PREPARING A PATIENT FOR DISCHARGE

WHAT THE CASE MANAGER WISHED YOU KNEW AND OTHER THINGS

KENDALL NOVOA-TAKARA MD

FEBRUARY 2023

SPECIAL THANKS TO BUMCP CASE MANAGERS

DISCHARGE PREPARATION BEGINS AT ADMISSION

- Where did this patient come from? Can they go back?
- Are there any obvious needs I can identify now?
- What sort of resources does this patient have?
- Is the patient mentally capable of taking of themselves?
- Is the patient able to do their ADLs? Feed self, toilet, get dressed?
- Can the patient get food?
- Does the patient have transportation?
- Who is at home with the patient and what kind of support can they provide?

PT/OT/SPEECH/NUTRITION CONSULTS

- PT: general mobility (gait, stairs, etc)
- OT: activities usually with upper extremities, fine motor
- Speech consults: assess if patient is safe to swallow, trach issues (passy muir valves)
- Nutrition: calorie counts, tube feeds, PPN, TPN
- Full consult staff available during week, variable on weekends (PT new consults, nutrition TF/PPN/PTN)
- Place consult ASAP if you think you need one

LEVELS OF CARE

- Long term acute care hospital (LTACH)-medically complex patients that need extended recovery time: vent, trach, complex wounds. Patient also need 24/7 physician/nursing care. LOS =25 days
- Acute rehab: patients that require intensive inpatient therapy services with at least 2 disciplines for 3 hours a day. Patients also need 24/7 physician/nursing care. LOS=approximately 2 weeks
- Skilled nursing facility (SNF)-for patients that have a skilled need (IV abx, wound care TWICE a day, or therapy needs) LOS=2-4 weeks or longer

NOT ALL SNFS ARE CREATED EQUAL

- High level SNF-will take patients with tracheostomy, vent, high flow O2 and duotubes. Examples: North Mountain, Symphony, Terra, and Plaza
- SNF may not be able to take patient past a certain FIO2—unlikely to take patient on higher setting of trach collar or ventimask, may have different standards at high elevation
- *Patient must be restraint/sitter/chemical sedation free for 24 hours*
- Do not refer to as a nursing home or extended care facility

WILL MEDICARE PAY FOR YOUR PATIENT'S POST HOSPITAL CARE?

- Medicare gives beneficiaries 100 acute days per year
- ACUTE=hospital, LTACH, and acute rehab
- These ACUTE days rejuvenate after a well time of 60 days (meaning that you have to be at home)
- Medicare gives beneficiaries 100 days for SNF
- SNF days do rejuvenate but only if you go home, there is a 60 days lifetime reserve but those days never rejuvenate

TO TRANSFER A PATIENT TO ACUTE CARE/SNF

- Complete depart—assume that this is the only document that the SNF will get so must include diet, wound care, activity level, and all medications must be on depart (including IV antibiotics)
- Must certify that there is no concern for TB, may need CXR if one not done recently
- Must have covid test in past 24-48 hours, if has ‘expired’ order another one to keep results current
- Complete hospital summary/continuing care orders***
- Pending discharge order—this cues CM your patient is almost ready for discharge
- Everything except the actual discharge order should be complete—will need to write discharge order once all issues addressed, if doesn’t discharge, will need new discharge order every day
- Discharge summary complete if possible**IF NOT COMPLETE BEFORE DC SNF WILL NOT GET IT
- Consider doing doc to doc on complex issues

CUSTODIAL CARE

- non-medical care that helps individuals with ADLs such as eating and bathing.
- providers of custodial care are not required to be medical professional
- Assisted living-housing for elderly or disabled people that provides nursing care, housekeeping, and prepared meals as needed
- Group home-a home where a small number of unrelated people in need of care, support, or supervision can live together, such as those who are elderly or mentally ill
- Memory care is considered custodial care

CUSTODIAL CARE NOT COVERED BY TRADITIONAL INSURANCE (INCLUDING MEDICARE)

- Covered by long term care insurance (private insurance)
- Most plans are reimbursement plans and only pay a percentage (eg 50% or a certain dollar amount per day for home care/per month for residential care) and have a waiting period, during which the patient is responsible for the costs incurred
- ALTCS-Arizona long term care system, is Medicaid (AHCCCS) long term care insurance
  - Income qualification similar to AHCCCS
  - 60 day approval period
  - Patient is responsible for costs incurred during waiting period

HOSPICE

- can be part of palliative care
- Last 6 months of life
- Inpatient units for respite, actively dying
- Home hospice does not provide 24/7 care—visits several times a week unless actively dying
- Family members, friends, or paid staff responsible to patient care if at home
- Hospice is a covered benefit under medicare and insurance.
- Hospice can *sometimes* be covered through charity care for the uninsured and even the undocumented
- **CANNOT DO HOSPICE IN A SNF** patient would be responsible for all SNF costs (5-7K/month)

WHAT CAN HOME HEALTH DO FOR MY PATIENT?

- 2-3 visits per week
- Duration is limited
- Home Physical Therapy
- Home OT—some insurances won't cover
- Home health nursing: check vitals, incision check, med compliance, diabetic education, lab draws (order must include instructions as to which physician is responsible for lab results), wound care (VAC), tracheostomy care, tube feeds, TPN, IV abx
- Home health is NOT personal care services (bathing, cooking, feeding, housekeeping→custodial care)

HOME HEALTH ORDERS AND SET UP

- Every home health order must be followed by a PCP
- If no pcp, sometimes subspecialists will agree to follow
- Takes a minimum of 4 hours to set up
- Easy to set up: PT, OT, HH nursing (max of 3x/week) specify rehab diagnosis, frequency, duration, and type.
- Allow at least one day to set up: trach, TPN, tube feeds, IV abx

IV ACCESS FOR HOME TPN AND ANTIBIOTICS

- For antibiotics PICC/central line or long dwell
- Is patient on dialysis? Can antibiotics be given with HD?, if yes, nephrology will need to give orders to dialysis center. Some abx can be given through PD, nephrology must order.
- Is patient AKI/CKD and **not** on dialysis? If yes, tunneled central line is needed—can only be placed in radiology.
- Sometimes, radiology/lines team will place PICC in AKI/CKD patients but ONLY with permission of nephrology
- No ports for TPN
- PICC/tunneled central lines cannot be placed if concerns for insufficiently treated bacteremia

HOME TPN AND TUBE FEEDS

- Appropriate IV access must be obtained for TPN (usually a PICC but sometimes a central line, avoid ports)
- patients can go home with duotube
- Copy information from nutrition note OR
- Under home health nurse in depart-follow prompts in drop down to provide order specifics (at Banner)
- TPN orders must include specific formula, rate, duration, type of line care AND OUTPATIENT PHYSICIAN FOLLOWING
- Tube feed orders must include formula, strength, rate, only nutrition patient receiving, type of tube, duration if known**indicate if OK to substitute with equivalent formula

HOME HEALTH ANTIBIOTICS

- Must have appropriate iv access
- First dose of abx must be received in the hospital
- Traditional medicare does not pay for home IV abx—must go to SNF or outpatient infusion clinic
- Banner infusion center can do once and twice a day abx and is open 7 days a week (other facilities have infusion centers too, check for hours, but not all can infuse meds that BUMCP can)
- IVDA patients generally can’t go home with PICC, too high risk for abuse
- Orders must include antibiotic, dose, dose frequency, duration, type of line care, what labs are to be draw, when and which physician results should be sent to

WOUND CARE

- HH wound care must include location of wound, type of dressing changes, frequency and duration
- HH wound can only go out 2- 3x/week
- If wound care needed more often than that, patient/family/friends will need to perform wound care at home
- HH wound will provide dressing change material
- If not getting wound care through HH, patient and family will need to purchase wound care materials

WOUND VAC

- Typically VAC dressings changed 3x/week
- Special VAC form must be signed prior to arranging HHC/SNF—this is the one type of DME order you will need to place on patient going to an inpatient facility if the facility does not have their own VAC
- VAC arrangements typically take at least a day
- Some VACs available through charitable services

APPROPRIATE OXYGEN ORDERS

- Be sure that your patient's FiO2 can be met at home (maximum is 4L at rest/exertion)
- Specify liter flow and how administered (NC, mask etc)
- Specify if continuous, exertional, nocturnal
- Specify if you want a concentrator (otherwise they might just get a tank)
- If patient is mobile, must specify patient needs portable O2 (mobile=leaving the house for any reason, eg doctor's appointments)
- Sat <88% at rest or ambulation
- Testing must be when patient is stable and within 48 hours of discharge
- Can't use acute diagnoses: pneumonia, pulmonary embolism
- Must have chronic diagnosis to qualify for O2: examples COPD, ILD, pulmonary hypertension, etc.
- Ordering physician must be PECOS certified—residents can be PECOS certified

CPAP/BIPAP

- Hard to get, dx must be respiratory failure
- Cannot qualify with simple OSA as inpatient
- Overnight oximetry will not qualify patient
- Typically need ABG with $PCO_2>58$ to qualify
- Extensive specialized documentation needed, pulmonary should be following

NEBULIZERS

- Provider order for machine + kit (kit=cup, mouthpiece/mask, tubing, tubing connectors)
- Usually picked up at pharmacy
- Will need to order all nebulized medications
- CF nebulizer treatments are typically ordered by pulmonologist as they require prior authorizations

DME-DURABLE MEDICAL EQUIPMENT

- Front wheel walker (FWW), wheelchair (WC), crutches
- Patient insurance will not cover 2 different items for same purpose (Eg FWW and crutches)
- Do not order these on pt going to acute care facility/SNF
- Insurance does not cover bathroom items

HOSPITAL BED REQUIREMENTS (MEET AT LEAST 1)

- positioning of the body in ways not feasible with an ordinary bed (elevation of the head/upper body less than 30 degrees does not usually require use of a hospital bed)
- positioning of the body in ways not feasible with an ordinary be in order to alleviate pain
- HOB elevated>30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration
- traction equipment when can only be attached to a hospital bed

WHEELCHAIRS

- Diagnosis that is related to mobility impairment
- Cane or walker will not meet mobility needs
- Needed to complete MRADL (mobility related activities to daily living)
- Home has sufficient space to maneuver
- Capable of self propelling the wheelchair or has caregiver who is willing to assist
- Pt shows willingness to use wheelchair in home on regular basis
- Documentation should include limitations of strength, endurance, ROM, or coordination, deformity or absence of upper extremities are relevant to assessment of upper extremity function

LABS AND STUDIES NEEDED FOR FOLLOWUP

- DON’T ORDER THEM unless you are certain you have a provider to follow up on them
- Should be ordered by PCP or physician who will follow them as outpatients
- If never seen by a certain physician, that physician is not likely to take responsibility for results

NO PCP?

- CM has list of sliding scale clinics
- Your hospital system likely has pcps in the system if patient has insurance or wiling to pay cash, most systems have clinics throughout valley

NO INSURANCE

- Can assist with some medications if patient cannot pay
- Not allowed to help with narcotics, sedatives
- Non citizens are difficult as there are no resources except charity care, repatriation often a consideration
- Hospice is sometimes available through charity care to the undocumented

HOMELESS

- If pt has financial resources, CM may be able to assist in find a place
- Patients may refuse CM assistance
- May need to be discharged back to the streets
- Circle the City: only for homeless, must be referred by hospital, must have medical need
- Additional help available through Human Services Campus in person (at CASS)--emergency shelter, housing, health care, food, clothing, employment, legal etc.

INCARCERATED PATIENTS

- Always call the infirmary to find out what is really doing on
- You can’t talk to patient’s friends/family
- Do NOT tell patients about discharge
- Patient only finds out when they are leaving their room
- Make arrangements with prison infirmary—may be hard to get in touch with on weekends
- Do not assume they can be discharged with a PICC—check with infirmary first

PRESCRIPTIONS

- Ensure that rx is complete, if done in EMR, this is less of an issue
- Can patient afford medication?
- Use generics when at all possible
- Are all rx necessary, polypharmacy is an issue
- Is it absolutely clear to your patient what medications should be stopped, continued, and what is new/changed
- Have your ordered enough—generally at least 1 week, may go longer if pcp or other follow up appointment scheduled later

MEDICATION PRIOR AUTHORIZATION

- Examples: LMWH (lovenox), DOACs (Xarelto/eliquis), Linezolid (zyvox), rifaximin (Xifaxin), tolvaptan
- If not commonly used medication, check if prior auth needed
- Typically must prove failure of other agent or have legitimate reason for use
- Plan ahead-approval hard to obtain over weekend/holiday
- Must write outpatient prescription in depart AND SEND TO BANNER FAMILY PHARMACY before CM can provide assistance
- Some prior auths take a long time—can patient be discharged without it (rifaximin=2 weeks)

MEDICATIONS REQUIRING PRIOR AUTHORIZATION (NOT ALL INCLUSIVE)		
Apixaban (assume all DOACs)	Canagliflozin	Colchicine
Daptomycin	Empagliflozin	Enoxaparin
Fidaxomicin	Lacosamide	Linezolid
Methadone	Montelukast	Oxycodone
Prasugrel	Pravastatin	Rifaximin
Ranolazine	Sacubatril-valsartan	Ticagralor
Tolvaptan	Vancomycin	

NARCOTIC/SEDATIVE PRESCRIPTIONS

- Find out if patient is on a pain contract
- These rx cannot be called in
- Must have DEA on your prescription (as a resident hospital will have one for you until you get your own license)
- Rx: drug name, dose, route, frequency, actual number of pills to dispense—remember this if cerner is down and you have to hand write prescription
- WRONG example: Percocet 5/325 tab, 1-2 tab po q 4-6 hours prn pain
- Prescribe enough to last until they can see own doctor, maximum of 1 week.
- Exceptions: cancer patients, those on pain contract
- Hospitals cannot provide financial help for prescriptions

EXEMPTIONS FOR 5 DAY LIMIT ON INITIAL RX; 14 DAYS POST OP; 90 MORPHINE EQUIVALENT/DAY LIMIT—USE THE DROP DOWN MENU IN CERNER TO SELECT INDICATION FOR USE

- A continuation of a prior prescription order that was issued within the previous 60 days.
- An opioid with a maximum approved total daily dose in the labeling as approved by the United States FDA.
- A prescription that is issued following a surgical procedure and is limited to not more than a 14 day supply.
- A patient who:
- Has an active oncology diagnosis.
- Has a traumatic injury, not including a surgical procedure.
- Is receiving hospice care.
- Is receiving end-of-life-care.
- Is receiving palliative care.
- Is receiving skilled nursing facility care.
- Is receiving treatment for burns.
- Is receiving medication-assisted treatment for substance use disorders.
- Is hospitalized.

THINK ABOUT DISCHARGE PLANNING DAILY

- Think about it on admission
- Ask yourself everyday, “what needs to happen so I can safely discharge this patient?”
- Answers to the question may be medical or more procedural and may raise other questions
- For me, the best time is at the end of the day when I am reviewing charts but if I missed asking myself that the previous afternoon, I ask myself in the morning
- Think about WHEN certain things need to happen—Friday comes quickly and certain things just don’t happen over the weekend (talking to the patient’s outpatient providers, setting up follow up appointments, getting tunneled lines placed etc.)