

CMS Proposed Rule:

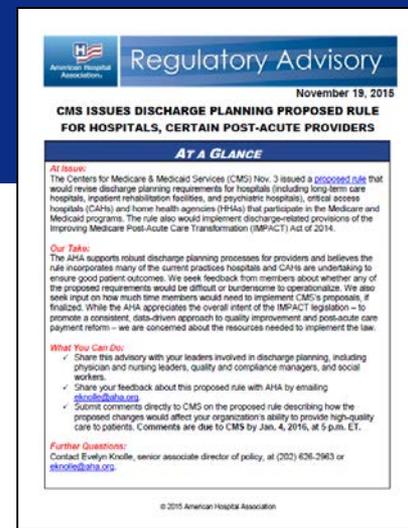
Revising the Requirements for Discharge Planning

Dec. 1, 2015



**American Hospital
Association**

Key Dates and Facts



CMS published the rule in the *Federal Register* on Nov. 3, 2015.

The proposed rule updates discharge planning requirements for:

- hospitals, including:
 - general acute, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals
- critical access hospitals (CAHs), and
- home health agencies (HHAs).

It also implements discharge-related provisions of the IMPACT Act of 2014.

Comments are due by 5 p.m. on Jan. 4, 2016.



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Hospitals and CAHs

CMS proposes that hospitals and CAHs implement effective discharge planning processes that:

- ✓ address the patient's goals, needs and treatment preferences
- ✓ prepare patients and their caregivers to be active partners/participants in post-discharge care
- ✓ promote effective transitions, and
- ✓ reduce the factors that lead to preventable readmissions.



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Hospitals/CAHs: Discharge Plans



Applicability: Hospitals and CAHs would need to create discharge plans for:

- ❑ All inpatients
- ❑ Some outpatients, including
 - observation patients
 - same-day patients receiving anesthesia or moderate sedation
 - emergency department patients identified by emergency department practitioners as needing a discharge plan, and
 - other categories of outpatients recommended by the medical staff and specified in the hospital's/CAH's discharge planning policies approved by the governing body.



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Hospitals/CAHs: Discharge Plans

Timing. Hospitals and CAHs would need to:

- begin to identify discharge needs for patients within 24 hours after admission/registration
- regularly re-evaluate a patient's condition to identify necessary modifications of the discharge plan, and
- complete the discharge planning process in a timely manner, prior to discharge or transfer. The process must not unduly delay the patient's discharge or transfer.

Emergency-level transfers for patients:

- No discharge evaluation or plan required, but hospital/CAH must send necessary information.



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Hospitals/CAHs: Discharge Plans



People involved in the development of individual discharge plans. CMS proposes that:

- A registered nurse, social worker or other personnel qualified in accordance with the hospital's/CAH's discharge planning policies would need to coordinate the discharge needs evaluation and development of the discharge plan.
- The practitioner responsible for the care of the patient must be involved in the ongoing process of establishing the patient's goals and treatment preferences that inform the discharge plan.
- The patient and caregiver/support person also must be involved in the development of the plan and informed of the final plan.



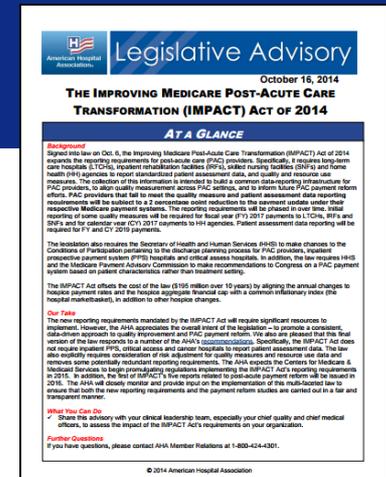
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Hospitals/CAHs: Discharge Plans

Criteria for the evaluation of discharge needs. CMS outlines numerous factors that must be considered in evaluating discharge needs, such as:

- caregiver/support person and community-based care availability
- the patient's or caregiver's capability to perform required care
- admitting diagnosis or reason for registration
- relevant co-morbidities and past medical and surgical history
- anticipated ongoing care needs and readmission risk
- relevant psychosocial history
- communication needs
- the patient's access to non-health care services, and
- the patient's goals and treatment preferences.

IMPACT Act of 2014



The IMPACT Act:

- expanded data reporting requirements for post-acute providers, and
- requires certain providers “to take into account” quality, resource use and other data in discharge planning.

The proposed rule would require hospitals and CAHs to:

- ✓ assist patients/support persons in selecting a post-acute provider by sharing relevant data that includes the quality and resource use measures for HHAs, SNFs, IRFs and LTCHs
- ✓ be available to discuss and answer questions about a patient’s post-discharge options and needs, and
- ✓ consider the IMPACT Act quality measure data in light of the patient’s goals and treatment preferences.

Hospitals/CAHs: Discharge to Home

Discharge Instructions. CMS proposes that discharge instructions be provided to patients and/or caregiver/support persons as well as any post-acute care providers. Components include:

- instruction on post-discharge care
- written information on warning signs and symptoms that may indicate the need to seek immediate medical attention
- prescriptions (and for hospitals, over-the counter medications) that are required after discharge
- reconciliation of all discharge medications with the patient's pre-hospital/CAH admission medications, and
- written instructions regarding the patient's follow-up care.



Post Discharge Follow-Up Process

Post-Discharge Follow-up. CMS proposes that hospitals and CAHs establish a post-discharge follow-up process for patients discharged to home. However:

- CMS does not specify the mechanism or timing of follow-up programs.
- The rule also is unclear as to whether the process would apply to *all* patients discharged to home.

Question: What would be reasonable in terms of follow-up processes for hospitals and CAHs?



Hospitals/CAHs: Transfers



Transfers. When transferring patients, hospitals and CAHs would be required to provide the following specific medical information to the receiving facility. *Note – no specified format.*

- Demographic information
- Contact information for the practitioner responsible for the care of the patient, and the patient's caregiver(s)/support person(s), if applicable
- Advance directive, if applicable
- Course of illness/treatment
- Procedures, diagnoses, and laboratory tests, and the results of pertinent laboratory and other diagnostic testing
- Consultation results
- Functional status assessment
- Psychosocial assessment, including cognitive status
- Social supports

(Cont'd)



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Hospitals/CAHs: Transfers



- Behavioral health issues
- Reconciliation of all discharge medications with the patient's prehospital admission/registration medications
- All known allergies, including medication allergies
- Immunizations
- Smoking status
- Vital signs
- Unique device identifier(s) for a patient's implantable device(s)
- All special instructions or precautions for ongoing care
- Patient's goals and treatment preferences; and
- All other necessary information, including a copy of the patient's discharge instructions, the discharge summary and any other documentation as applicable, to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.



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PDMPs



Prescription drug monitoring programs.

CMS specifically asks for comments on:

1. whether providers, in evaluating patient discharge needs, should be required to consult with their state's PDMP to review a patient's risk of non-medical use of controlled substances and substance use disorders; and
2. whether PDMPs should be used in the medication reconciliation process.



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Hospitals/CAHs: Behavioral Health Focus

Improving focus on Behavioral Health. CMS states that hospitals and critical access hospitals (CAHs) should improve their focus on psychiatric and behavioral health patients, including patients with substance use disorders. CMS does not propose, but mentions its expectations, that hospitals and CAHs must:

- identify the types of services needed upon discharge, including options for tele-behavioral health services as available/appropriate
- identify organizations offering community services in the psychiatric hospital or unit's community, and try to establish partnerships
- arrange, as applicable, for the development and implementation of a specific psychiatric discharge plan for the patient as part of the patient's overall discharge plan, and
- coordinate with the patient for referral for post-acute psychiatric or behavioral health care.

Home Health Agencies

CMS proposes that HHAs implement effective discharge planning processes that:

- ✓ prepare patients to be active partners in post-discharge care
- ✓ promote effective transitions to post-HHA care, and
- ✓ reduce the factors that lead to preventable readmissions.



HHAs: Discharge Plans



CMS's new discharge planning proposals would require HHAs to:

- develop a discharge plan for each patient that addresses his or her goals, needs, and treatment preferences, and
- regularly re-evaluate patients and update their discharge plans as needed.



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Development of the Plan

Evaluation factors. In evaluating discharge needs of patients, the HHA must consider:

- the goals, preferences, and needs of each patient
- caregiver/support person availability, and
- the patient's or caregiver's capability to perform required care.



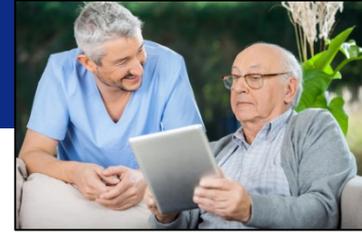
Development of the Plan

People involved. The rule would require that:

- the physician responsible for the home health plan of care be involved in the ongoing process of establishing the discharge plan, and
- the patient and caregiver(s) be involved in the development of the discharge plan and informed of the final plan.



HHAs: Completion of the Discharge Plan



The evaluation of the patient's discharge needs and the discharge plan must be:

- documented
- completed on a timely basis, and
- included in the clinical record.

The results of the evaluation must be discussed with the patient or patient's representative.



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IMPACT Act of 2014



The IMPACT Act:

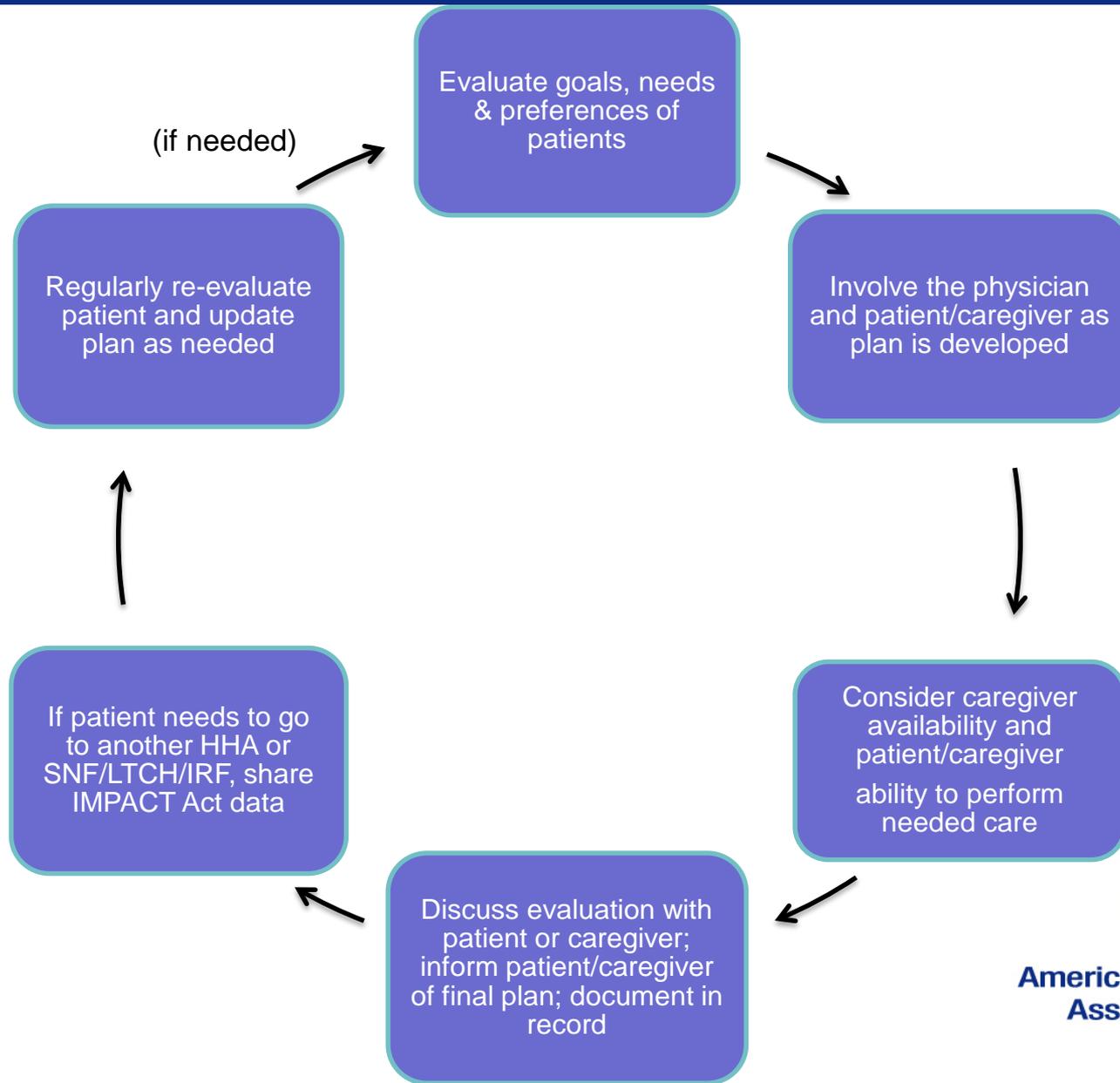
- expanded quality data reporting requirements for HHAs, and
- requires HHAs “to take into account” certain quality, resource use and other data in discharge planning.

As with hospitals and CAHs, HHAs must assist patients and their caregivers in selecting a post-acute provider by sharing HHA quality and resource use measure data.



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HHAs: Overview- Key Steps in the Process



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Discharge/Transfer Summary

The rule lists specific medical information that HHAs would need to send to a receiving facility or health care practitioner:

- Demographic information
- Physician contact information
- Advance directive, if applicable
- Course of illness/treatment
- Procedures
- Diagnoses
- Laboratory tests and results of pertinent laboratory and diagnostic testing
- Consultation results
- Functional status assessment
- Psychosocial assessment
- Social supports
- Behavioral health issues
- Reconciliation of all discharge medications

(Cont'd)



Discharge/Transfer Summary

- Known allergies, including medication allergies
- Immunizations
- Smoking status
- Vital signs
- Unique device identifier(s) for implantable device(s), if any
- Recommendations for ongoing care
- Patient's goals of care & treatment preferences
- The patient's current plan of care, and
- Any other information necessary to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.

**For any elements that do not apply to a patient, HHAs would need to use "N/A" or another appropriate notation.*



Discussion Questions

1. How closely do the agency's proposals for discharge planning resemble what you are already doing? What are the main differences?
2. Would the proposed requirements create additional administrative burden or necessitate an increase in your organization's workforce?
3. What timeframe would you need to implement CMS's proposals, if they are finalized?



Contact Information

Evelyn Knolle
Senior Associate Director, Policy
American Hospital Association
eknolle@aha.org
(202) 626-2963



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