Discharge Planning:

Guidance for Adult Protective Services Programs

Developed by the
National Adult Protective Services Association
Regional Representatives Advisory Board
2017

NAPSA NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

Discharge to APS, in the absence of other necessary services, does not constitute an acceptable discharge plan.

A referral to APS indicates, by definition, that the reporter suspects that the client is at risk.

FEDERAL REGULATIONS

CMS regulations on hospital discharge planning are found at 42 CFR section 482.43

Discharge Planning Defined

Discharge planning is a process involving the transition of a patient's care from one level of care to the next. Health care professionals and the patient and the patient's representative (if any) participate in discharge planning activities.

The federal Center for Medicare & Medicaid Services (CMS) states that Discharge Planning involves:

- Determining the appropriate post-hospital discharge destination for a patient
- Identifying what the patient requires for a smooth and safe transition from the acute care hospital/post- acute care facility to his or her discharge destination
- Beginning the process of meeting the patient's identified pre- and post-discharge needs.

The discharge process must be thorough, clear, comprehensive and understood by acute care hospital/post-acute care facility staff as well as the patient and/or the patient's representative.

(CMS Medicare Learning Network, *Discharge Planning*, Oct. 2014)

Common Discharge Planning Issues Faced by APS

Although discharge planning is primarily a responsibility of health professionals (including hospital/facility social work staff), issues relating to discharge planning often impact on the work of APS. When a hospital or facility seeks a "discharge to APS" for a vulnerable adult, without an adequate review of the health/behavioral health and social needs of the individual to be discharged, the results may include:

- Discharge to the community for a patient who needs assisted living or nursing home care
- Home care denial of admission or a determination to discharge a "difficult to serve" adult
- Discharge to the community of a person with developmental disability who needs a specialized supported residential care
- A vulnerable adult who wants to (or whose spouse/family wants adult to) return home or to a lower than needed level of care, i.e.:
  - the home supports are insufficient to meet the needs, address risks or monitor an unstable medical situation
  - when home services are refused, or
  - when home environment is in poor condition or hazardous.
- An APS client who experiences multiple unsuccessful discharges, resulting in overuse of the ER, trashing of motels or shelters, and non-compliance with residence rules.

How is the Process *Supposed* to Work?

To better assist their clients to receive the discharge planning services and the appeals rights they are entitled to, APS workers need to know how the discharge planning system is supposed to work.

For hospitals participating in Medicare, Federal law requires the institution to notify Medicare beneficiaries who are hospital inpatients about their hospital discharge rights. Within two days of admission, patients who are Medicare beneficiaries must be given a document called an *Important Message From Medicare*. The patient is asked to sign the form. If the patient refuses to sign, the hospital is to note the fact of the refusal and this is considered the date of the notice. If the patient is unable to understand the notice, the hospital is to send the notice to the patient's representative.

The CMS Medicare *Learning Network Guide to Discharge Planning* states that the discharge planning process includes:

- Implementing a complete, timely and accurate discharge planning evaluation process, including identification of high risk criteria.
- Maintaining a complete and accurate list of appropriate community-based services, supports, and facilities where the patient can be transferred or referred.
- Providing notification to patients that they may request a discharge planning evaluation.
- Completion by appropriate qualified personnel of discharge planning evaluations for every patient who is identified at potential risk of adverse health consequences without a discharge plan, or if the patient, the patient's representative or attending physician requests such evaluation.
- A discharge planning evaluation in the patient's clinical record. The evaluation considers the patient's care needs immediately upon discharge and whether the needs are expected to remain constant, lessen or worsen over time. It identifies appropriate and available after-acute care services, supports and facilities.
- A summary of the patient's stay is developed, including treatments, symptoms, pain management and whether the patient was in seclusion or restrained. This summary will be available for release to authorized individuals and agencies, with the consent of the patient or representative.
- A pharmacist's assessment of the patient's medication compliance and treatment; the patient's capacity for self-care; the patient's preferences and goals, as applicable; and the availability, willingness and ability of family/caregivers to provide care.
- Education by the hospital/facility of the patient, family/caregivers and community providers about the patient's post hospital/facility care needs. They must provide the patient and family/caregivers with information and written and verbal instructions for the patient's care.
- A notice that advises that a patient has a right to request a review of the discharge decision, by asking for an expedited review by a Quality Improvement Organization (QIO) when the hospital determines that inpatient care is no longer necessary. For more information on the Medicare appeals rights, visit http://www.medicare.gov/publications to view the booklet ***Medicare Appeals***."

Discharge planning requirements apply only to *inpatients*, not to outpatients, persons receiving treatment at an Emergency Department who are not admitted as inpatients, or those under "observation" status but not admitted as inpatients.

In addition to these federal standards, it is important to know whether there are additional laws or policies governing discharge planning in your own State. In some States there may be additional required procedures for hospitals/facilities to follow regarding rights to participate in discharge planning, appeals rights, documentation to be issued/maintained in the client case record, and more.

Suggested APS Best Practices

- Know the rules regarding discharge planning and appeals rights so you can be in position to provide support to clients and their families/representatives in appropriate cases;
- Consider issuance of written **guidance** to APS, shared with hospitals and facilities, stating that **discharge to APS, in the absence of other necessary services, does not constitute an acceptable discharge plan**.
    - While APS may be an important component of a plan of care to maintain a vulnerable person in the community upon discharge, the hospital/facility must provide information to APS which leads APS to conclude that the patient will be returning to the community upon discharge and that the patient may be eligible for APS upon such return to the community. To determine this, APS needs to receive all pertinent information regarding the patient's medical, cognitive and social condition of the patient.
    - An APS assessment of a patient in hospital/facility, should be conducted in close cooperation with discharge planning staff. The APS assessment should place special emphasis on the client's physical environment in the community and the degree to which the client's support systems will be able to meet the client's needs upon discharge.
    - Even though APS may conduct such an assessment, nothing shall diminish the hospital/facility's primary responsibility for discharge planning set forth in federal and state health laws. The hospital/facility retains responsibility for accessing all necessary post hospital/facility services, such as personal care and home health services, prior to the patient's discharge.
    - APS does not accept primary case management responsibility for an APS case until the patient has been discharged from the hospital and returned to the community.
- Patients have a **right to self-determination** in choosing or agreeing to a discharge plan. This means a patient who is insisting on returning to a dangerous home environment upon discharge is free to do so unless it is determined that a patient lacks capacity to make and understand decisions related to his/her care. If the patient is choosing a course of action which will place him/her at risk of harm and there is doubt about the patient's mental capacity, APS should strongly encourage the hospital to obtain a psychiatric evaluation prior to the individual's discharge. The evaluation should focus on the patient's present ability to make and express choices about his/her decisions, to provide reasons for these choices, to make choices based on reality and to understand and to appreciate the potentially harmful consequences of his/her course of action
    - If a determination is made that the patient is not presently able to make care-related decisions and that the patient will be at risk of harm upon discharge, the hospital must act to prevent or delay the discharge in accordance with applicable law. For patients who are determined to have decision-making capacity, the hospital/facility and APS has no choice but to allow the patient to return to the community.
- APS can enter into **agreements** with hospitals/facilities setting forth the respective responsibilities of APS and hospitals/facilities for patients facing discharge. Some states have provided APS with models of such agreements.
- Some APS units (e.g. New York City APS) have developed **standard letters** to send to hospitals or facilities in cases where APS clients receive notification that they will soon be discharged and where APS believes such a discharge would violate applicable State or federal law because the services necessary to ensure a safe discharge have not been provided. In appropriate cases APS sends a letter to the hospital/facility requesting that the discharge be postponed until such time as the necessary services are reasonably available. The letter cites applicable regulations with discharge planning requirements, lists the services that are necessary to meet patient's continuing health needs and states why these services have not been made available. The letter also states: "Discharge to APS, in the absence of other necessary services, does not constitute an acceptable discharge plan. APS is opposed to discharging the patient at this time until such time as the services necessary to ensure a safe discharge are available."

A copy of the sample NYC letter is available at…

http://www.napsa-now.org/SAMPLEDischargeLetter