CMS Proposed Rule:
Revising the Requirements for Discharge Planning

Dec. 4, 2015
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.
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.
Discharge Plan Policies

Written discharge planning policies and procedures must be developed with input from . . .

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<thead>
<tr>
<th>Hospital</th>
<th>CAH</th>
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<tbody>
<tr>
<td>Medical staff</td>
<td>Professional health care staff</td>
</tr>
<tr>
<td>Nursing leadership</td>
<td>Nursing leadership</td>
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<tr>
<td>Other relevant departments</td>
<td>Other relevant departments</td>
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. . . and reviewed/approved by the governing body or, for CAHs, either the governing body or responsible individual.

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

- All inpatients
- Some outpatients, including
  - observation patients
  - same-day patients receiving anesthesia/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 hospital/CAH policy.
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.

*There are exceptions for emergency-level transfers.*
People involved in the development of discharge plans:

<table>
<thead>
<tr>
<th>Person</th>
<th>Role</th>
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<tr>
<td>A registered nurse, social worker or other personnel qualified in accordance with the hospital’s/CAH’s discharge planning policies . . .</td>
<td>coordinates the discharge needs evaluation and development of the discharge plan.</td>
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<tr>
<td>The practitioner responsible for the care of the patient . . .</td>
<td>must be involved in the ongoing process of establishing the patient’s goals and treatment preferences that inform the discharge plan.</td>
</tr>
<tr>
<td>The patient and caregiver or support person . . .</td>
<td>must be involved in the development of the plan and informed of the final plan.</td>
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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
- Relevant co-morbidities and past medical and surgical history
- Admitting diagnosis or reason for registration
- The patient's goals and treatment preferences
- The patient's access to non-health care services
- Communication needs
- Relevant psychosocial history, and
- Anticipated ongoing care needs and readmission risk.
The IMPACT Act of 2014

The IMPACT Act:

- expanded quality and resource use 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.
**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)
- 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. 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?
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)*
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.
Other Hospital Requirements

For hospitals, when referring patients for post-acute care:

- include a list of post-acute care providers in discharge plan
  - notify patients in managed care organizations to check networks, or share that data if hospital has it
- inform patient of freedom to choose among Medicare providers
- discharge plan must identify any HHA or SNF to which the patient is referred in which hospital has disclosable financial interest.
PDMPs

Prescription drug monitoring programs.

CMS asks:

1. Should providers, in evaluating patient discharge needs, consult with their state’s PDMP?

2. Should PDMPs be used in the medication reconciliation process?
**Improving focus on Behavioral Health.** CMS wants hospitals and critical access hospitals (CAHs) to improve their focus on psychiatric and behavioral health patients.

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.
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?
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