Admission Process

University of Missouri
QIPMO Program
Mark Francis, MS, LNHA
Leadership Coach

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University of Missouri Health Care

Overview

Focus on 2 areas:

1. Communication
2. Customer Service

Action steps:
Create your own unique processes

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DAD JOKE

- Why do fathers take an extra pair of socks when they go golfing?

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Dad Joke

- In case they get a hole in one!

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Dad Joke

What did the ocean say to the beach?

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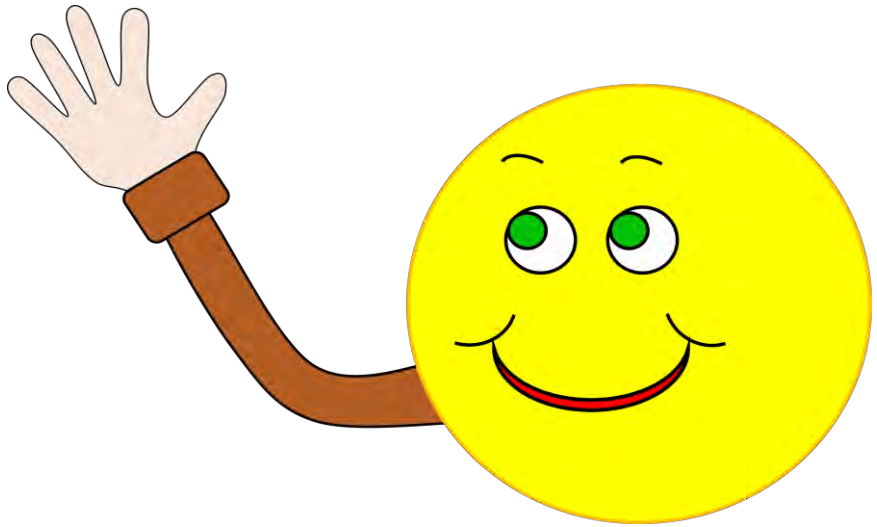
Dad Joke

Nothing.

It just waved!!



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Regulations

F620

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.15(a) Admissions policy.

§483.15(a)(1) The facility must establish and implement an admissions policy

Regulations

§483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Regulations

A nursing facility may charge a beneficiary who receives Medicaid for a service the beneficiary has requested and received, only if:

- That service is not defined in the State plan as a "nursing facility" service;
- The facility informs the resident and the resident's representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and
- The resident's admission or continued stay is not conditioned on the resident's requesting and receiving that service.

Regulations

F621

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)§483.15(b) Equal access to quality care.

§483.15(b)(1) A facility must establish, maintain and implement identical policies and practices regarding transfer and discharge, as defined in §483.5 and the provision of services for all individuals regardless of source of payment, consistent with §483.10(a)(2)

Regulations

F635 Admission orders

- Physician orders for immediate care

Regulations

F636 Resident assessment

- RAI/MDS

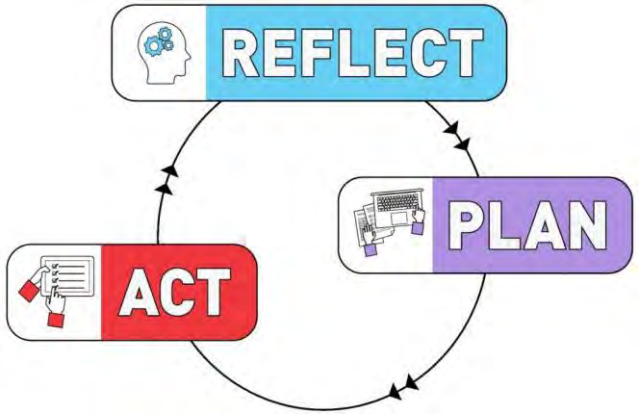
Regulations

Care plans:

F655 Baseline Care Plan

F656 Comprehensive Care Plan

F657 Care Plan Timing and Revision (Comprehensive)



Regulations

F644 Coordination of PASARR and Assessments

F645 PASARR Screening/Services for MD & ID

Resource: https://health.mo.gov/seniors/nursinghomes/pasrr.php

Communication Process

Ineffective communication is a

root cause of nearly 66 percent

of all sentinel events reported*

* (The Joint Commission Root Causes and Percentages

for Sentinel Events (All Categories) January

1995–December 2005

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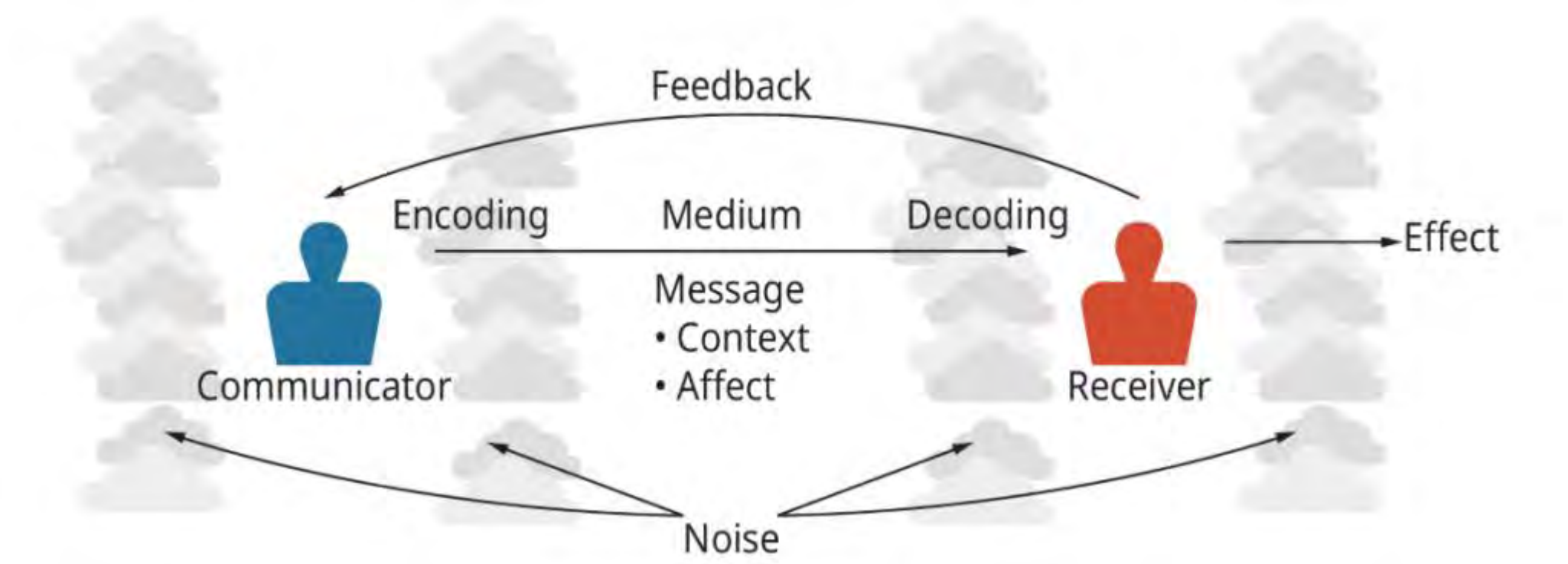
Communication Process



Communication Process

Parts of the process:

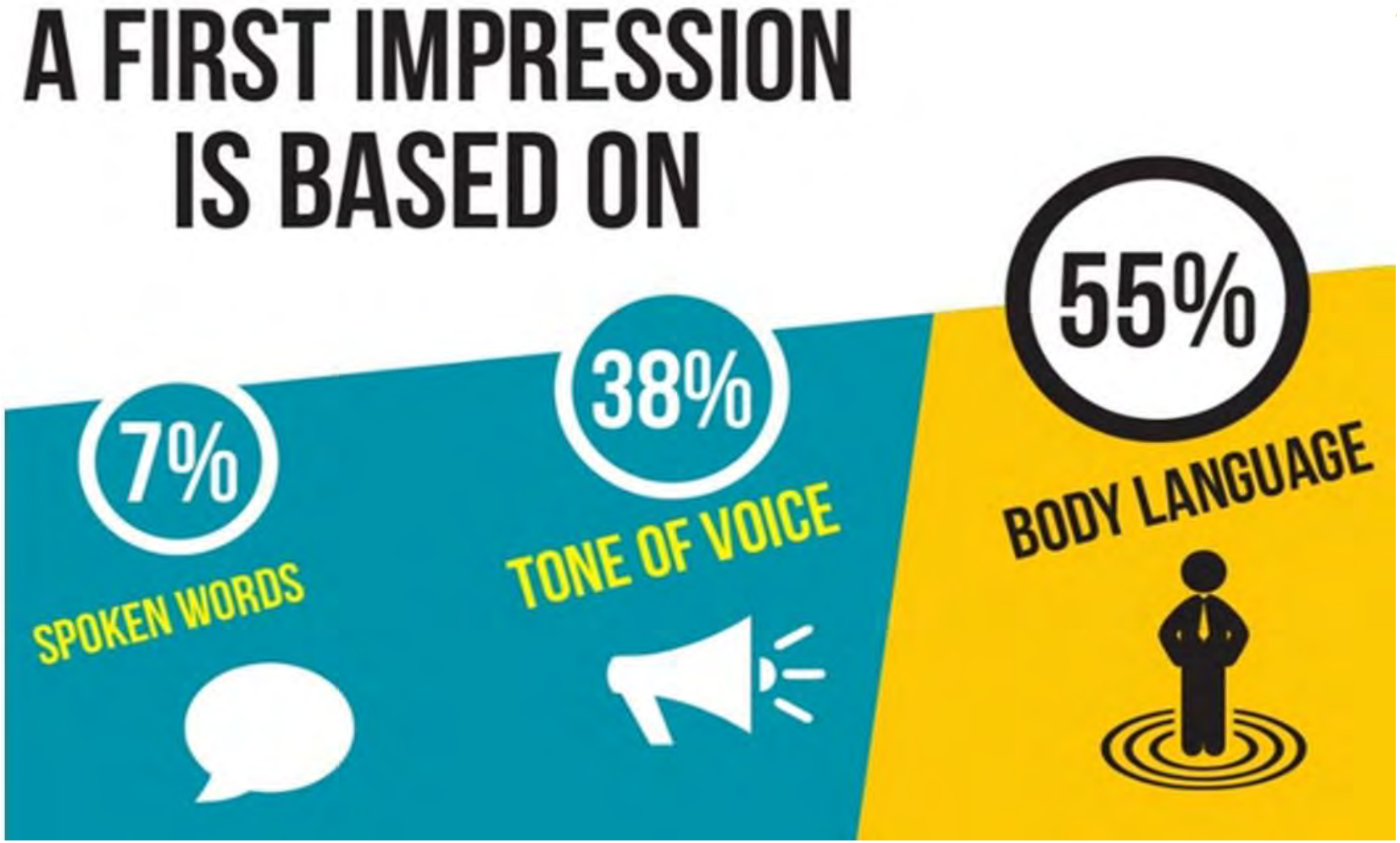
1. **Sender**

Communication Process

Parts of the process

1. Sender
2. **Message**

Communication Process



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Communication Process

Parts of the process

1. Sender
2. Message
3. **Channel of communication (encoding)**

Communication Process

Verbal

In-person speech
Phone conversation
Voice-over-internet protocol (VoIP)
Radio
Podcast
Voicemail message
Intercom

Written

Email
Text, instant message
Report, article, essay
Letter
Memo
Blog
Tweet

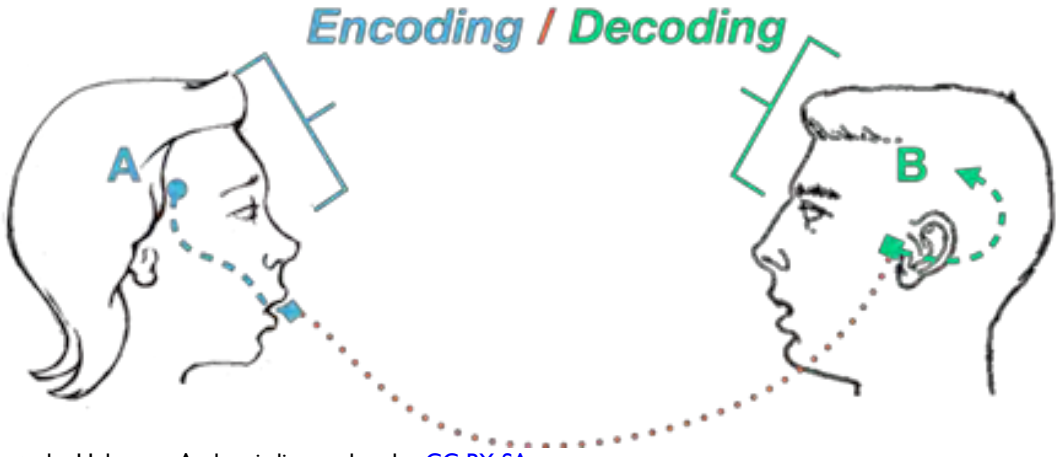
Visual

Drawings, paintings
Photos, graphic designs
Body language (e.g., eye contact, hand gestures)
Graphs
Font types
Semaphore
Architecture

Communication Process

Parts of the process

1. Sender
2. Message
3. Channel of communication
4. **Decoding**



Communication Process

Communication Process

Parts of the process

1. Sender
2. Message
3. Channel of communication
4. Decoding
5. **Receiver**

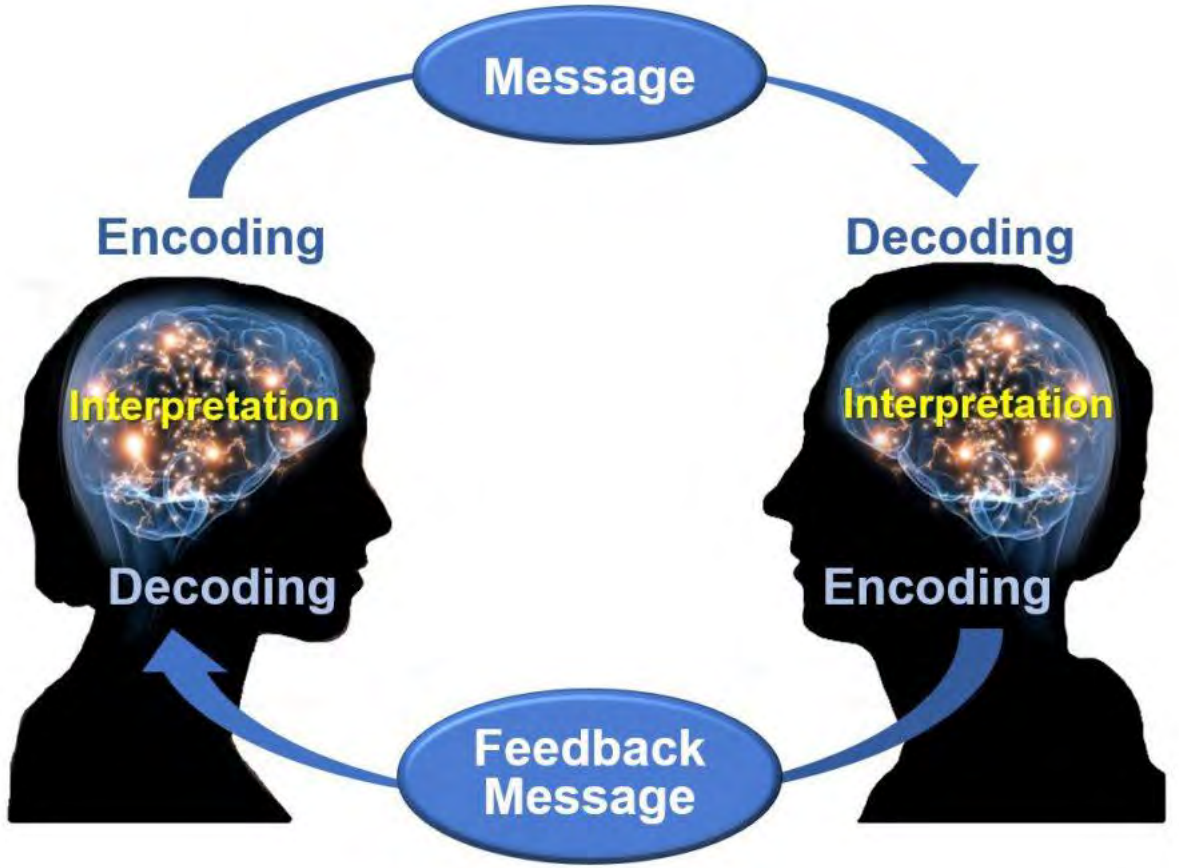
Communication Process

Communication Process

Parts of the process

1. Sender
2. Message
3. Channel of communication
4. Decoding
5. Receiver
6. **Feedback**

Communication Process



Communication Process

- What information does your department need that you are not getting?
- What information do you need to share with other departments?

Communication Process

- What are current holes in your admission communication process?
  - Ask every single person in your home. (Staff, residents, family members, vendors)

Prior to admission: Appearance

Prior to admission- Appearance

Building and grounds-

1. Parking area (adequate spaces, striping)
2. Landscaping
3. Grass mowed
4. Trash picked up
5. No cigarette butts
6. Entrance clearly marked (signs on door)

Create checklist

Complete checklist with different people, at different times

Prior to admission- Appearance

Lobby

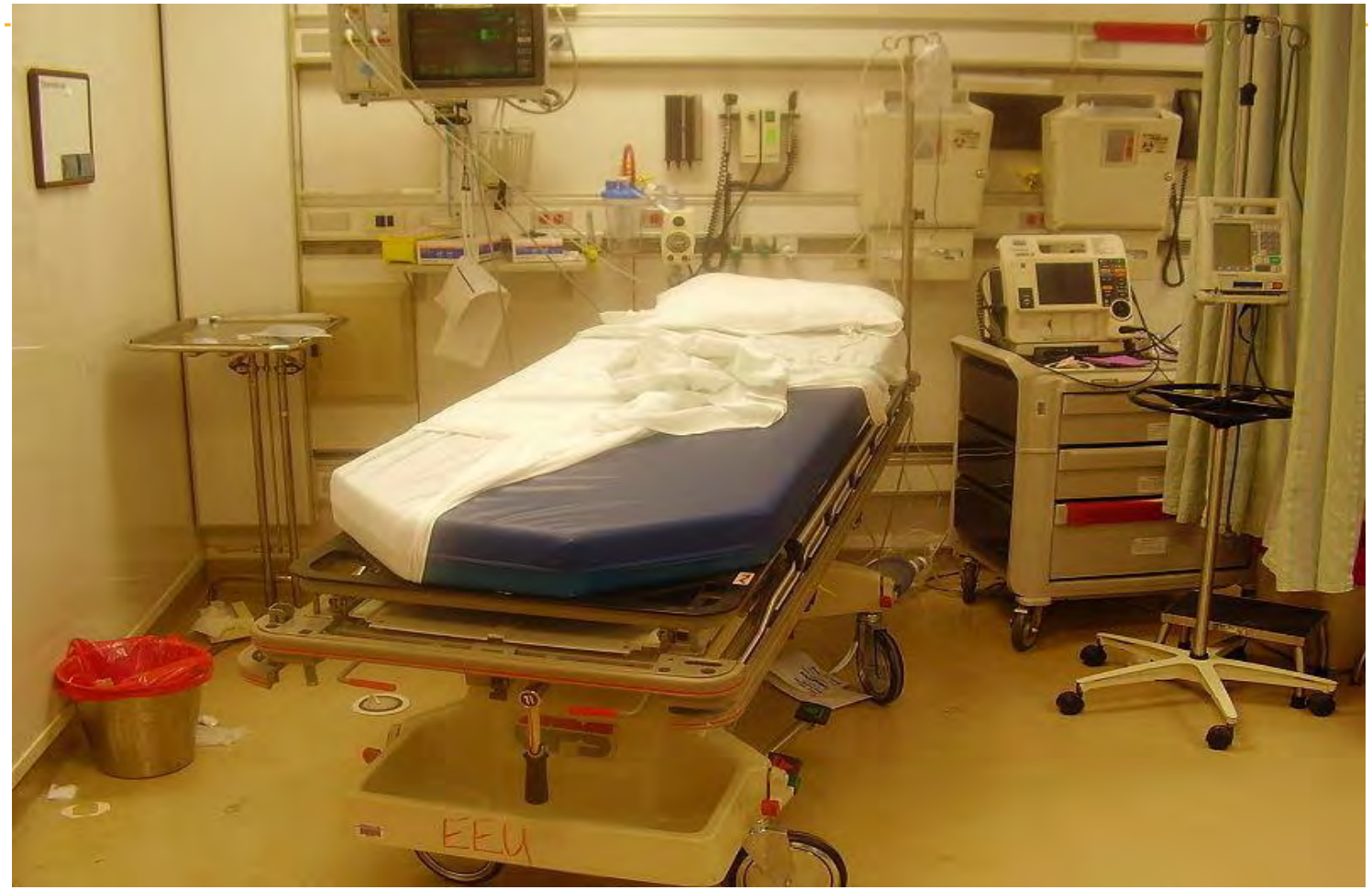
- Appearance
- Refreshments

Prior to admission- Appearance

Rooms

Take group to a room. Sit for 15 minutes and note any/all improvements that could be made

Prior to admission- Appearance



Prior to admission- Appearance

Prior to admission- Appearance

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Prior to admission- Appearance

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Prior to admission- Appearance

Rooms

What do you want your ideal resident room to look like?

- Furniture
- Signage
- Information
- Welcome gift
- Additional touches

Prior to admission- Welcoming

Admission contract:

- Be thoroughly familiar with all aspects of contract
- Arbitration agreements: (F847)
  - Cannot be mandatory for admission, stay
  - Must be understandable
  - Must explicitly inform of right not to sign
  - 30 days to change their mind

Prior to admission- Welcoming

Department welcome to new residents

- Housekeeping
- Maintenance
- Dietary
- Laundry
- Business office
- Activities

Prior to admission- Welcoming

Each department create a welcome plan:

- **How can our department make each resident/family feel genuinely welcomed?**

Prior to admission- Welcoming

Resident welcome

- CNA concierge
- Welcome letter
- Ambassador
- Family orientation meeting

Prior to admission- Welcoming

Challenges in going to a long-term care facility:

- Losses
  - Home (quiet, familiar, personalized)
  - Personal health
  - Privacy
  - Choice
  - Friends
- Facing death
- "I'll never put you in a nursing home"

Prior to admission- Information

Nursing: Create your list

- Medical
- Special care needs (equipment, staff training)
- Cost of special treatments, care, equipment
- Special cases (psych)

Prior to admission- Information

Business office (create list of needed documents, information)

- Insurance cards,
- Person with financial information
- Medicaid status: (type, information, assets, etc.)
- If you don't get needed information before admission, you probably won't get it!

Prior to admission- Information

Social services:

- Establish relationship/rapport
- Family history
- Resident likes/dislikes

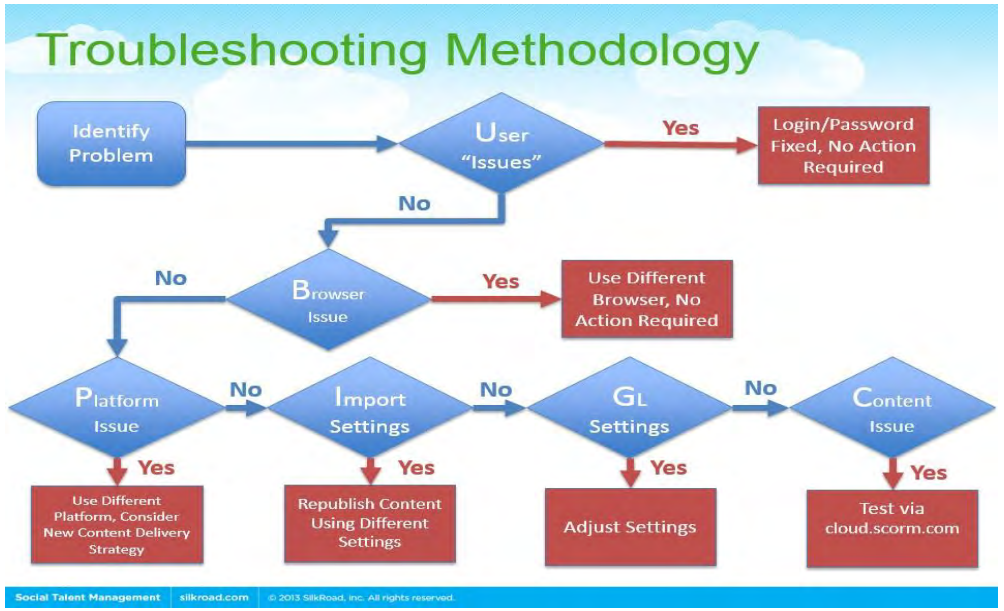
Prior to admission-Referral process

Who receives the referral?

How does the referral come?

What is the decision-making process? (Green, yellow, red light)

What is the information flow?



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Prior to admission

Who is the legal decision maker?

Advance Care Planning

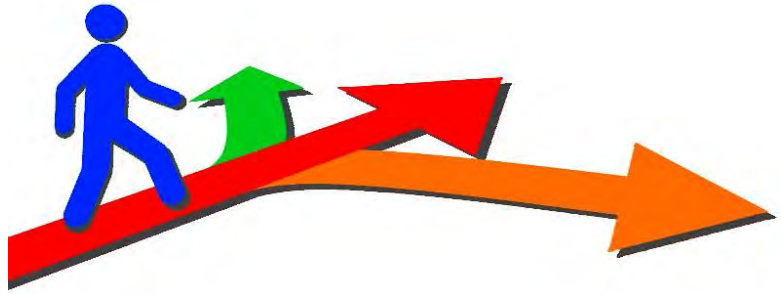
2 common components

- Healthcare Directive (aka Living Will)
- Assigning an Agent: Durable Power of Attorney for Health Care

Living will

Purpose: To specify particular treatments that should or should not be administered under specific circumstances.

- What specific circumstances could happen
- What treatments should or should not occur



Living will

- Revocable at any time
- Directions of declarant shall at all times supersede declaration

Durable power of attorney for healthcare

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

Durable power of attorney for healthcare

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

Durable power of attorney for healthcare

"Resident representative" For purposes of this subpart, the term resident representative may mean any of the following:

1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
2. A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or

Durable power of attorney for healthcare

3. Legal representative, as used in section 712 of the Older Americans Act; or
4. The court-appointed guardian or conservator of a resident.
5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

DPOA Decisions

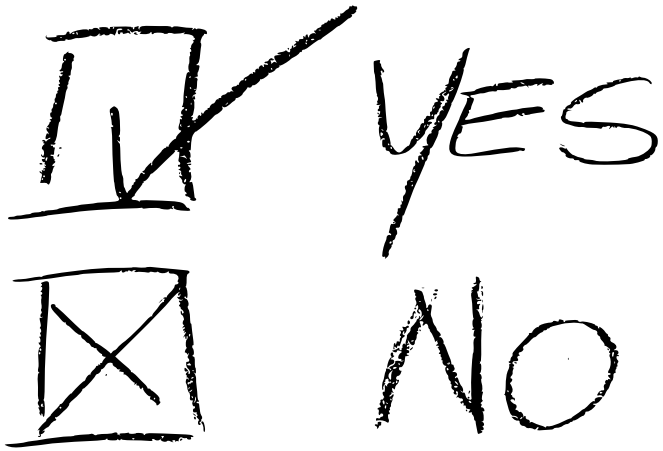
Decisions an agent can make for you:

- Which doctors or facilities to provide care for you
- What medical tests to perform
- What medicines you take
- If/when you have surgery
- How aggressively to treat a disease
- Whether to authorize your participation in medical research related to your condition
- Whether to disconnect life support
- Whether to authorize organ donation or an autopsy after death

DPOA CANNOT

Agent **cannot** make the following decisions:

- Agree to an abortion
- Agree to hospitalize for mental health services
- Agree to psychosurgery or ECT
- Refuse care that will keep the resident comfortable



Durable power of attorney for healthcare

Limits of Medical POA in Missouri:

- Your agent must make decisions within the terms of the legal POA document
- The agent is not allowed to make decisions that break the agreement and can be held liable for any fraud or negligence
- Two certified physicians (or one if you choose) must declare you incapacitated before the POA can take effect
- Your agent can't designate another person to act as your agent unless you authorize it in the form
- A POA can only be signed when the principal is of sound mind

DNR Order

GUIDANCE §483.24(a)(3)

- Just because a resident has an advance directive/living will, they do not always have a DNR order.
- Evidence in record of discussion leading to DNR order.
- Document resident choices (admission and changed) with signed order.
- Documented discussions of CPR refusal should be made if there is a delay in getting orders. Verbal declination should have 2 staff witnesses.

DNR Order

Facility staff should verify the presence of advance directives or the resident's wishes with regard to CPR, upon admission. This may be done while doing the admission assessment. If the resident's wishes are different than the admission orders, or if the admission orders do not address the resident's code status and the resident does not want to receive CPR, facility staff should immediately document the resident's wishes in the medical record and contact the physician to obtain the order (SOM appendix PP)

DNR Order

While awaiting the physician's order to withhold CPR, facility staff should immediately document discussions with the resident or resident representative, including, as appropriate, a resident's wish to refuse CPR. At a minimum, a verbal declination of CPR by a resident, or if applicable a resident's representative, should be witnessed by two staff members, though individual States may have more specific requirements related to documenting verbal directives. While the physician's order is pending, staff should honor the documented verbal wishes of the resident or the resident's representative, regarding CPR (SOM appendix PP)

During Admission Process

- Nursing assessment: DNR process
- Who starts the process?

Nursing & Social Work

- Common goals with varying approaches
- Is *not* standardized
- Education and skills vary among SW and nurses
- Expectations in role differ
- DO NOT wrongly assume what the other person is handling
- Communicate!

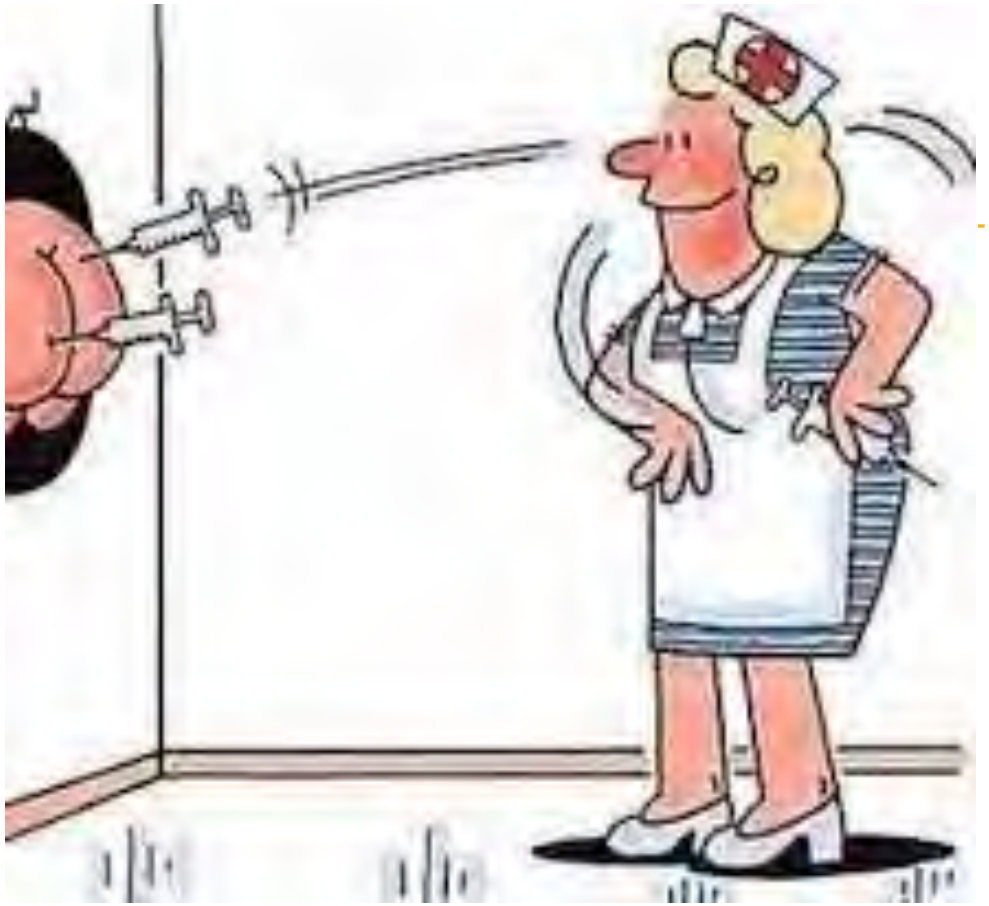
During Admission Process

Who greets the resident, family when they walk in the door?

- Settle in

Give them something to talk about

- Include them in the exam (without making it weird)
- Ask questions that matter clinically
- Trust your instincts...
- Sit down, Pen down…give them your full attention



Approach is everything

Quickie Cognitive Analysis
Conversation

How are you today?

It's cold out today. I don't like the cold. What is your favorite time of year?

Can you introduce me to your guest?

How was your hospital stay?

Have you ever been to our home? No? When we are finished here and you're ready, we'd love to give you a tour.

Are you having any pain? Can you tell me about it? We'll see what we can do to get that taken care of for you.

May I get you something to drink?

MOVE FROM "PATIENT" TO *PERSON*

During Admission Process

- Schedule for each dept. to greet, welcome and assess resident
- Each department manager to greet, leave card/contact information in first 2-4 hours, in 24-48 hours, in 1 week, PRN

After Admission

- Each department/role do a brief service questionnaire
  - What has _____ done well?
  - What could _____ do better?
  - Additional specific questions
    - Common areas of concern
    - Specific goals for the dept. (PIPs, etc.)

Where do we start?

Action Steps

- ❑ Identify holes in current admission process (survey everyone)
- ❑ Outside appearance checklist
- ❑ Detailed examination of current resident room
- ❑ Detailed list of ideal room
- ❑ Each dept to create specific welcome
- ❑ Each person in nursing dept to create list of info needed to do admission
- ❑ Each dept do brief follow-up questionnaire

Where do we start?

Action Steps

Start with a brainstorming session- include all dept managers and any other leaders in your home.

1. What works well with our current admission process?
2. What could we do better with our admission process?

Prioritize ideas/tasks for implementation (start small)

Review changes monthly, continue adding new ideas

Discharge Process

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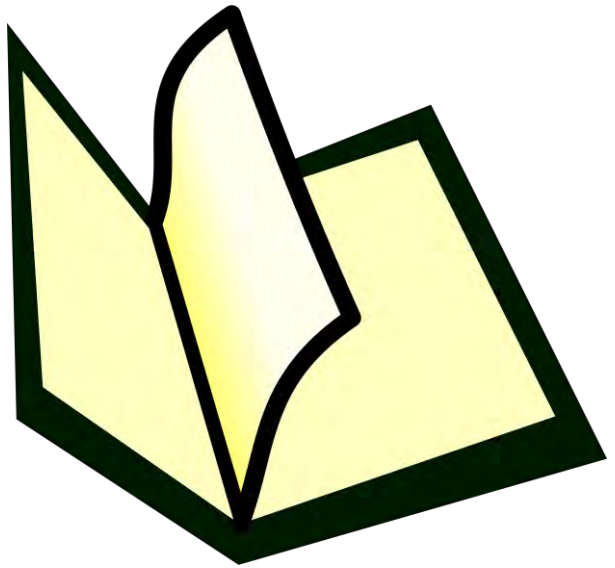
Discharges

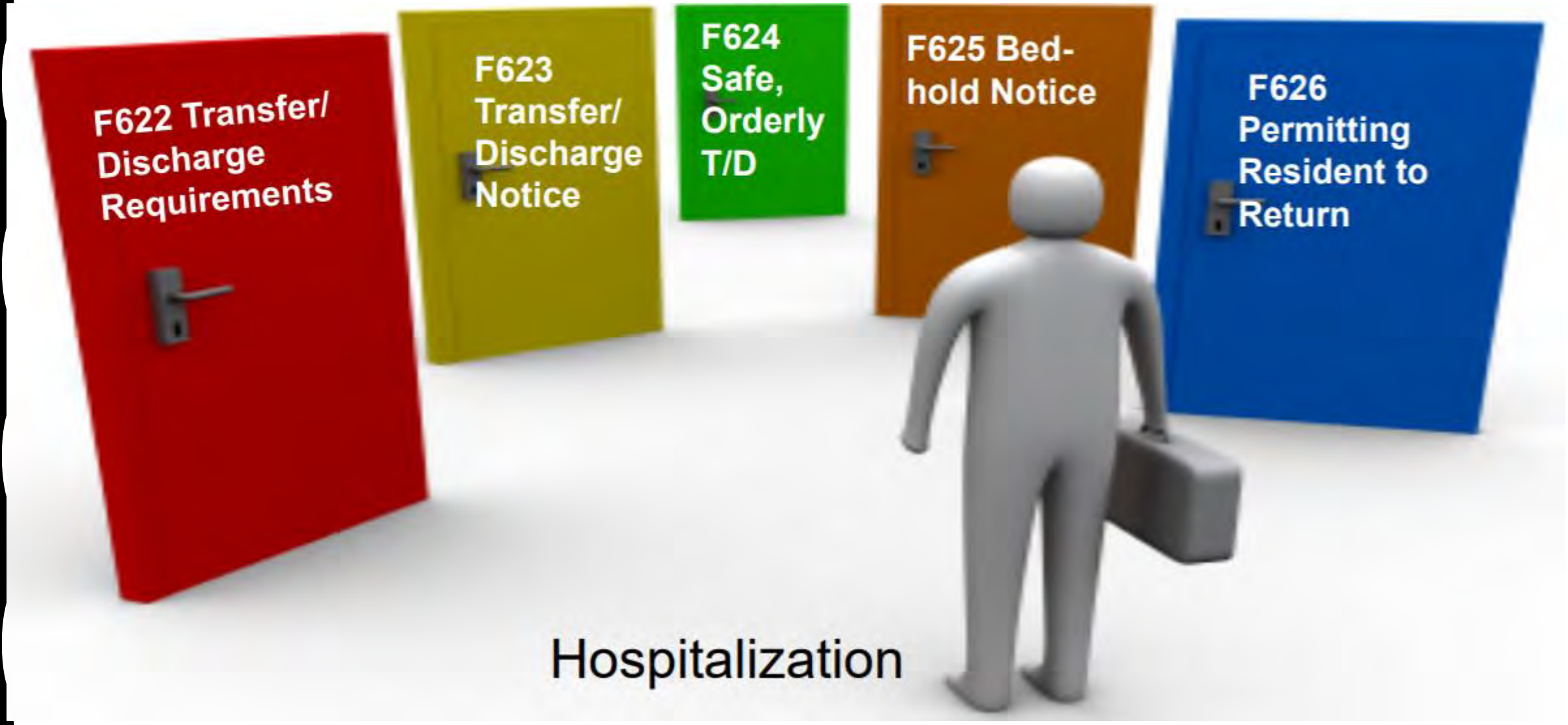
- Regulations
- Key steps, processes
- Tips



How many F tags related to discharge

- F660- Discharge Planning Process
- F661- Discharge Summary
- F622- Transfer and discharge
- F623- Notice before transfer
- F624 -Orientation for transfer or discharge
- F625- Notice of bed-hold policy and return
- F626- Permitting residents to return to facility
- F842- Resident records
- F843- Transfer agreement.
- F560- Right to Refuse Certain Transfers
- F559- Choose/Be Notified of Room/Roommate Change

- ***F553: participate in care plan***
- ***F580: Notification of change***
- *F620: Admission policy*
- *F637: Significant changes*
- ***F656: Care plan***
- *F658: Professional standard*
- *F838: Facility assessment*
- *F845: Facility Closure*
- *F846: Facility closure*
- ***F553: Person centered Care Plan***
- ***F580: Notification of Change***
- *F745: Medically Related Social Services*



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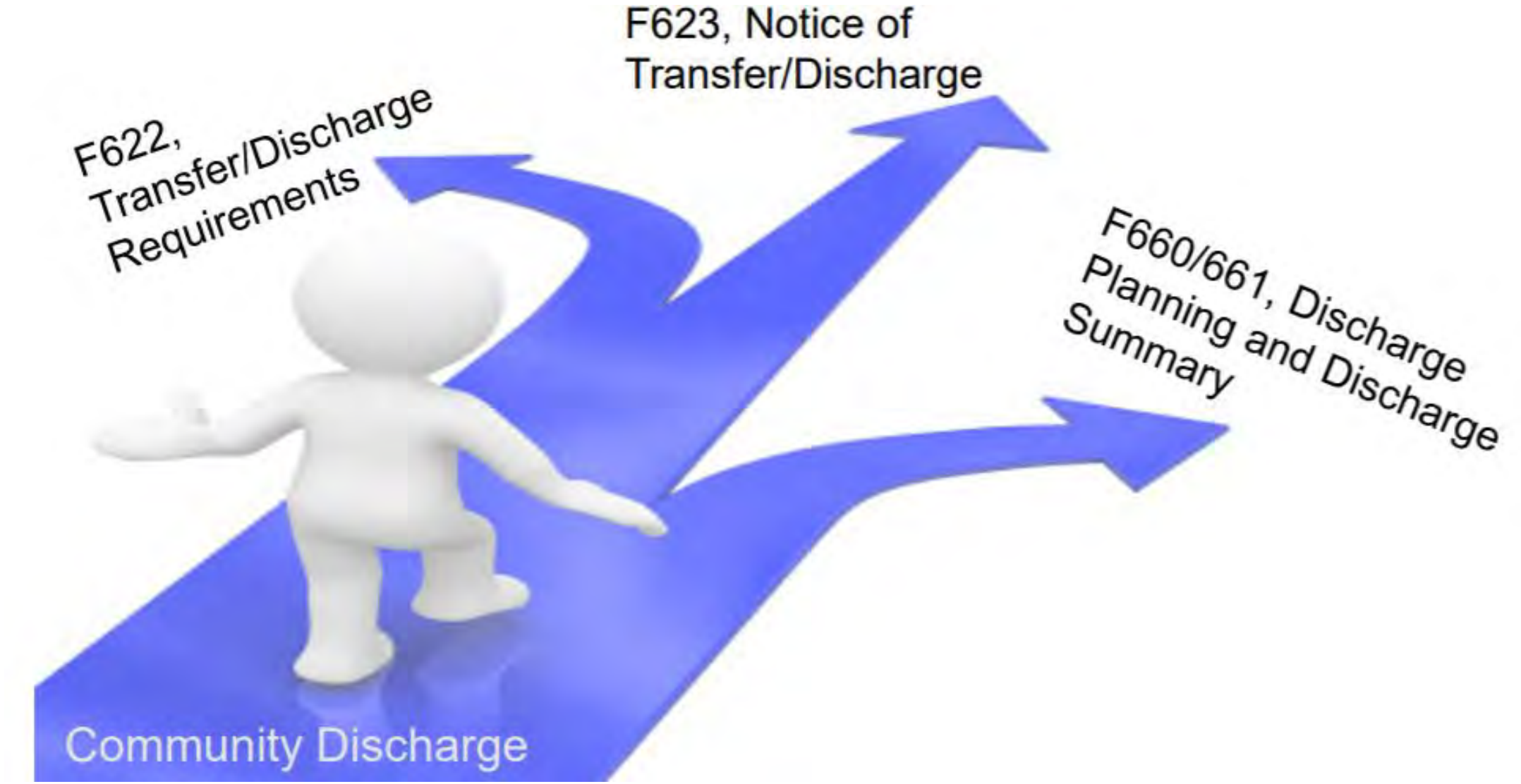
F623, Notice of Transfer/Discharge
F622, Transfer/Discharge Requirements
F660/661, Discharge Planning and Discharge Summary
Community Discharge

F660-Discharge Planning Process

- The facility must develop and implement an **effective discharge planning** process that focuses on
  - The resident's discharge goals
  - The preparation of residents to be active partners and effectively transition them to post-discharge care, and
  - The reduction of factors leading to preventable readmissions.

F660-Discharge Planning Process

The discharge care plan is ***part of the comprehensive care plan*** *and must:*

- *Address the resident's goals for care and treatment preferences*
- *Be re-evaluated regularly and updated when the resident's needs or goals change;*
- *Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;*
- *Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance*
- *Document the resident's interest in, and any referrals made to the local contact agency;*
- *Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;*

F660-Discharge Planning Process

- *If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care, and must:*

- *Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;*
- *Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;*
- *Document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings;*
- *Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.*

Transfer and discharge Facility requirements-F622 : when?

The transfer or discharge **is necessary** for the resident's welfare and the resident's needs cannot be met in the facility;

The transfer or discharge is **appropriate** because the resident's health has improved sufficiently so the resident **no longer needs** the services provided by the facility;

The safety of individuals in the facility is **endangered** due to the clinical or behavioral status of the resident;

The health of individuals in the facility would otherwise be **endangered**

The resident has failed, after reasonable and appropriate notice, to **pay** for (or to have paid under Medicare or Medicaid) a stay at the facility. **Nonpayment** applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

The facility **ceases to operate.**

F623-Notice before transfer

- Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman

- **Timing of the notice**
  - Provide notice of the transfer or discharge to the resident/representative 30 days in advance, or as soon as practicable prior to the transfer or discharge
  - Notice must be made as soon as practicable before transfer or discharge when—
  - The safety of individuals in the facility would be endangered
  - The health of individuals in the facility would be endangered,
  - The resident's health improves sufficiently to allow a more immediate transfer or discharge
  - An immediate transfer or discharge is required by the resident's urgent medical needs, or
  - A resident has not resided in the facility for 30 days

F623- Contents of the Notice

Must include the following:

- *The reason for transfer or discharge;*
- *The effective date of transfer or discharge;*
- *The location to which the resident is transferred or discharged;*
- *A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;*
- *The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;*
- *For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities*
- *For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.*

DISCHARGES

Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the facility assessment.

• Resident transfers to an acute care setting are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected.

➢ In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident's status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the allowed criteria.

• It is the responsibility of the facility to notify the resident of changes in payment status, and the facility should ensure the resident has the necessary assistance to submit any third-party paperwork (if paperwork has been submitted and a decision is pending, that is not considered nonpayment status).

• CMS, SOM, Appendix PP (F622); available at: https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf

Discharge

- Start discharge ~~at~~ **before** admission
- Don't admit unless you can provide care
- Avoid facility-initiated discharge when possible
- Know and communicate with potential resources (hospitals, gero-psych, etc)

Resources

- Resources:
  - https://nursinghomehelp.org/
  - https://health.mo.gov/safety/longtermcare.php
  - https://www.cms.gov/about-cms/what-we-do/nursing-homes
  - CMS SOM
  - CMS CEP

Clinical Education Nurses

www.nursinghomehelp.org/qipmo-program
musonqipmo@missouri.edu

Wendy Boren
borenw@missouri.edu
Region 2

TBA
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Region 1

Katy Nguyen
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Crystal Plank
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Regions 5, 6

Debbie Pool
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Infection Control Team

www.nursinghomehelp.org/icar-project
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Shari Kist
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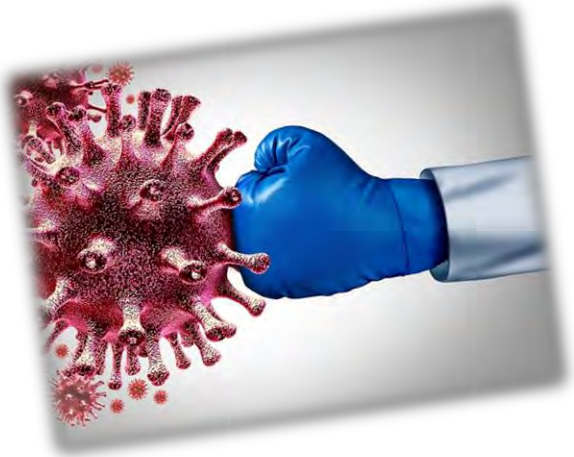

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QIPMO
Partnering With You to Promote Quality

Leadership Coaching
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Sinclair School of Nursing
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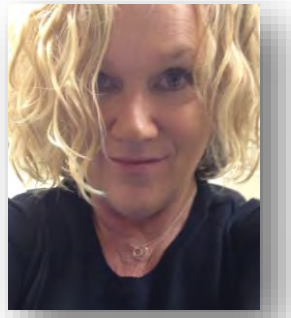

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