Discharge/Transitional Planning, Level of Care, DRGs, and Insurance Criteria

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Case Management: Role Process

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Discharge Planning, Levels of Care and Transfer in Patients

The purpose of this paper is to discuss discharge planning, understanding levels of care and transfer in patients, the impact of Diagnosis related Groups (DRGs) on transitional planning, and insurance criteria.

 It is noted in appendix A. Medicaid and Medicare have set forth standards for providers and suppliers who are eligible to participate in these programs. The goal is to achieve effective and safe discharge of patients. Discharge planning policy and procedures are detailed in writing to guide the process. Safe discharge planning can lead to reduction in hospital readmission, cost effective and excellent medical care (DHHS-CMS, 2015). Powell and Tahan (2010) explained that patients discharge process begins at the time of admission. The process of discharge planning is the organization of care within the multi-disciplinary team. The team consists of the patient and family members and staff members from many discipline that are necessary to provide care to support or promote health. The Case manager makes sure that patients’ physical health, mental health, safety, social support, and environment are suitable in order to deliver care during hospitalization and after discharge (Powell and Tahan 2010). According to Family Caregiver Alliance (2015) discharge planning is a method use to facilitate a smooth process through transitional level of care from one area to next. This transition provides for minimal interruption and or gaps in care that is needed to allow for patient recovery. Transitioning from one level of care to next may include a patient who had knee surgery then transition to post surgery unit, once cleared will be safely transferred to a rehabilitation facility and then to home with follow up physical therapy in home and or out patient ,based on need and or what insurance may or may not approve.

Discharge care coordination is a process that begins at the inception of the patient being admitted to the unit and often ends upon follow up when the patient is transferred to the next level of care. Elements of the discharge planning process include evaluation or assessment of need when the patient is admitted in an attempt to plan for and or project areas of need, discussion with patient family, significant other to identified needs. Additionally determining the level of need and or support required if any exist, establishment of a plan of action in meeting and or addressing needs to ensure follow - up on care, referrals to organization that might address need, coordinating and or arranging for support and follow up to ensure discharge plan to include referrals and coordination occurred in a timely matter so as to facilitate smooth transition for the patient (Family Caregiver Alliance, 2015). The review process for discharge procedures includes ongoing reassessment of the patient’s need while assigned to the case-manger to ensure that all changes in the patients status and or needs are noted, considered and accounted for in the discharge plan (Department of Health and Human Services, 2014). The patient and their supports are involved in the planning at all times. An individual such as an older adult who entered the hospital for a minor procedure and planned to return home post procedure may encounter complications; therefore, instead of being discharged to home the patient may have to go to a nursing facility due to lack of support in the home to meet discharge needs if in-home care cannot be coordinated. Lattimer (2013) defined transition as the safe transferal of care from one provider to another provider as patients’ health needs change. Also transition is not only between providers at different location but that transition can occur within the same health care facility from one unit to another, or to patients home Transition examples are being transferred from a medical-surgical unit to an intensive care unit, or from the hospital to hospice care facility, also from an emergency room to patients residence. Similarly, transition of care was defined by Powell and Tahan (2010) as an interactive process between varying multiple disciplines that are required to provide health services for patients and their families during the course of an illness and after the illness. Also mentioned was that case managers should be acquainted with the repute of facilities that patients are being relocated to.

In order to be a proficient case manager the nurse must possess advocacy skills, effective communication skills, knowledge of cost efficient utilization of resources, and insurance policies and guidelines because they are necessary in the overall care practices in discharge planning. Throughout management of care accurate documentation regarding all aspects of discharge planning is a vital task performed by the case mangers (Powell & Tahan, 2010 & Phaneuf, 2008). Precise documentation is mentioned by Powell and Tahan (2010) is a key component that can serve as protection in the event of a lawsuit or an insurance appeal. The case manager documentation should include every meeting or communication that transpired with anyone who is involved in patients care, whether they work in the hospital or for an organization outside of the hospital. Also any materials or information provided to patients and families concerning patient care must be documented. The acceptance or rejection of proposals, materials, and any changes made and who requested the changes should be documented. moreover patient education about medication administration and self care; the response to teaching; the need for more teaching; patients medical stability twenty four hours before discharge or transition to applicable level of care, functionality, and appearance are important aspects of documentation (Powell, Tahan 2010).

According to Powell and Tahan (2010) there are different Levels of care to which patients are assigned. The condition of patients’ health status regarding diagnosis, self determination, and identified needs determine their level of care during discharge planning. Levels of care include acute, sub acute, long term and custodial levels. Powell and Tahan (2010) mentioned that the American Health Care Association (AHCA) explained acute level of care as care needed in an emergent situation; subacute care is an all-inclusive inpatient program that is planned for individual who experienced a serious event due to an illness; aggravation of a disease process; has a definite path way of treatment, and does not need invasive and or intensive diagnostic procedures. Long term level is required for patients who are in need of health maintenance, promotion and support with independence and quality of life concern. Custodial level is required for people who need help with activities of daily living (ADLs) pertaining to personal hygiene and assistance with domestic help. These levels are used to move patients from one setting to another in order to place them in the appropriate setting that will ensure safe transition of care that can promote patients health and reduce readmissions.

The Department of Health Care Services Safety Net Financing Division (2014) defines diagnoses related groups (DRG) as a payment system that compensates hospitals based the clinical characteristics of patient that are clustered into diagnosis groups. Compensation to hospital for care/services rendered is not based on individualized scales for services rendered but is actually based on patient acuity. DRG’s allow patient to be grouped by similarity based on level of hospital care and resources needed. Determination and appropriate level of classification through the use of International Classification of Diseases (ICD) codes is a critical aspect of care and case-management in relation to reimbursement (Department of Health Care Services Safety Net Financing Division, 2014). ICD codes along with other factors ultimately help to decide and justify DRG weight of reimbursement. ICD codes falls into three classifications neutral, comorbid condition, or major comorbid condition with major comorbid conditions codes generating higher compensation for services. Correct documentation allows health care organization to garner the correct compensation while incorrect documentation may cost the organization loss of funds (Department of Health Care Services Safety Net Financing Division, 2014). Furthermore,

Russell,( 2011) explained that the DRGs has a taxonomy system that distributes possible diagnosis into more than twenty focal body systems and then splits them into groups of about 500 to be used for reimbursement for services for patients who have Medicare insurance coverage. DGR payments are determined by factors such as the diagnosis and the facility where the condition was treated. There is a fixed rate paid to hospitals for inpatient services based on the group of the DRG assigned to the patient (Russell, 2011). For example, when a patient is admitted to the hospital, the patient is assigned a DRG based on the admitting diagnosis if the payment for the DRG exceeds the actual cost of length of stay the hospital will gain a profit. If the patient length of stay exceeds the DRG payment the hospital will loose revenue.

Insurance is the financial engine that propels the medical and health care system. Powell and Tahan (2010) stated that the case manager must have a good knowledge of insurance company’s policies and guide lines. Every insurance company has its own standards rules and by laws. Some companies are rigid while other are flexible and will modify their rules base on patient’s situation. However, most insurance follow the standards set by Medicare. There are several types of insurance such as private insurance patient are self insured also , preferred provider options (PPO), function as a broker with payment for service a and a health maintenance organization(HMO) Physician who work for HMO, which is a state license organization, are contracted by the state to provide care for a set price. Point of service (POS) has high deductible and premium it is combination of PPO and HMO however, members do not need referrals they can visit any doctor of their choice any time desired. Powell and Tahan (2010) pointed out that Medicare requirements entail four main categories for authorization in an inpatient rehabilitation facility; other insurance companies might use the same overall standards. These categories are; 1-the admitting diagnosis must be a specific condition; 2- the main problem must include a new loss of function; 3- the physician must document an expected time for substantial development in functional ability, and 4- a patient who was previously in a rehabilitation program without improvement, must now have a change in status that indicate they will be able to show progress (Powell and Tahan, 2010). According to Medicare, Rights Center(2014) Medicaid is a program that is funded by state and federal government which provides medical care for low income people and people who have none or insufficient insurance. This includes pregnant women, children people with disabilities, blind people and older adults.). Medicare has different parts of coverage. There is Part A, B, C, and D. Medicare Part A covers hospital, home health, hospice care, skilled nursing facility, it is free once taxes and Social Security are paid for at least ten years. Medicare Part B covers most medical services such as preventive care, doctors visits mental health care, hospital outpatient services, durable medical equipment, laboratory tests, x-rays, ambulance, and some home health services. This coverage has a fee. Medicare Part D provides outpatient prescription drug coverage. This is done by private insurances that are contracted by the government. Medicare Part C is not a separate benefit; it allows private health insurance companies such as HMOs and PPOs, to provide Medicare benefits known as Medicare Advantage Plans. This type of Medicare coverage can be chosen in stead of original Medicare.

Cultural competency is of great significance regarding case managers’ interaction with patients they encounter. Self-awareness is primary in the case managers’ personality. Being able to assess oneself and biases before meeting with patients and their family members is of optimal value to the case manager. The case manger ought to engage in constant self-evaluation to recognize and address any biases that may impede fostering relationship with patients and families. According to Esposito (2013) culture affect the way in which health care information is accepted and that culture affects all parts of life. Evidence based practice has revealed that communicating with patients respectfully about heath- full recommendations expands their knowledge and enable them to make choices that would promote their health status.

Bailey (2012) additionally revealed that studies have shown that constant access to basic discharge plan information for all patients through written directions; follow–up calls, toll free phone calls, and internet services can significantly help patients’ involvement in the promotion of their health. Case managers should familiarize themselves with the basic cultural norms, customs or belief of patients to whom they provide care in order to nurture a good relationship and to promote autonomy promote.

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