

# JUST SAY YES

## Discharge Planning Process



WE ARE FAMILY  
SERVING  
FAMILIES



# JUST SAY YES

## Program Overview



# JUST SAY YES

## PROGRAM OVERVIEW

### How to Say “Yes”

- Evaluate ALL possible room changes
- Evaluate pending discharges
- Always know your baseline for custodial care
- Change the NO to YES by requesting equipment, med changes from IV to PO
- Don't deny today's skilled referral based on custodial needs tomorrow
- A bed hold is “A BED” hold not a specified bed
- Yellow on the GO SHEET means drill down – not stop
- Beds are not gender specific
- Approach each inquiry with the attitude of how can we say “YES”

### Review and Re-commit to the Go Sheet

- This means each BLT member has signed off on the Go Sheet
- Go Sheet reviewed quarterly at a minimum
- ASM and SAM have Go Sheet on hand
- ASM and SAM are not involved in bed management
- ED is responsible for bed management and to ensure this program is in place, functioning timely and effectively allowing for quick admit decision and turn around

### Saying YES 200% of the time gets you 95% FULL

- The ASM/SAM say YES to referrals based on the Go Sheet
  - Not bed availability
  - Not on how many admits scheduled already
  - Not on staffing complaints
  - Not after running the referral from office to office (shopping the referral)
- Define what your base custodial census goal is
- Don't have the perception of “full” (no slotting names in beds)



## Prepare to be Full

- Develop your own Dashboard or “admission board” – need OPR
  - Calculate how many active working referrals you need in order to keep the pipeline full and achieve and maintain 90% occupancy or better
  - Board contains: (build the board as a team)
    - Pending admissions – new working admits
    - Discharges/Payor/status changes
    - Bed hold/Accute pending
    - Part B
    - Room Changes
    - 30 day review
    - Meetings
    - TLU
    - Color code payors
    - Today’s census (actual vs. goal)
- ED must be champion for process and backup support

## Embrace Change

- Room changes are necessary to maximize bed availability
- Team participation in room changes required – can’t always fall on SS
- Copy of room change notification
- Daily PPS meetings

## Discharge Planning

- Bed lock may require your team to re-evaluate discharge dates
- Are discharge dates based on non-clinical issues?
- Discharge room checklist
- Empowering SS to discharge plan effectively



# JUST SAY YES

## Discharge Planning Process



## Instructions to complete this course:

1. Watch and discuss segments of the video
2. Read and discuss the material below
3. Complete all activities and complete “Acknowledgement of Training”

**This workbook and the Video “Discharge Planning Process Training” are designed to work together to provide an interactive two-hour course.**

## Course Introduction:

1. Please watch the Introduction presented by the Executive Director. It will assist you in the background of the “Just Say Yes” program and will familiarize you with this next important component the “Discharge Planning Process Training”. This introduction will cover some of the methods you may utilize to better prepare your residents and team for successful discharge planning and bed management.
2. Next watch the Introduction by the Social Services & Discharge Planning Director. She will provide you with the THREE Key Components to successful Discharge Planning that you and your team can practice with the four provided scenarios. You can then apply these THREE Key Components to some of your own unique discharge and bed management challenges.

**NOW TURN ON THE DVD AND WATCH BOTH INTRODUCTIONS. WHEN PROMPTED, PLEASE PAUSE VIDEO AND PROCEED TO READ THE FOLLOWING SCENARIO AND FORMULATE YOUR DISCHARGE PLAN.**



## Scenario #1: Dueling Daughters

### SCENE SETUP:

Mrs. Smith has been admitted several times to the Skilled Nursing Facility.

On her first visit she was admitted for an elective knee replacement. She was discharged home with her husband at an independent level. She was able to climb the stairs which was something that was difficult for her to complete prior to the surgery.

She was admitted a second time 6 months ago with a right wrist and ankle fracture after a fall from a three-step ladder. During walking-rounds, her daughter informed the IDT that her mother's husband of approx. 50 years had just recently passed away. Staff had noted a change in her recall ability and therapy reported that the resident was requiring cues for safety reminders and would now require 24 hour supervision. The daughter, Liz, who had been helping her mother in the morning and evening since her father died, decided to quit her full-time job and move in with her mother. She felt this was something she wanted to do in order for her mother to return to her home.

Now, six months since she was last here, she has been readmitted for multiple medical issues including urosepsis, dehydration and a UTI. Liz has expressed that she has been having difficulty caring for her mother for the past six months. She has had multiple sessions with the social worker as she feels "guilty" for feeling overwhelmed in caring for her mom and that this may have contributed to her mother's current medical issues. She hired someone that her mother promptly fired in order to get some respite.

Staff had interaction with only one daughter who is local, providing her with support and reassurance. Her other daughter, Kathleen, lives in Arizona and calls her mother nightly. She has never had direct contact with staff and has not visited her mom in the past year. Kathleen has not seen or experienced the changes over the last six months.

The scene begins the day prior to discharge when Kathleen arrives from Arizona and wants to stop the discharge as she has concerns that her mother's benefits are not being fully utilized and that she was not returning home as she had done previously.



**NOW DISCUSS YOUR TEAM'S DISCHARGE PLAN:**

Please utilize the THREE Key Components; 1.) Assessment 2.) Vision Casting 3.) Teamwork/Staff

**Brief Overview of your Team's Discharge Plan:** \_\_\_\_\_  
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**AT THIS POINT RE-START THE VIDEO AND WATCH WHAT THIS TEAM CAME UP WITH AS A DISCHARGE PLAN.**

**Take a few minutes and write brief answers to the following questions. Compare your Team's Discharge plan to the Team on the video. This should be an interactive discussion.**

1.) Assessment: How did your team utilize this component compared to the Team in the video?  
Briefly Describe:

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2.) Vision Casting: How did your team utilize this component compared to the team in the video?  
Briefly describe:

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3.) Teamwork/Staff: How did your team utilize this component compared to the team in the video?  
Briefly Describe:

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WHEN PROMPTED, PLEASE PAUSE VIDEO AND PROCEED TO READ THE FOLLOWING SCENARIO AND FORMULATE YOUR DISCHARGE PLAN.

## Scenario #2: The Cat Man

### SCENE SETUP:

Steven is a 78 year old man who was admitted for skilled therapy services under his HMO plan. He has a history of strokes; the most recent was very debilitating resulting in losses in his physical mobility.

He lives by himself and has a cat who he has a strong attachment to and appears to be his closest companion. He becomes frustrated with staff as he wants to return to his home despite safety concerns that were raised and would tell staff he would “manage things” on his own.

Steven has a PhD. in mathematics and has been a well known author and scholar in his community. He has no family in the area and his closest companion is his cat. He has a colleague/friend who has been willing to assist him. In the past, Steven has lived with him, but is unable to do so at this time. The friend is willing to help manage Steven’s finances and is also willing to assist staff with making arrangements for Steven.

Due to Steven’s strong desire to return to the community and previous home with his cat, staff has been working with him on this potential. Steven has voiced concerns because of his share of cost. He has \$931.00 a month between his pension check and social security. He is concerned with how he will be able to manage caring for his beloved pet and the expenses associated with upkeep, as well as afford having assistance in his home.



**NOW DISCUSS YOUR TEAM'S DISCHARGE PLAN:**

Please utilize the THREE Key Components; 1.) Assessment 2.) Vision Casting 3.) Teamwork/Staff

Brief Overview of your Team's Discharge Plan:

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**AT THIS POINT RE-START THE VIDEO AND WATCH WHAT THIS TEAM CAME UP WITH AS A DISCHARGE PLAN.**

Take a few minutes and write brief answers to the following questions. Compare your Team's Discharge plan to the Team on the video. This should be an interactive discussion.

1.) Assessment: How did your team utilize this component compared to the team in the video?  
Briefly describe:

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2.) Vision Casting: How did your team utilize this component compared to the team in the video?  
Briefly describe:

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3.) Teamwork/Staff: How did your team utilize this component compared to the team in the video?  
Briefly Describe:

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WHEN PROMPTED, PLEASE PAUSE VIDEO AND PROCEED TO READ THE FOLLOWING SCENARIO AND FORMULATE YOUR DISCHARGE PLAN.

## Scenario #3: Car-Dominium

### SCENE SETUP:

Sam is a 78 Year old man who has a dx of DM, HTN, and is insulin dependent. Prior to going to the hospital, Sam resided in a van that was located in a field. He has no family, and he has no friends. He was admitted for skilled services under his HMO plan, has no other insurance and very little finances.

When he was admitted, Sam had expressed a desire to return to his vehicle. He was wheelchair bound, had poor endurance and was very weak. Staff were concerned about his ability to care for himself and manage his medical needs independently.

During the course of his 380 day stay, Sam became very comfortable within the facility, befriending staff members and participating in group activities. He has had difficulty with roommates; preferring quiet areas and expressing a desire to have a private room.

Sam has been working well with therapy and is now able to ambulate at a SBA level around the facility, and is able to propel himself in a wheelchair. Due to his improvements and changes which occurred during the course of his stay, staff are working with him on a discharge plan. Sam has expressed some concerns regarding what he can pay for in regards to services. He has also made statements about leaving the environment and said that since he has done so well in the facility he can expect to continue to do well here and might not be able to do so if he leaves. He has also said that if he is doing so well...why isn't he able to return to his van.



**NOW DISCUSS YOUR TEAM'S DISCHARGE PLAN:**

Please utilize the THREE Key Components; 1.) Assessment 2.) Vision Casting 3.) Teamwork/Staff

**Brief overview of your Team's Discharge Plan:**

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**AT THIS POINT RE-START THE VIDEO AND WATCH WHAT THIS TEAM HAS COME UP WITH AS A DISCHARGE PLAN.**

**Take a few minutes and write brief answers to the following questions. Compare your Team's Discharge plan to the team on the video. This should be an interactive discussion.**

1.) Assessment: How did your team utilize this component compared to the team in the video?  
Briefly describe:

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2.) Vision casting: How did your team utilize this component compared to the team in the video?  
Briefly describe:

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3.) Teamwork/Staff: How did your team utilize this component compared to the team in the video?  
Briefly describe:

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## Scenario #4: Bariatric Patient

### SCENE SETUP:

Miss Mary Love is a 45-year-old woman who came to the Skilled Nursing Facility with multiple medical issues, including a diagnosis of a stage 4 healing sacral wound that required a wound vac. Complications included obesity, paraplegia, diabetes, Bipolar Disorder and GERD. She is receiving coverage through an HMO and has no secondary payer source. She has limited income that she receives from her monthly disability. She has had previous stays at two other skilled nursing facilities, which resulted in premature returns to the hospital related to her non-compliance.

Family dynamics include a 20 year “close friendship” with Susan, who is also considered to be her “caregiver”. Susan works full-time and she and Mary have a volatile relationship, often appearing to be verbally aggressive to each other.

During the course of her stay she has refused bathing and care from most of the licensed staff. There were multiple sessions with the ED and the Social Services Director in order to help manage care issues. During these meetings she would express a desire to return home after her wound healed. However, when it came to the end of her stay she would bring up many “barriers” to why she couldn’t leave yet.

After addressing her many “barriers”, the final road block was that she felt she couldn’t get home due to her paraplegia (which was a long standing diagnosis), as well as her morbid obesity. To further complicate her discharge plan, her previous home had been condemned. Her friend, Susan, has since found an alternative place for them to live.



**NOW DISCUSS YOUR TEAM'S DISCHARGE PLAN:**

Please utilize the THREE Key Components; 1.) Assessment 2.) Vision Casting 3.) Teamwork/Staff

**Brief Overview of your Team's Discharge Plan:**

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**AT THIS POINT RE-START THE VIDEO AND WATCH WHAT THIS TEAM CAME UP WITH AS A DISCHARGE PLAN.**

Take a few minutes and write brief answers to the following questions. Compare your Team's Discharge plan to the Team on the video. This should be an interactive discussion.

1.) Assessment: How did your team utilize this component compared to the team in the video?  
Briefly Describe:

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2.) Vision Casting: How did your team utilize this component compared to the Team in the video?  
Briefly describe:

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3.) Teamwork/Staff: How did your team utilize this component compared to the team in the video?  
Briefly describe:

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