future.

To Vishnubhatla, the benefits are profound. “Quality discharge planning positively affects the quality of healthcare by better patient engagement and health outcomes, increased patient and caregivers satisfaction, fewer unplanned hospital readmissions, and significant cost savings,” he says.

Vishnubhatla urges SNFs to familiarize themselves with the 2014 Impact Act, carefully and objectively evaluate their current discharge planning process, establish key hospital referral partnerships, initiate quality assurance and performance improvement (QAPI) and other measures, and keep current with evolving dialogue at the state and national level.

“SNFs need to be partners in care. If there’s a preferred provider network in play and a value-based healthcare system at play, and you’re having more readmissions, you’re not going to be the preferred destination for referrals coming out of a particular hospital,” he warns. “It’s going to hurt you. So, you’re better off being more proactive and getting in front of it and having a system and process in place and understanding the data and having protocols on how to handle things. That collaboration, that handshake, and how these transfers happen, will be more and more critical. All stakeholders have to get better at it.”
About TransitionRx®

TransitionRx is a pre-admission referral program that partners with hospital discharge planners and care coordinators. This partnership allows PharMerica to provide admission assessments, complete with medications and lower cost alternatives to review with the admitting physician, before or during the resident’s admission.

When hospital discharge planners prepare a patient for discharge to a nursing home or other setting, PharMerica electronically receives the resident information and medications list from the hospital several days prior to discharge. PharMerica completes its Price Forecaster Assessment, providing lower cost therapeutic alternatives and coverage checks, then provides the information to a client facility for review with the resident and the physician. The process allows skilled nursing facilities to make informed, clinically appropriate, cost effective decisions about patients’ care.

“When PharMerica is getting ready for a discharge, they’re making that cognizant effort to know that medication regimens become complex for these individuals and ensures they’re set up for success,” says Chukk Nielson, a TransitionRx client and clinical operations manager for Promontory Healthcare Companies, a network of short term rehab and sub acute care skilled nursing facilities, home health operations, and acute care and psychiatric hospitals.

“Whether it’s how they package the material, or the education that’s provided in layman’s terms, that’s important,” Nielson adds. “Ultimately just to be able to have a pharmacist a nursing facility can pick up the phone and call, on day of discharge, and say ‘I’m noticing something that I’m not really comfortable with the medication regimen,’ and having someone work with physicians on possible alternatives could mean the difference between a good and bad outcome. So having PharMerica acts as that advocate to complement our own pharmacy staff efforts is a double safeguard for our facilities.”

About PharMerica

PharMerica has served the pharmacy needs of nursing facilities for more than 30 years, operating over 100 pharmacy locations that fulfill the daily medication needs of hundreds of thousands of residents throughout the country. At PharMerica, we have a singular focus on service, collaborating with our clients to develop products and services that help them provide quality care, control costs, and remain compliant with ever-changing regulations.
Headquartered in Louisville, Kentucky, with nearly $2 billion in annual revenues, PharMerica is one of the largest and fastest-growing institutional pharmacy companies in America. We are a premier pharmacy services provider dedicated to delivering innovative solutions for customers and patients.