Angina or Chest Pain

ORG: M-5040 (RFC)
Link to Codes

MCG Health
Recovery Facility Care
27th Edition

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Clinical Indications for Admission to Recovery Facility

- Skilled nursing facility (SNF) or subacute facility care is/was needed for appropriate care of patient because of **ALL** of the following:
  - There are no acute hospital care needs.(1)
  - The patient has Intense and complex care needs that make recovery facility care safer and more practical than attempting care at a lower level and **ALL** of the following[A][B](4):
    - These care needs include the multiple components of care that are delivered by skilled professionals at a recovery facility.[C][D][E]
    - There is a plan to provide **ALL** of the following(14):
      - Care plan management and evaluation to meet patient needs, achieve treatment goals, and ensure medical safety(15)
      - Observation and assessment of patient's changing condition to evaluate need for treatment modification or for additional procedures until condition stabilized
      - Education services to teach patient self-maintenance or to teach caregiver patient care(16)(17)
      - Skilled care treatments daily (or more frequent), including **1 or more** of the following:
        - Nursing treatments needed for **1 or more** of the following(18):
          - Intravenous (IV) infusion, IV injection, or intramuscular (IM) injection(1)(16)
          - Oxygen administration, starting or managing changes(19)(20)
          - Patient care training and assistance for **1 or more** of the following(21):
            - Exercise program (eg, range of motion, pulmonary, cardiac)(22)(23)(24)
            - Safe performance of ADL (eg, dressing, communicating, eating)
        - Rehabilitation therapy treatments (PT, OT, or SLP) needed for **1 or more** of the following[F](18)(26)(27):
          - Ongoing assessment of rehabilitation needs and potential (eg, range of motion, strength, balance)
          - Supervision of therapeutic exercises or activities to ensure patient safety and treatment effectiveness
          - Gait evaluation and training

Alternative Levels of Care

- Patient may be candidate for other levels of care, including:
  - Home care. For admission criteria, see Angina HC.

Length of Stay

Length of stay is displayed as percentiles that are based on the observed utilization of subacute or skilled rehabilitation facility length of stay for this diagnosis. For guidelines with low claims data volume, length of stay statistics that are displayed are from combined categories (eg, major postoperative and major medical). Individual patients may require shorter or longer stays as appropriate for their clinical status and care needs. This table is designed to allow organizations to define their goals for subacute or skilled rehabilitation utilization by choosing from the displayed range.

Subacute or Skilled Nursing Rehabilitation Commercial Length of Stay					Subacute or Skilled Nursing Rehabilitation Medicare Length of Stay				
10%ile	20%ile	30%ile	40%ile	50%ile	10%ile	20%ile	30%ile	40%ile	50%ile
4	8	13	16	20	7	10	14	16	19

Evaluation and Treatment

General Treatment Course

Stage	Clinical Status	Interventions
1	• **Clinical indications for admission met** • Recovery facility comprehensive assessment and initial evaluation complete[G](18) • Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment SR complete for evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator) **QM** • Psychosocial Assessment SR complete **QM**(28)	• Transition of care planning initiated with evaluation for next level of care **QM** (32) • Interdisciplinary care plan established and implemented **QM** • Chronic condition management as indicated(33)(34) • Device monitoring

	• Social determinants of health screening complete. See Social Determinants of Health Screening Tool SR for more information. **QM** • Medication reconciliation complete. See Medication Reconciliation Tool SR for more information. **QM**(29)(30) • Hospital readmission risk factor evaluation **QM**(31) • Rehabilitation program initiated with service frequency (eg, 4 to 6 times per week) at patient's maximum participation level without compromising safety or exceeding ability or tolerance • Skilled needs identified	• DVT prophylaxis • Education for self-care **QM** (35)(36) • Fall risk management **QM** (37) • Medication management **QM** (38)(39) • Nutrition management(40)(41) • Pain management **QM** (42) • Pressure injury risk management **QM** (43) • Psychosocial issues identified and management initiated, as needed **QM** (44) • Respiratory care(42) • Thromboprophylaxis **QM** (45) • Physical therapy (PT) referral and evaluation(46) • Occupational therapy (OT) referral and evaluation(46)
2	• **Therapeutic response to interventions QM** • **Rehabilitation program established and patient participating as able with evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator) QM(47)** • Skilled services cannot be managed at lower level of care. • **Physical therapy (PT) progression** • **Occupational therapy (OT) progression**	• Care plan continues. • Ongoing assessment of clinical needs • Transition of care planning continues with evaluation for next level of care. **QM** • Education continues. **QM**
3	• **Medication regimen established and reconciliation completed QM** • **Medical status stable for patient's condition and manageable at lower level of care** • **Inserted or implanted device discontinued, or functioning normally and manageable at lower level of care** • Medical equipment and supplies available at next level of care and safe use demonstrated • **Rehabilitation completed for safe transfer to lower level of care or patient no longer demonstrating significant functional gains (eg, Activities of Daily Living (ADL) Scoring Tool Calculator)** • **Skilled services (as needed) and logistical requirements can be met at lower level of care.** • **Transition plans and education understood**	• **Transition of care planning completed QM** • Discharge from recovery facility care

Recovery Milestones are indicated in **bold**.

Extended Stay

Extended recovery facility stay may be: brief (1 to 3 days), moderate (4 to 7 days), or prolonged (more than 7 days).

- Extended recovery facility stay may be indicated when **ALL** of the following exist[H]:
  - Continued absence of acute hospital care needs
  - There are Intense and complex care needs making inpatient care a more efficient option.
  - Skilled services needed **at least daily** for **1 or more** of the following:
    - Deep venous thrombosis (DVT) or pulmonary embolus (PE) management; examples include(49):
      - Pharmacoprophylaxis initiation(50)
      - Hemodynamic measurements outside normal limits
      - Laboratory values outside normal limits; examples include:
        - Oxygen saturation below 90% (or below baseline)
        - Coagulation studies remain outside therapeutic range.
      - Signs of active bleeding
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Fall management; examples include(51):
      - Functional status significantly impaired, impacting ability to perform ADL or IADL
      - Evaluation and treatment for underlying medical etiology of fall
      - Treatment of fall injury, and injury regimen not established
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Respiratory management; examples include(20):
      - Breathing abnormalities and oxygen regimen not established
      - Laboratory values outside normal limits; examples include:
        - Oxygen saturation below 90% (or below baseline)
        - Cultures positive or identification of infective source pending, and treatment regimen not established
      - Respiratory status assessment to evaluate patient's response to treatment (eg, suctioning or pulmonary hygiene that requires skilled intervention or monitoring)(18)
      - Assessment or care unmanageable at lower level of care
      - Expect brief to moderate stay extension.
    - Significant comorbid disease exacerbation with need for skilled clinical intervention and monitoring
      - Assessment or care unmanageable at lower level of care
      - Stay extension varies depending on condition.
    - PT, OT, or SLP services; examples include(52):
      - Unanticipated functional problems impacting safe completion of therapy
      - Multiple comorbidities or frailty impairing functional improvement
      - Cognitive impairment requiring additional intervention and education(53)

- Communication impairment requiring additional intervention and education(54)
- Assessment or care unmanageable at lower level of care
- Expect brief to moderate stay extension.

Patient Education

- Patient and caregiver education. See:
  - Angina: Patient Education for Clinicians SR
  - Chest Pain: Patient Education for Clinicians SR

Discharge Planning

- Transition of care planning may include:
  - Assessment and early establishment of anticipated discharge destination and plans for care, including(4):
    - Treatment plan development involving multiple providers(55)
    - Premorbid functioning
    - Patient and caregiver preferences and abilities
    - Evaluation for skilled services at next level of care as appropriate for patient's continued needs
    - Psychosocial status. See Psychosocial Assessment SR for further information. **QM**(56)
    - Social determinants of health screening. See Social Determinants of Health Screening Tool SR for further information.(57)
    - Acceptance for care for patient at next level of care, as appropriate
  - Transition of care plan complete, which may include:
    - Patient and caregiver education complete. See Teach Back Tool SR for further information.
    - Medication reconciliation completion includes **QM** (58)(59):
      - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
      - Assess each medication for correlation to disease state or medical condition.
      - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
      - Provide reconciled medication list to all treating providers.
      - Confirm that patient or caregiver can acquire medication.
      - Educate patient and caregiver.
        - Provide complete medication list to patient and caregiver.
        - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
        - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(60)
      - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
      - See Medication Reconciliation Tool SR for more information.
    - Appointments planned or scheduled:
      - Primary care provider(61)(62)
      - Cardiologist
      - Neuropsychologist(28)
      - Outpatient imaging, tests, or procedures(24)
      - Rehabilitation program (eg, cardiac, pulmonary) at next level of care(22)(63)(64)
      - Specialists for management of comorbidities as needed
      - Surgeon(45)
      - Other
    - Referrals made for assistance or support, which may include:
      - Educational program (eg, chronic condition management, self-management)(17)
      - Financial, for follow-up care, medication, and transportation
      - Home healthcare[I][J](67)
      - Self-help or support groups(68)
      - Social services (eg, social programs, advance directives)(41)
      - Tobacco use treatment, as needed **QM** (69)(70)
      - Other
    - Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), as indicated:
      - Cardiac care equipment and supplies (eg, compression stockings)
      - Respiratory equipment and supplies
      - Other
    - Transition plan communicated to all members of patient's care team **QM**

Quality Measures

- HEDIS Measures include(71):
  - Medication reconciliation is completed.
  - Transition of care needs are assessed and addressed.
  - Psychosocial status (eg, depression screening) is assessed and addressed.
  - Fall risk is assessed and addressed.
  - Tobacco use is assessed and addressed.
  - Immunization status is assessed and addressed.
  - Readmission risk is assessed and addressed.
  - Social needs screening and intervention is completed.
- Nursing Home Compare Quality Measures include(72):
  - ADL status is assessed for improvement.
  - Readmission risk is assessed and addressed.
  - Antipsychotic medication-associated risk is reduced.
  - Immunization status is assessed and addressed.
  - Pressure injury risk is assessed and addressed.

- Fall risk is assessed and addressed.
- Medication reconciliation is completed.
- Skilled Nursing Facility Quality Reporting Program measures include(73):
  - Pressure injury risk is assessed and addressed.
  - Medication reconciliation is completed.
  - Readmission risk is assessed and addressed.
  - Transfer of health information to patient and provider is completed.
- Skilled Nursing Facility Value-Based Purchasing Program quality measures include(74):
  - Readmission risk is assessed and addressed.
- The Joint Commission Nursing Care Center National Patient Safety Goals include(75):
  - Medication reconciliation is completed. Education is provided on medication administration including the importance of bringing up-to-date medication lists to all provider visits.
  - Healthcare-associated infection risk is reduced.
  - Fall risk is assessed and addressed.
  - Pressure injury risk is assessed and addressed.
  - Blood thinning medication-associated risk is reduced.

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Footnotes

[A] **Evidence:** A retrospective cohort study evaluated 17,235,854 hospitalized patients who were discharged either to home with home healthcare or to a skilled nursing facility (SNF). The patients studied were those whose need for home health vs SNF was borderline, and either setting would be reasonable. The study found that discharge to a SNF was associated with lower readmission rates than discharge to home with home healthcare. There were no significant differences in 30-day mortality rates or improved functional status.(2) [A in Context Link 1]

[B] **Evidence:** A statistical analysis of 702,304 adults age 65 or older with pre-existing healthcare-associated infections (excluding respiratory) found that patients discharged to a skilled nursing facility had fewer avoidable readmissions than patients discharged to home or with home healthcare.(3) [B in Context Link 1]

[C] Telehealth services may be indicated in the skilled nursing facility for certain clinical situations. The Centers for Medicare and Medicaid Services (CMS) is currently providing waivers around telehealth usage that will end at the conclusion of the COVID-19 Public Health Emergency (PHE).(5)(6)(7)(8)(9)(10)(11) [C in Context Link 1]

[D] **Evidence:** A retrospective cohort study of 11,380 hospitalized adult patients found predictors for skilled nursing facility transition were functional impairments in mobility and bathing; demographic variables were older age, single, Medicare insurance, living alone, facility dwelling, and home less than 50 miles (80.5 km) from hospital.(12) [D in Context Link 1]

[E] **Evidence:** A case study of 313 patients in a skilled nursing facility found that providing after-hours telemedicine care with a physician for evaluation of a change in condition during admission was associated with a reduction in both avoidable hospitalizations and estimated payer costs.(13) [E in Context Link 1]

[F] **Evidence:** A claims-based study of 1.4 million Medicare beneficiaries discharged from an acute care hospital to a post-acute care setting, including an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or home care (HC), found that more hours of occupational therapy and physical therapy services were associated with greater functional improvements, and fewer hours of occupational therapy and physical therapy services were associated with a higher risk for 30-day hospital readmission across all post-acute care settings.(25) [F in Context Link 1]

[G] **National guidelines:** The Centers for Medicare and Medicaid Services uses a data collection system to establish best practice, understand costs, and identify cost-effective systems and procedures. The current data collection system for eligible patients is the Minimum Data Set (MDS). MDS is an assessment tool used to identify patient problems, strengths, and preferences. The MDS used to create an individualized care plan can be found at www.cms.gov and search Minimum Data Set.(18) [G in Context Link 1]

[H] **Evidence:** A retrospective analysis of 91,113 episodes of care in skilled nursing facilities found that risk factors for prolonged length of stay included functional and cognitive impairment, greater pressure ulcer risk, paralysis, antibiotic resistant infection, HIV infection, need for a feeding tube, dialysis, tracheostomy, ventilator or respirator, and psychological therapy.(48) [H in Context Link 1]

[I] **Evidence:** A retrospective descriptive study of 1129 Medicare beneficiaries identified that being discharged home with home healthcare may decrease the likelihood of multiple hospital readmissions.(65) [I in Context Link 1]

[J] **Evidence:** A retrospective database analysis of 1543 Medicare patients discharged from a skilled nursing facility (SNF) found that a home care visit, but not an outpatient provider visit, within 1 week of SNF discharge was associated with reduced risk of 30-day hospital readmission.(66) [J in Context Link 1]

Definitions

Custodial care

- Custodial care is personal unskilled care to support the patient's care of activities of daily living (ADL), such as bathing, dressing, and eating.(1)

References

1. Mauk KL. Post-acute care. In: Larsen PD, editor. Lubkin's Chronic Illness: Impact and Intervention. 11th ed. Jones & Bartlett Learning; 2022:477-520.

Hospital readmission risk factor evaluation

- **Evidence:** A retrospective cohort study of 693,808 Medicare patients transferred from a hospital to a skilled nursing facility then discharged home found that potentially preventable hospital readmissions were higher for patients with decreased functional status at discharge, including decreased mobility, self-care, and cognition.(1) **Evidence:** A retrospective cohort study evaluated 17,235,854 hospitalized patients who were discharged either to home with home healthcare or to a skilled nursing facility (SNF). The patients studied were those whose need for home health vs SNF was borderline, and either setting would be reasonable. The study found that discharge to a SNF was associated with lower readmission rates than discharge to home with home healthcare. There were no significant differences in 30-day mortality rates or improved functional status.(2) **Evidence:** A statistical analysis of 14,666 skilled nursing facilities found lower 30-day hospital readmissions in skilled nursing facilities with location inside a hospital facility, rural designation, higher registered nurse-to-nurse ratios, and not-for-profit status.(3)

References

1. Middleton A, Downer B, Haas A, Lin YL, Graham JE, Ottenbacher KJ. Functional status Is associated with 30-day potentially preventable readmissions following skilled nursing facility discharge among Medicare beneficiaries. Journal of the American Medical Directors Association 2018;19(4):348-354.e4. DOI: 10.1016/j.jamda.2017.12.003.
2. Werner RM, Coe NB, Qi M, Konetzka RT. Patient outcomes after hospital discharge to home with home health care vs to a skilled nursing facility. JAMA Internal Medicine 2019;179(5):617-623. DOI: 10.1001/jamainternmed.2018.7998.
3. Smith TB, English TM, Naidoo J, Whitman MV. The hospital readmissions reduction program's impact on readmissions from skilled nursing facilities. Journal of Healthcare Management 2019 May-Jun;64(3):186-196. DOI: 10.1097/JHM-D-18-00035.

Intense and complex care needs

- Intense and complex care needs require assessment of the patient's clinical needs, ability, and tolerance for treatment, with an evaluation of logistical requirements of needed services. Care must support positive outcomes and safe transition to the next level of care.(1) Logistical requirements of needed services is the ability to coordinate and transfer the patient from various care settings. Logistical requirements may increase the complexity of the patient's care, for example, conditions requiring extensive assistance (eg, body cast, burns, being bedbound) may create an excessive physical hardship for the patient to receive needed care on an outpatient basis.(2)

References

1. Shyu SG. The physiatric history and physical examination. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 6th ed. Philadelphia, PA: Elsevier; 2018:3-13.
2. Centers for Medicare and Medicaid Services. "Criteria for 'practical matter'." 42 CFR Pt. 409.35 Washington, DC 2022 Oct [accessed 2022 Oct 17] Accessed at: https://www.ecfr.gov/.

Occupational therapy (OT) progression

- OT progression includes **ALL** of the following(1)(2):
  - Ongoing evaluation of treatment plan with short-term and long-term goals
  - Ongoing evaluation of rehabilitation potential toward achieving goals
  - Patient demonstrates resolution of barriers to transition of care and **1 or more** of the following:
    - Measured improvements in performance of short-term goals in reasonable and predictable time frame based on treatment plan[A](3)(4)(5)
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals within 3 days as condition improves

References

1. Shotwell MP. Evaluating clients. In: Schell BA, Gillen G, editors. Willard & Spackman's Occupational Therapy. 13th ed. Philadelphia, PA: Wolters Kluwer; 2019:369-389.
2. Pryor J, O'Reilly K, Bonser M, Garret G, McKenchnie D. Rehabilitation for the individual and family. In: Chang E, Johnson A, editors. Living With Chronic Illness and Disability. 4th ed. Chatswood NSW 2067: Elsevier; 2022:161-182.
3. Halmai E. Quality and outcome measures for medical rehabilitation. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 6th ed. Philadelphia, PA: Elsevier; 2018:39-43.
4. Steinmetz JP, Bourkel E. Clinical-instrumental evaluation of elderly patients during rehabilitation. In: Masiero S, Carraro U, editors. Rehabilitation Medicine for Elderly Patients. Cham, Switzerland: Springer; 2018:199-212.
5. Barker K, Eickmeyer S. Therapeutic exercise. Medical Clinics of North America 2020;104(2):189-198. DOI: 10.1016/j.mcna.2019.10.003.

Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, FIM®).(3)(4) Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of restorative therapy. Speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.

Physical therapy (PT) progression

- PT progression includes **ALL** of the following(1)(2)(3):
  - Ongoing evaluation of treatment plan with short-term and long-term goals
  - Ongoing evaluation of rehabilitation potential toward achieving goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Measured improvements in performance of short-term goals in reasonable and predictable time frame based on treatment plan[A](4)(5)
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals as condition improves

References

1. O'Sullivan SB. Clinical decision making. In: O'Sullivan SB, Schmiz TJ, Fulk GD, editors. Physical Rehabilitation. 7th ed. Philadelphia, PA: F.A. Davis; 2019.
2. Malone DJ. Introduction to physical therapist management of the acute care patient. In: Malone DJ, Bishop KL, editors. Acute Care Physical Therapy. 2nd ed. Slack, Inc.; 2020:1-50.
3. Centers for Medicare and Medicaid Services. "Skilled services requirements." 42 CFR Pt. 409.44 Washington, DC 2022 Oct [accessed 2022 Oct 17] Accessed at: https://www.ecfr.gov/.
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5. Barker K, Eickmeyer S. Therapeutic exercise. Medical Clinics of North America 2020;104(2):189-198. DOI: 10.1016/j.mcna.2019.10.003.

Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, increased ROM/strength, increased balance scores, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, FIM®, WeeFIM®, Tinetti, BERG Balance Scale).(2)(4) Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.

Rehabilitation completed for safe transfer to lower level of care or patient no longer demonstrating significant functional gains

- **National guideline:** Rehabilitation services are not considered skilled for the supervision of taught exercises, repetitious exercise administration (unless there is a loss of function), or are provided for assistance only.(1)

References

1. Centers for Medicare and Medicaid Services. "Examples of skilled nursing and rehabilitation services." 42 CFR Pt. 409.33 Washington, DC 2022 Oct [accessed 2022 Oct 17] Accessed at: https://www.ecfr.gov/.

Skilled care

- Skilled care is that which must be performed or supervised by professional or technical personnel, be reasonable and necessary for patient's treatment, and exceed scope of Custodial care . Skilled care may be direct (eg, in-person assessment and administration of treatments) or indirect (eg, coordinating care between providers, supervising care aides).[A](2)(3)

References

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2. Transitional planning: understanding levels and transitions of care. In: Powell SK, Tahan H, editors. Case Management a Practical Guide for Education and Practice. 4th ed. Philadelphia, PA: Wolters Kluwer, Lippincott, Williams & Wilkins; 2019:156-211.
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Footnotes

A. **National guidelines:** The Centers for Medicare and Medicaid Services defines skilled care as a service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel."(1)

Telehealth services

- Telehealth services involve a remote exchange of health data between patient and provider. The data are exchanged in real time, using equipment that may send data via the internet, audio interaction, or video conferencing. The types of services delivered could include medical or rehabilitation examination, assessment, condition management, care coordination, or education.(1)(2)

References

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2. Gies CE. Health-related quality of life. In: Larsen PD, editor. Lubkin's Chronic Illness: Impact and Intervention. 11th ed. Jones & Bartlett Learning; 2022:49-86.

Transition of care planning completed

- Transition of care planning completed; components for safe transition include(1)(2)(3):
  - Transition plan communicated to all members of patient's healthcare team
  - Summary of care, discharge list of medications, and transition plan communicated to primary care provider
  - Medication reconciliation complete
  - Education on condition management and complications to report provided to patient or caregiver[A]
  - Follow-up appointments scheduled
  - Referrals to continue medical and rehabilitation goals (eg, outpatient) arranged, if needed
  - Services (eg, equipment, environment modifications, transportation) arranged, if needed
  - Psychosocial issues addressed, or plan for management, if needed

References

1. Transitional planning: understanding levels and transitions of care. In: Powell SK, Tahan H, editors. Case Management a Practical Guide for Education and Practice. 4th ed. Philadelphia, PA: Wolters Kluwer, Lippincott, Williams & Wilkins; 2019:156-211.
2. Gupta S, Perry JA, Kozar R. Transitions of care in geriatric medicine. Clinics in Geriatric Medicine 2019;35(1):45-52. DOI: 10.1016/j.cger.2018.08.005.
3. Saleeby J. Communication and collaboration. In: Perry AG, Potter PA, Ostendorf WR, editors. Nursing Interventions and Clinical Skills. 7th ed. Elsevier; 2020:9-21.
4. Hudson T. The role of social determinates of health in discharge practices. Nursing Clinics of North America 2021;56(3):369-378. DOI: 10.1016/j.cnur.2021.04.004.

Footnotes

A. Health education materials should be given in patient's and caregiver's native language using trained language interpreters whenever possible.(4)

Codes

ICD-10 Diagnosis: I20.0, I20.1, I20.2, I20.8, I20.9, I23.7, I24.0, I24.8, I24.9, I25.110, I25.111, I25.112, I25.118, I25.119, I25.700, I25.701, I25.702, I25.708, I25.709, I25.710, I25.711, I25.712, I25.718, I25.719, I25.720, I25.721, I25.722, I25.728, I25.729, I25.730, I25.731, I25.732, I25.738, I25.739, I25.750, I25.751, I25.752, I25.758, I25.759, I25.760, I25.761, I25.762, I25.768, I25.769, I25.790, I25.791, I25.792, I25.798, I25.799, M94.0, R07.1, R07.2, R07.81, R07.82, R07.89, R07.9, T82.855A, T82.855D, T82.855S [Hide]

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