The “Ideal” Hospital Discharge

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Why is discharge planning important?

• Surging interest from professional societies, payers, Joint Commission

• Among reasons for the challenge
  – Aging, increasingly complex population
  – More, and more specialized, venues
  – Providers defining practice by location
Scope of the problem

- Hospital admission = first of multiple care transitions for the older patients
  - 25% of patients ≥ 65 years and older are discharged to another facility
  - 12% are discharged with home health care
  - Of those transferred to rehab/skilled nursing care facility, 50% will 4 or more health care transitions in the next 12 months

- All of this leads to poor communication and insufficient care
CASE

• 68 yo man transferred from acute hospital to distant suburban SNF after uneventful valve replacement
• On warfarin + enoxaparain until INR 2.5-3.5
• Progressively less ambulatory
• INR rises to 17, even after warfarin held and vitamin K administered
• Cardiac arrest
Quality of Care Transitions

• Active process for patients and caregivers
• Bi-directional communication needed between hospital and skilled nursing facility

• Accessible medical record
  – Current problem list
  – Medications
  – Advance directives
  – Baseline physical and mental status
  – Family and healthcare profession contact information

Coleman and Boult, JAGS 2003
Other considerations

• Early involvement of PT and SW
• “Dispo” daily in thought, speech, prose
• Discuss discharge by goals, not schedule
• Avoid discharge to SNF or home with HHC on weekends
• Involve primary care provider
• Involve clinical pharmacist
4 Core Elements Needed to Determine Discharge Care

1. Medical needs
2. Functional capability
3. Nursing needs
4. Rehabilitative needs
4 Core Elements

• **Medical needs**
  – Summary of problems/course
  – Recent and important pending labs
  – Reconciled medication list*
  – Advanced directives

• **Functional capability**
  – Baseline and present status
  – Social support/contact information

• **Nursing needs**
  – Wounds
  – Monitoring

• **Rehab needs**
  – PT
  – OT
  – Inpatient capabilities
Discharge Locations & Services

DC ITAC SNF

NH ALF HHC
Possible Discharge Destinations

• Home with family support
• Home with home health care (HHC)
• SNF
• Nursing home, ALF, custodial care
• Acute rehab
• LTAC
• Hospice
Home Health Care

• Medicare qualifiers
  – Reasonable and necessary
  – Skilled services (RN, PT, or ST) needed
  – May involve OT, SW, HHA
  – Home bound: Leaving home is infrequent
    • requires great, taxing effort
    • requires supportive devices, transportation, help of others
    • medically contraindicated

• Sufficient and willing caregiver*
Qualifying Services for HHC

• Diabetes management
• Ostomy care
• IV management
• Medications
• Self-catheterization
• Self-injections
• Tube feedings
• Wound care (no more than b.i.d)
Financing

• Medicare A: RN, PT, OT, ST, HHA
• Medicare B: MD home visits, DME, labs – but with 20% co-payment
• Homemaker services: no Medicare or Medicaid coverage
• VA does provide homemaker services for eligible veterans
Skilled Nursing Facilities

- Patient requires skilled care: IV therapy, artificial nutrition and hydration, complex wound care, ostomy care, rehab
- Medicare pays 100% for first 20 days, then 80% for remaining 80 days
- Coverage stops when goals met or patient stops improving
- Infrequent outside provider visits (~monthly)
Post-discharge SNF Facts

• Friday late admissions to SNF rarely seen until Monday
• Physician sees patient on admit and usually handles management by phone thereafter
• Xrays and labs may take 24 hours for final report
• RN staffing very poor
• No pharmacy access after hours
Acute Rehab Hospital

• Medicare criteria:
  – Close medical supervision by physiatrist/rehab physician
  – Needs 24h rehab nursing care
  – Multidisciplinary needs, coordinated program
  – Reasonable expectation of gain
  – Able to participate in 3 hr/d of intense therapy

• Typical patients: head/spine injuries, stroke patients
LONG-TERM ACUTE CARE (LTAC)

• For complex, potentially unstable patients requiring ongoing hospital-level care
• Chronic ventilator patients, multiple IV medications, extensive wound care, TPN
• Medicare qualifiers
  – Frequent physician monitoring
  – Need for highly-skilled care
  – Expected LOS 25+ days
Nursing Home/Long Term Care

- Custodial care
- Assistance in ADLs
- Lack of caregiver support
- Medicare does NOT cover
- Financing via private pay, Medicaid, long-term care insurance
Case Follow Up

- Patient sent urgently to ER
- Patient coded unsuccessfully
- Autopsy: 1500 mL grossly bloody fluid in pericardium, hepatic congestion
- No communication between SNF MD and CT Surgery re significance of climbing INR values