Anthem Blue Cross and Blue Shield

Tips for Improving Skilled Nursing Discharge Planning

Skilled nursing facilities are responsible for caring for members who are admitted but also in assisting the transition of members who are ready to leave the facility. The transition process begins at the moment that the member is accepted to the facility for medically necessary care. In order to ensure that your facility receives a timely authorization and/or update to the authorization, your clinical information needs to be sent 24 hours before the last approved day (LAD) with accurate and current clinical information. In order to facilitate a safe, efficient and effective discharge, discharge planning with the member and family should begin when the member is admitted. Please follow these tips and include the progress in your clinical information to include but not be limited to:

- Identify and set realistic goals for the member
- Include medical updates related to ongoing medical issues
- Begin and continue discharge planning along with identifying barriers to returning home or to community when the member is admitted
- Schedule and include information about care conferences with PT, OT, ST, Social Workers and family to discuss discharge planning
- Include summary of discussions with member and family the needs for DME, home care, Passport, Meals on Wheels, Life Alert, etc. (precertification may be required for some of these services so submit your precertification requests as early as possible)
- Beginning with admission to the facility, determine if home evaluations are needed and include the status of how your facility is teaching the member to handle medical conditions once home. Examples include but are not limited to wound care, trach care and management, peg care, tube feeding administration, diabetes management and ostomy care and management
- Make follow up appointments with doctors and other health care providers who will manage the member’s care when they leave the facility and communicate those appointments to the member and family
- Reconcile and fill member prescriptions before the member leaves the facility so that they do not miss their medications

Following these guidelines will ease the transition of the member and their family once the member leaves your facility. Our shared goal is to ensure that members are returned safely to home or community with improved quality of life and help to avoid hospital or skilled nursing facility re-admissions. The end result will be a member and their family ready to move forward and better manage their medical conditions in the future.

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