

DISCHARGE PLANNING

A-0799**(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)****§482.43 Condition of Participation: Discharge Planning**

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

Interpretive Guidelines §482.43

Hospital discharge planning is a process that involves determining the appropriate post-hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient's identified post-discharge needs. Newer terminology, such as "transition planning" or "community care transitions" is preferred by some, since it moves away from a focus primarily on a patient's hospital stay to consideration of transitions among the multiple types of patient care settings that may be involved at various points in the treatment of a given patient. This approach recognizes the shared responsibility of health care professionals and facilities as well as patients and their support persons throughout the continuum of care, and the need to foster better communication among the various groups. Much of the interpretive guidance for this CoP has been informed by newer research on care transitions, understood broadly. At the same time, the term "discharge planning" is used both in Section 1861(ee) of the Social Security Act as well as in §482.43. In this guidance, therefore, we continue to use the term "discharge planning."

When the discharge planning process is well executed, and absent unavoidable complications or unrelated illness or injury, the patient continues to progress towards the goals of his/her plan of care after discharge. However, it is not uncommon in the current health care environment for patients to be discharged from inpatient hospital settings only to be readmitted within a short timeframe for a related condition. Some readmissions may not be avoidable. Some may be avoidable, but are due to factors beyond the control of the hospital that discharged the patient. On the other hand, a poor discharge planning process may slow or complicate the patient's recovery, may lead to readmission to a hospital, or may even result in the patient's death.

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Jencks et al. analyzed Medicare claims data for a two-year period in an attempt to more accurately identify readmission (called “rehospitalization”) rates and associated costs. They found approximately 19.6% of Medicare fee-for-service beneficiaries were rehospitalized within 30 days of discharge and 34.0% within 60 days of discharge. 70.5% of those surgical patients subsequently readmitted within 30 days had a medical cause for the readmission. Only approximately 10% of rehospitalizations were estimated to have been planned.

Reducing the number of preventable hospital readmissions is a major priority for patient safety, and holding hospitals accountable for complying with the discharge planning CoP is one key element of an overall strategy for reducing readmissions.

With respect to the causes of the high rate of preventable readmissions, “Multiple factors contribute to the high level of hospital readmissions in the U.S.... They may result from poor quality care or from poor transitions between different providers and care settings. Such readmissions may occur if patients are discharged from hospitals or other health care settings prematurely; if they are discharged to inappropriate settings; or if they do not receive adequate information or resources to ensure a continued progression of services. System factors, such as poorly coordinated care and incomplete communication and information exchange between inpatient and community-based providers, may also lead to unplanned readmissions.” The discharge planning CoP requirements address all of these factors. While hospitals are not solely responsible for the success of their patients’ post-hospital care transitions, under the discharge planning CoP hospitals are expected to employ a discharge planning process that improves the quality of care for patients and reduces the chances of readmission.

For Information – Not to be Cited under the CoP

These interpretive guidelines address hospital discharge requirements under the Medicare statute and regulations. However, hospitals should be aware that, as entities receiving Federal financial assistance (including Medicaid and Medicare payments) and public accommodations, they are subject to the requirements of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. These statutes and their implementing regulations require that covered entities administer their services, programs and activities in the most integrated setting appropriate to individuals with disabilities and prohibit covered entities from utilizing criteria or methods of administration that lead to discrimination. CMS does not interpret or enforce these requirements. However, hospitals should ensure that their discharge practices comply with applicable Federal civil rights laws and do not lead to needless segregation.

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The plain language of the regulation requires hospitals to have a discharge planning process in effect for “all” patients. However, the preamble to the adoption of this regulation on December 13, 1994 makes it clear that this “all patients” language was meant to distinguish the final rule from the proposed rule, which would have applied only to hospital inpatients who were Medicare beneficiaries. It was not intended to apply the discharge planning process to outpatients as well as inpatients. Specifically, the preamble stated, “Discharge planning presupposes hospital admission and section 9305(c) of OBRA ’86 specifically indicates that discharge planning follows hospitalization.” (59 FR at 64141, December 13, 1994). Accordingly, under the regulation, hospitals are required to have a discharge planning process that applies to all inpatients; discharge planning is not required for outpatients.

For Information – Not Required/Not to be Cited

Hospitals might consider utilizing, on a voluntary basis, an abbreviated post-hospital planning process for certain categories of outpatients, such as patients discharged from observation services, from same day surgery (including invasive procedures – see the definition of surgery in the guidance for the surgical services CoP), and for certain categories of emergency department discharges. Given the increasing complexity of services offered in the outpatient setting, many of the same concerns for effective post-hospital care coordination arise as for inpatients.

The discharge planning CoP (and Section 1861(ee) of the Act on which the CoP is based) provides for a four-stage discharge planning process:

- Screening all inpatients to determine which ones are at risk of adverse health consequences post-discharge if they lack discharge planning;
- Evaluation of the post-discharge needs of inpatients identified in the first stage, or of inpatients who request an evaluation, or whose physician requests one;
- Development of a discharge plan if indicated by the evaluation or at the request of the patient’s physician; and
- Initiation of the implementation of the discharge plan prior to the discharge of an inpatient.

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The hospital is required to specify in writing its discharge planning policies and procedures. The policies and procedures must address all of the requirements of 42 CFR 482.43(a) – 482.43(e). The hospital must take steps to assure that its discharge planning policies and procedures are implemented consistently.

For Information – Not Required/Not to be Cited

It would be advisable for the hospital to develop its discharge planning policies and procedures with input from the hospital’s medical staff prior to review and approval by the governing body.

Hospitals are also encouraged to obtain input from:

- Other healthcare facilities and professionals who provide care to discharged patients, including but not limited to: nursing homes/skilled nursing facilities, home health agencies, primary care physicians and clinics, etc.; and

The discharge planning CoP specifically addresses the role of the patient, or the patient’s representative, by requiring the hospital to develop a discharge planning evaluation at the patient’s request, and to discuss the evaluation and plan with the patient. This is consistent with the regulations at 42 CFR 482.13(b)(1) & (2), that provide the patient has the right to participate in the development and implementation of his/her plan of care, and to make informed decisions regarding his/her care. Accordingly, hospitals must actively involve patients or their representatives throughout the discharge planning process. Further, the specific discharge planning evaluation requirement to assess a patient’s capability for post-discharge self-care requires the hospital, as needed, to actively solicit information not only from the patient or the patient’s representative, but also from family/friends/support persons.

For Information – Not Required/Not to be Cited

If a patient exercises the right to refuse to participate in discharge planning or to implement a discharge plan, documentation of the refusal is recommended.

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Survey Procedures §482.43

- Determine whether the hospital has written policies and procedures for discharge planning.

Evaluate compliance with each standard within the discharge planning CoP in accordance with the guidance below. Following standard practice, depending on the manner and degree of deficiencies identified related to specific discharge planning standards, determine whether deficiencies in one or more of these areas rises to the level of substantial, i.e., condition-level, noncompliance with this CoP.

A-0800

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(a) Standard: Identification of Patients in Need of Discharge Planning

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

Interpretive Guidelines §482.43(a)

For Information – Not Required/Not to be Cited

Given the high level of readmissions that hospitals experience, a hospital would be well advised to assume that every inpatient requires a discharge plan to reduce the risk of adverse health consequences post-discharge. Providing a discharge plan for every inpatient means the hospital avoids the problems that result if it utilizes a screening process that fails to predict adequately which patients need a discharge plan to avoid adverse consequences.

This does not mean that every discharge plan will be equally detailed or complex; some may be comparatively simple, for example, focusing on clear instructions for self-care for patients whose post-care needs may be readily met in their home environment. On the other hand, other patients may have complex needs for care after discharge. It is common for many patients to be discharged with a need for numerous on-going services/therapies, such as intravenous (IV) medications, intensive physical and occupational therapy, remote monitoring, wound care, etc. The key is that the discharge plan must reflect a thorough evaluation of the patient's post hospital care needs and must address the needs identified.

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If a hospital does not voluntarily adopt a policy of developing a discharge plan for every inpatient, then the hospital must evaluate all inpatients to identify those patients for whom the lack of an adequate discharge plan is likely to result in an adverse impact on the patient's health. While there is no one nationally accepted tool or criteria for identifying those patients who require discharge planning, the following factors have been identified as important: the patient's functional status and cognitive ability; the type of post-hospital care the patient requires, and whether such care requires the services of health care professionals or facilities; the availability of the required post-hospital health care services to the patient; and the availability and capability of family and/or friends to provide follow-up care in the home.

For hospitals that do not develop a discharge plan for every inpatient, the hospital's discharge planning policies and procedures must document the criteria and screening process it uses to identify patients likely to need discharge planning, including the evidence or basis for the criteria and process. They must also identify which staff are responsible for carrying out the evaluation to identify patients likely to need discharge planning.

The regulation requires that the identification of patients must be made at an early stage of the patient's hospitalization. This is necessary in order to allow sufficient time to complete discharge planning evaluations and develop appropriate discharge plans, for those patients who need them. (See §482.43((b)(5)) Ideally the identification process will be completed when the patient is admitted as an inpatient, or shortly thereafter. However, no citations will be made if the identification of patients likely to need discharge planning is completed at least 48 hours in advance of the patient's discharge and there is no evidence that the patient's discharge was delayed due to the hospital's failure to complete an appropriate discharge planning evaluation on a timely basis or that the patient was placed unnecessarily in a setting other than where he/she was admitted from primarily due to a delay in discharge planning. For example, a delay in identification of a patient in need of discharge planning might result in discharging the patient to a nursing facility, because such placements can be arranged comparatively quickly, when the patient preferred to return home, and could have been supported in the home environment with arrangement of appropriate community services.

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If the patient's stay is for less than 48 hours, hospitals must nevertheless ensure that they are screened so that, if needed, the discharge planning process is completed before the patient's discharge.

Changes in the patient's condition may warrant development of a discharge plan for a patient not identified during the initial screening process. The hospital's discharge planning policies and procedures must address how the staff responsible for discharge planning will be made aware of changes in a patient's condition that require a discharge planning evaluation.

In the event that a patient is transferred to another hospital, any pertinent information concerning the identification of the patient's post-hospital needs should be in the patient's medical record that is transferred with the patient. The receiving hospital then becomes responsible for the discharge planning process for the patient.

Survey Procedures §482.43(a)

- In every inpatient unit surveyed is there evidence of timely screening to determine if a discharge planning evaluation is needed? (Not applicable in hospitals that require a discharge planning evaluation for all inpatients.)
- Conduct discharge tracers for several open and closed inpatient records to determine:
 - When was the screening done to identify inpatients needing a discharge planning evaluation?
 - If the hospital conducts an evaluation for all inpatients, or if it documents in the medical record screening of an inpatient before or at time of admission, or at least 48 hours prior to discharge, it is in compliance.
 - For patients whose stay was less than 48 hours is there any evidence of screening to determine if discharge planning was needed?
 - Can hospital staff demonstrate that the hospital's criteria and screening process for a discharge planning evaluation are correctly applied.

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- For patients not initially identified as in need of a discharge plan, is there a process for updating this determination based on changes in the patient's condition or circumstances?
 - Does the discharge planning policy address changes in patient condition that would call for a discharge planning evaluation of patients not previously identified as in need of one?
 - Are inpatient unit staff aware of how, when, and whom to notify of changes in the patient's clinical condition that might warrant a change in the discharge planning process?

A-0806

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§482.43(b) Standard: Discharge Planning Evaluation

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

(4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

Interpretive Guidelines §482.43(b)(1), §482.43(b)(3) & §482.43(b)(4)

For every inpatient identified under the process required at §482.43(a) as at potential risk of adverse health consequences without a discharge plan, a discharge planning evaluation must be completed by the hospital. In addition, an evaluation must also be completed if the patient, or the patient's representative, or the patient's attending physician requests one. Unless the hospital has adopted a voluntary policy of developing an evaluation for every inpatient, the hospital must also have a process for making patients, including the patient's representative, and

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attending physicians aware that they may request a discharge planning evaluation, and that the hospital will perform an evaluation upon request. Hospitals must perform the evaluation upon request, regardless of whether the patient meets the hospital's screening criteria for an evaluation.

In contrast to the screening process, the evaluation entails a more detailed review of the individual patient's post-discharge needs, in order to identify the specific areas that must be addressed in the discharge plan.

§482.43(b)(4) requires that the evaluation include assessment of the patient's capacity for self-care or, alternatively, to be cared for by others in the environment, i.e., the setting, from which the patient was admitted to the hospital. In general, the goal upon discharge is for a patient to be able to return to the setting in which they were living prior to admission. This may be the patient's home in the community or residence in a nursing home. In the case of transfer from another hospital, generally the preferred goal is to return the patient to the setting from which he/she presented to the transferring hospital.

The evaluation must consider what the patient's care needs will be immediately upon discharge, and whether those needs are expected to remain constant or lessen over time. If the patient was admitted from his/her private residence, the evaluation must include an assessment of whether the patient is capable of addressing his/her care needs through self-care. The evaluation must include assessment of whether the patient will require specialized medical equipment or permanent physical modifications to the home, and the feasibility of acquiring the equipment or the modifications being made. If the patient is not able to provide some or all of the required self-care, the evaluation must also address whether the patient has family or friends available who are willing and able to provide the required care at the times it will be needed, or who could, if willing, be trained by the hospital sufficiently to provide the required care.

§482.43(b)(3) requires the evaluation to consider the patient's likelihood of needing post-hospital services and the availability of such services.

If neither the patient nor the patient's family or informal caregiver(s) are able to address all of the required care needs, then the evaluation must determine whether

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there are community-based services that are available to meet the patient's needs while allowing the patient to continue living at home.

Such health care services include, but are not limited to:

- Home health, attendant care, and other community-based services;
- Hospice or palliative care;
- Respiratory therapy;
- Rehabilitation services (PT, OT, Speech, etc.);
- End Stage Renal Dialysis services;
- Pharmaceuticals and related supplies;
- Nutritional consultation/supplemental diets; and/or
- Medical equipment and related supplies.

However, services may also include those that are not traditional health care services, but which may be essential to a patient's ongoing ability to live in the community, including, but not limited to:

- Home and physical environment modifications;
- Transportation services;
- Meal services; and/or
- Household services, such as housekeeping, shopping, etc.

Some of the information related to needed services will emerge from the required evaluation of the patient's ability to receive care in the home, either as self-care or provided by someone else. All patients, even those with a high capability for self-care, are likely to require some follow-up ambulatory health care services, e.g., a post-discharge appointment with their surgeon, specialist or primary care physician, or a series of appointments for physical or occupational therapy. Some patients might have more complex care needs which nevertheless may still be met in the home setting, depending on the specific clinical needs and the services available in the patient's community.

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For example, some patients require wound care that exceeds the capabilities of their family or others who act as informal caregivers. But they may be able to receive sufficient care in the home setting through a home health service, if such services are available.

Some patients with chronic conditions may prefer to remain in their home and would be able to do so using available community-based services, but also require financial supports, such as Medicaid-financed home and community-based waiver services. If such supports are not immediately available at the time of discharge while an application for waiver services is pending, the evaluation should consider the availability of other short term supports that would allow the patient to be discharged home.

If the result of the evaluation is that the patient cannot receive required care if he/she returns to home, then an assessment must be made of options for transfer to another inpatient or residential health care facility that can address the patient's needs, including other types of hospitals, such as rehabilitation hospitals; skilled nursing facilities; assisted living facilities; nursing homes; or inpatient hospice facilities.

If prior to the hospital admission the patient was a resident in a facility that he or she wishes to return to, such as an assisted living or nursing facility or skilled nursing facility, the evaluation must address whether that facility has the capability to provide the post-hospital care required by the patient. The post-discharge care requirements may be different than the care that was previously provided. This requires dialogue and cooperation between hospitals and post-hospital care facilities in the area served by the hospital, as well as with the physicians who provide care to patients in either or both of these settings.

Long term care facilities often express concern that hospitals discharge patients to their facilities with care needs that exceed their care capabilities, necessitating sending the patient to the emergency department for care and possible readmission. On the other hand, hospitals often express concern that long term care facilities send patients to the emergency department with ambulatory care-sensitive conditions, i.e., conditions that either do not require an acute level of care, or which could have been prevented from escalating to an acute level had appropriate primary care been provided in a timely manner.

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While hospitals cannot address these concerns in isolation, they are expected to be knowledgeable about the care capabilities of area long term care facilities and to factor this knowledge into the discharge planning evaluation.

Hospitals are expected to have knowledge of the capabilities and capacities of not only of long term care facilities, but also of the various types of service providers in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient's needs in theory, but also can be implemented. This includes knowledge of community services, as well as familiarity with available Medicaid home and community-based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients.

If the hospital is one with specialized services that attract a significant number of patients who will receive their post-hospital care in distant communities, the hospital is expected to take reasonable steps to identify the services that will be available to the patient.

Once the determination has been made that services will be necessary post-discharge, the team must then determine availability of those services or identify comparable substitutions. Included in the evaluation is coordination with insurers and other payers, including the State Medicaid agency, as necessary to ensure resources prescribed are approved and available.

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For Information– Not Required/Not to be Cited

Although not required under the regulations, hospitals would be well advised to develop collaborative partnerships with post-hospital care providers to improve care transitions of care that might support better patient outcomes. This includes not only skilled nursing facilities and nursing facilities, but also providers of community-based services. For example, Centers for Independent Living (CIL) and Aging and Disability Resource Centers (ADRC) are resources for community-based services and housing available to persons with disabilities and older adults. Hospitals can find local CIL's at <http://www.ilru.org/html/publications/directory/index.html> and ADRC's and other resources at <http://www.adrc-tae.org/tiki-index.php?page=HomePage> .

The ability to pay out of pocket for services must also be discussed with the family or other support persons. Although hospitals are not expected to have definitive knowledge of the terms of any given patient's insurance coverage or eligibility for community-based services, or for Medicaid coverage, they are expected to have a general awareness of these matters and their impact on the patient's post-discharge needs and prospects for recovery. For example, if the patient is a Medicare beneficiary, the hospital is expected to be aware of Medicare coverage requirements for home health care or admission to a rehabilitation hospital, a skilled nursing facility, or a long term care hospital, etc. and to make the beneficiary aware that they may have to pay out of pocket for services not meeting the coverage requirements.

Similarly, for Medicaid, they should know coverage options for home health, attendant care, and long term care services or have contacts at the State Medicaid

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agency that can assist with these issues. As noted above, hospitals are also expected to have knowledge of community resources to assist in arranging services. Some examples include Aging and Disability Resource Centers and Centers for Independent Living (see box above).

For Information– Not Required/Not to be Cited

Providing a discharge planning tool to patients and their family or other support persons may help to reinforce the discharge plan. Use of the tools may encourage patients' participation in developing the plan as well as provide them an easy-to-follow guide to prepare them for a successful transition from the hospital. The tool should be given to patients on admission, reviewed throughout their stay, and updated prior to discharge.

Examples of available tools include:

- Medicare's "Your Discharge Planning Checklist" (available at <http://www.medicare.gov/publications/pubs/pdf/11376.pdf>)
- Agency for Healthcare, Research and Quality's (AHRQ) "Taking Care of Myself: A Guide For When I Leave the Hospital," (available at <http://www.ahrq.gov/qual/goinghomeguide.pdf>)
- Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient Toolkit" (available at <http://www.patientsafety.org/page/transtoolkit/>)

The hospital CoP governing patients' rights at §482.13(b) provides that "The patient has the right to participate in the development and implementation of his or her plan of care." (CMS views discharge planning as part of the patient's plan of care). "The patient or his/her representative (as allowed under State law) has the right to make informed decisions regarding his/her care" and "The patient's rights include...being involved in care planning and treatment." Accordingly, hospitals are expected to engage the patient, or the patient's representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient's goals and preferences as much as possible into the evaluation. A patient's goals and preferences may be, in the hospital's view, unrealistic. Identifying

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divergent hospital and patient assessments of what is realistic enables a discussion of these differences and may result in an assessment and subsequent development of a discharge plan that has a better chance of successful implementation.

For Information – Not Required/Not to be Cited

If a patient exercises the right to refuse to participate in the discharge planning evaluation, documentation of the refusal is recommended in the medical record.

Survey Procedures §482.43(b)(1), §482.43(b)(3) & §482.43(b)(4)

- In every unit with inpatient beds surveyed, is there evidence of discharge planning evaluation activities?
- Are staff members who are responsible for discharge planning evaluation correctly following the hospital's policies and procedures?
- If the hospital does not require a discharge planning evaluation for all inpatients:
 - Does the hospital have a standard process for notifying patients, their representative, and physicians that they may request a discharge planning evaluation and that the hospital will conduct an evaluation upon request?
 - Can discharge planning and unit nursing staff describe the process for a patient or the patient's representative to request a discharge planning evaluation?
 - Interview patients and their representatives. If they say they were not aware they could request a discharge planning evaluation, can the hospital provide evidence they received notice of their right?
 - Interview attending physicians to see if they are aware they can request a discharge planning evaluation. If they are not aware, can the hospital provide evidence of how they inform the medical staff about this?
- Review a sample of cases to determine if the discharge planning evaluation documents the patient's (or the patient's representatives) goals and preferences for post-discharge placement and care.

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- Review a sample of cases to determine if the discharge planning evaluation includes an assessment of:
 - The patient's post-discharge care needs being met in the environment from which he/she entered the hospital? What the patient's care needs will be immediately upon discharge, and whether those needs are expected to remain constant or lessen over time
 - The patient's insurance coverage (if applicable) and how that coverage might or might not provide for necessary services post-hospitalization?
 - For patients admitted from home –
 - Whether the patient can perform activities of daily living (personal hygiene and grooming, dressing and undressing, feeding, voluntary control over bowel and bladder, ambulation, etc.)?
 - The patient's or family/other support person's ability to provide self-care/care?
 - Whether the patient will require specialized medical equipment or home modification?
 - If yes, did the evaluation include an assessment of whether the equipment is available or if the modifications can be
 - If the patient or family/support person is unable to meet care needs or there are additional care needs above their capabilities, did the evaluation include an assessment of available community-based services to meet post-hospital needs?
 - For patients admitted from a nursing facility, skilled nursing facility or assisted living facility did the evaluation assess whether the prior facility has the capability to provide necessary post-hospital services to the patient (i.e. is the same, higher, or lower level of care required and can those needs be met?) If yes, is there any documentation that the patient's care needs fall within the capabilities of the facility.
 - Are the results of the discharge planning evaluation documented in the medical record?

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§482.43(b)(2) - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

Interpretive Guidelines §482.43(b)(2)

The patient's discharge planning evaluation must be developed by a registered nurse, social worker, or other appropriate qualified personnel, or by a person who is supervised by such personnel. State law governs the qualifications required to be considered a registered nurse or a social worker. The hospital's written discharge planning policies and procedures must specify the qualifications for personnel other than registered nurses or social workers who develop or supervise the development of the evaluation.

The qualifications must include such factors as previous experience in discharge planning, knowledge of clinical and social factors that affect the patient's functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and assessment skills. All personnel performing or supervising discharge planning evaluations, including registered nurses and social workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient's expected post-discharge care needs can be met. It is acceptable for a hospital to include new staff who may not have had previous discharge planning experience, but who are being trained to perform discharge planning duties and whose work is reviewed by qualified personnel.

For Information – Not Required/Not to be Cited

A well designed discharge planning evaluation process uses a multidisciplinary team approach. Team members may include representatives from nursing, case management, social work, medical staff, pharmacy, physical therapy, occupational therapy, respiratory therapy, dietary, and other health care professionals involved with the patient's care. The team approach helps to ensure that all of the patient's post-discharge care needs are identified, so that they can be taken into consideration when developing the evaluation.

Survey Procedures §482.43(b)(2)

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- Review a sample of cases to determine if the discharge planning evaluation was developed by an RN, Social Worker, or other qualified personnel, as defined in the hospital discharge planning policies and procedures, or someone they supervise? In order to assess this:
 - Review the hospital's written policy and procedure governing who is responsible for developing or supervising the development of the discharge planning evaluation. Does the policy permit someone other than a RN or social worker to be responsible for developing or supervising such evaluations? If yes, does the policy specify the qualifications of the personnel other than a RN or social worker to perform this function?
 - Determine which individual(s) is (are) responsible for developing or supervising discharge planning evaluations. Review their personnel folders to determine if they are a RN, social worker, or meet the hospital's criteria for developing/supervising the discharge planning evaluation. If they are not, are they supervised by an individual who is an RN, social worker or is qualified according to the hospital's policies? Are their discharge planning evaluations reviewed by their supervisor before being finalized?
 - Ask personnel who supervise or develop discharge planning evaluations to give examples illustrating how they apply their knowledge of clinical, social, insurance/financial and physical factors when performing an evaluation.

A-0810

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§482.43(b)(5) - The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

Interpretive Guidelines §482.43(b)(5)

After a patient has been identified as needing an evaluation, or after a request for an evaluation has been made by the physician, patient and/or patient's

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representative, the evaluation must be completed timely. This means there must be sufficient time after completion to allow arrangements for post-hospital care to be made, without having to delay the patient's discharge in order to do so, or requiring the patient to transfer to a different setting from where he/she was admitted from primarily due to the delay in making appropriate arrangements. The comparatively short average length of stay of a short term acute care hospital inpatient necessitates prompt attention to patients' discharge planning needs in that type of hospital. Failure to complete the evaluation in a timely manner could make it more difficult to implement the patient's final discharge plan, and/or may cause an unnecessary delay in the patient's discharge from the hospital. While other types of hospitals with a longer average length of stay may be able to complete the evaluation at a later point after admission, they too must complete it on a timely basis to avoid delays in discharge.

Where a team approach is utilized by the hospital in developing the discharge planning evaluation, there must be a process to promote efficient collaboration among team members to complete the evaluation in a timely manner. Changes in patient condition throughout the hospitalization warrant adjustments to the discharge plan.

Survey Procedures §482.43(b)(5)

- Review a sample of cases to determine if the discharge planning evaluation was completed on a timely basis to allow for appropriate arrangements to be made for post-hospital care and to avoid delays in discharge. In order to assess this:
 - Determine when the discharge planning evaluation was initiated. If the evaluation was not begun within 24 hours of the request or identification of the need for an evaluation, ask why.
 - Is there a pattern of delayed start or completion of the evaluation? If so, is the delay due to circumstances beyond the hospital's control (e.g., inability to reach the beneficiary's support person(s), continuing changes in the patient's condition) and/or is the delay due to the hospital's failure to develop timely discharge planning evaluations?

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(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(b)(6) - The hospital ... must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

Interpretive Guidelines §482.43(b)(6)

The results of the discharge planning evaluation must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the results of the evaluation. It is not necessary for the hospital to obtain a signature from the patient (or the patient's representative, as applicable) documenting the discussion.

The patient or the patient's representative must be actively engaged in the development of the plan, so that the discussion of the evaluation results represents a continuation of this active engagement. It would not be appropriate for a hospital to conduct an evaluation without the participation of the patient or the patient's representative, and then present the results of the evaluation to the patient as a finished product, since this would place the patient in a passive position that is not consistent with the requirements of the patients' rights CoP at §482.13(b).

Survey Procedures §482.43(b)(6)

- Review a sample of cases to determine if the discharge planning evaluation results were discussed with the patient or the patient's representative.

A-0812

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(b)(6) – [The hospital must] include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan....

Interpretive Guidelines §482.43(b)(6)

The hospital must include the discharge planning evaluation in the patient's medical record in order for it to guide the development of the patient's discharge plan. Timely placement of the evaluation in the medical record facilitates

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communication among members of the patient's healthcare team who should participate in a multidisciplinary process to develop and implement the discharge plan. The evaluation and subsequent planning process may be a continuous one and hospitals may choose not to divide the process into distinct documents. The key requirement is that the evaluation results are included in the patient's medical record and are used in the development of the features of the discharge plan.

Survey Procedures §482.43(b)(6)

- Review a sample of cases to determine if the discharge planning evaluation results are included in the medical record.

A-0818

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(c) Standard: Discharge Plan

(1) - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

Interpretive Guidelines §482.43(c)(1)

The discharge plan that is based on the findings of the discharge planning evaluation must be developed by a registered nurse, social worker, or other appropriate qualified personnel, or by a person who is supervised by such personnel. State law governs the qualifications required to be considered a registered nurse or a social worker. The hospital's written discharge planning policies and procedures must specify the qualifications for personnel other than registered nurses or social workers who develop or supervise the development of the plan.

The qualifications should include such factors as previous experience in discharge planning, knowledge of clinical and social factors that affect the patient's functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and assessment skills. All personnel performing or supervising development of discharge plans, including registered nurses and social workers, must have knowledge of clinical, social,

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insurance/financial and physical factors that must be considered when evaluating how a patient's expected post-discharge care needs can be met.

For Information – Not Required/Not to be Cited

A well designed discharge planning process uses a multidisciplinary team approach. Team members may include representatives from nursing, case management, social work, medical staff, pharmacy, physical therapy, occupational therapy, respiratory therapy, dietary, and other healthcare professionals involved with the patient's care. The team approach helps to ensure all of the patient's post-discharge care needs are addressed in the plan, increasing the likelihood of successful recovery and avoidance of complications and readmissions.

The hospital CoP governing patients' rights at §482.13(b) provides that "The patient has the right to participate in the development and implementation of his or her plan of care." (CMS views discharge planning as part of the patient's plan of care). "The patient or his/her representative (as allowed under State law) has the right to make informed decisions regarding his/her care" and "The patient's rights include...being involved in care planning and treatment." Accordingly, hospitals are expected to engage the patient, or the patient's representative, actively in the development of the discharge plan, not only to provide them the necessary education and training to provide self-care/care, but also to incorporate the patient's goals and preferences as much as possible into the plan. A patient will be more likely to cooperate in the implementation of a discharge plan that reflects his/her preferences, increasing the likelihood of a successful care transition and better health outcomes.

A patient's goals and preferences may be, in the hospital's view, unrealistic. A hospital is not obligated to develop a discharge plan that cannot be implemented. However, the fact that a plan incorporating the patient's goals and preferences might be more time-consuming for the hospital to develop and implement than another alternative does not make the patient's preferred plan unrealistic.

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For Information – Not Required/Not to be Cited

If a patient exercises the right to refuse to participate in discharge planning or to implement a discharge plan, documentation of the refusal in the medical record is recommended.

Survey Procedures §482.43(c)(1)

- Review a sample of cases to determine if the discharge plan was developed by an RN, Social Worker, or other qualified personnel, as defined in the hospital discharge planning policies and procedures, or someone they supervise? In order to assess this:
 - Review the hospital's written policy and procedure governing who is responsible for developing or supervising the development of the discharge plan. Does the policy permit someone other than a RN or social worker to be responsible for developing or supervising development of such plans? If yes, does the policy specify the qualifications of the personnel other than a RN or social worker to perform this function?
 - Determine which individual(s) are responsible for developing or supervising the development of discharge plans. Review their personnel folders to determine if they are a RN, social worker, or meet the hospital's criteria for developing/supervising the discharge plan. If they are not, are they supervised by an individual who is an RN, social worker or qualified according to the hospital's policies? Are their discharge plans reviewed by their supervisor before being finalized?
 - Ask personnel who supervise or develop discharge plans to give examples illustrating their knowledge of healthcare and other resources available in the community that could be utilized to meet patients' expected post-discharge care needs.
- Ask the discharge planner how the patient or patient's representative is engaged to participate in the development of the discharge plan. Does the discharge plan identify the patient's or patient's representative discharge preferences?

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- Does the discharge plan match the identified needs as determined by the discharge planning evaluation?

A-0819

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(c)(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient’s physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

Interpretive Guidelines §482.43(c)(2)

If a patient is not identified through the hospital’s discharge planning evaluation process as requiring a discharge plan, the patient’s physician may nevertheless request a discharge plan. The hospital must develop a discharge plan when requested to do so by the patient’s physician.

If the hospital’s policies and procedures call for a discharge plan for every hospital inpatient, then it is not necessary to include a separate provision in those policies requiring development of a plan upon physician request, since such a provision would be superfluous.

Survey Procedures §482.43(c)(2)

- Review the hospital’s discharge planning policies and procedures to determine whether it requires the development of a discharge plan for all inpatients, or only for those identified as needing a plan through a risk-based identification and evaluation process.
- If the hospital does not require a discharge planning evaluation for all inpatients:
 - Does the hospital have a standard process for notifying physicians that they may request a discharge plan evaluation and that the hospital will develop a plan upon request?
 - Interview attending physicians to see if they are aware they can request a discharge plan. If they are not aware they can request a discharge plan, can the hospital provide evidence of how they inform the medical staff about this?

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A-0820

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(c)(3) - The hospital must arrange for the initial implementation of the patient's discharge plan....

§482.43(c)(5) - As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

Interpretive Guidelines §482.43(c)(3) & §482.43(c)(5)

The hospital is required to arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. It also includes arranging:

- Transfers to rehabilitation hospitals, long term care hospitals, or long term care facilities;
- Referrals to home health or hospice agencies;
- Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;
- Referral to medical equipment suppliers; and
- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation, or other post-discharge needs.

(See §482.43(d) for more discussion about the hospital's transfer or referral obligations and the initial implementation of the plan relating to transfer/referral.)

The discharge planning process is a collaborative one that must include the participation of the patient and the patient's informal caregiver or representative, when applicable. In addition, other family or support persons who will be providing care to the patient after discharge need to be engaged in the process. Keeping the patient, and, when applicable, the patient's representative and other support persons informed throughout the development of the plan is essential for its success. Providing them with information on post-discharge options, what to expect after discharge and, as applicable, instruction and training in how to provide

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care is essential. The patient needs clear instructions regarding what to do when concerns, issues, or problems arise, including who to call and when they should seek emergency assistance. Although it may be an important component of the discharge instructions, it is not acceptable to only advise a patient to “return to the ED” whenever problems arise.

There are a variety of tools and techniques that have focused on improving the support provided to patients who are discharged back to their homes. A comprehensive approach employing combinations of these techniques has been found to improve patient outcomes and reduce hospital readmission rates, including, but not limited to:

- Improved education) to patients and support persons regarding disease processes, medications, treatments, diet and nutrition, expected symptoms, and when and how to seek additional help. Teaching methods must be based on recognized methodologies. CMS does not prescribe any specific methodologies, but examples include the teach-back, repeat-back approach and simulation laboratories;
- Written discharge instructions, in the form of checklists when possible, that are legible, in plain language, culturally sensitive and age appropriate;
- Providing supplies, such as materials for changing dressings on wounds, needed immediately post-discharge; and
- A list of all medications the patient should be taking after discharge, with clear indication of changes from the patient’s pre-admission medications;

The education and training provided to the patient or the patient’s caregiver(s) by the hospital must be tailored to the patient’s identified needs related to medications, treatment modalities, physical and occupational therapies, psychosocial needs, appointments, and other follow-up activities, etc. Repeated review of instructions with return demonstrations and/or repeat-backs by the patient, and their support persons will improve their ability to deliver care properly. This includes providing instructions in writing as well as verbally reinforcing the education and training.

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It is also necessary to provide information to patients and their support persons when the patient is being transferred to a rehabilitation or a long term care hospital, or to a long term care setting, such as a skilled nursing facility or nursing facility. The information should address questions such as: the goal of treatment in the next setting and prospects for the patient's eventual discharge home.

The hospital must document in the patient's medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver or representative, as applicable.

For Information – Not Required/Not to be Cited

Additional actions hospitals might consider taking to improve the patient's post-discharge care transition:

- Scheduling follow-up appointments with the patient's primary care physician/practitioner and in-home providers of service as applicable;
- Filling prescriptions prior to discharge;
- If applicable, arranging remote monitoring technologies, e.g., pulse oximetry and daily weights for congestive heart failure (CHF) patients; pulse and blood pressure monitoring for cardiac patients; and blood glucose levels for diabetic patients; and
- Follow-up phone calls within 24 -72 hours by the hospital to the patient after discharge.

The communication with the patient to ensure implementation of the discharge plan does not stop at discharge. An initiative showing significant success in reducing preventable readmissions involves the hospital contacting the patient by phone in the first 24 to 72 hours after discharge. The phone contact provides an opportunity for the patient to pose questions and for the hospital to address any confusion related to medications, diet, activity, etc., and to reinforce the education/instruction that took place in the hospital prior to discharge. This also helps to reduce patient and family member anxieties as they manage post-hospital care needs.

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Hospital staff placing the calls should be familiar with the patient's discharge plan and qualified to address typical questions that might be expected. They should also be knowledgeable about when to instruct the patient to seek a more immediate evaluation, including where to go for such evaluation. Although this follow-up phone call can serve as a customer service initiative for the hospital, the primary intent would be to provide an opportunity for questions and to reduce or eliminate any confusion or concerns regarding post-hospital care.

Survey Procedures §482.43(c)(3) & §482.43(c)(5)

- Review cases of discharged patients to determine if the hospital arranges initial implementation of the discharge plan by providing:
 - For patients discharged to home:
 - In-hospital training to patient and family/support persons, using recognized methods;
 - Written discharge instructions that are legible and use non-technical language;
 - A legible, complete, reconciled medication list that highlights changes from the post hospital regimen;
 - Referrals as applicable to specialized ambulatory services, e.g. physical therapy, occupational therapy, home health, hospice, mental health, etc.;
 - Referrals as applicable to community-based resources other than health services, e.g. Departments of Aging, elder services, transportation services, Centers for Independent Living, Aging and Disability Resource Centers, etc.;
 - Arranging essential durable medical equipment, e.g. oxygen, wheel chair, hospital bed, commode, etc.;
 - Sending necessary medical information to providers that the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first; and

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- For patients transferred to another inpatient facility, was necessary medical information ready at time of transfer and sent to the receiving facility with the patient?
- Were there portions of the plan the hospital failed to begin implementing, resulting in delays in discharge?

A-0821

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(c)(4) - The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

Interpretive Guidelines §482.43(c)(4)

Changes in a patient's condition may warrant adjustments to the discharge plan. Hospitals must have in place either a routine reassessment of all plans or a process for triggering a reassessment of the patient's post-discharge needs, capabilities and discharge plan when significant changes in the patient's condition or available supports occur.

Survey Procedures §482.43(c)(4)

- Review a sample of cases to determine if any significant changes in the patient's condition were noted in the medical record that changed post-discharge needs, and if the discharge plan was updated accordingly.
- In making this determination, ask staff responsible for discharge planning when and how they reassess a patient's discharge plan. If none of the records being used for the tracers suggest a need to revise the discharge plan, ask staff to present one or more clinical records that document reassessment.

A-0823

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(c)(6) - The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic

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area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) - This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) - For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

§482.43(c)(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient

§482.43(c)(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

Interpretative Guidelines §482.43(c)(6), §482.43(c)(7) & §482.43(c)(8)

The hospital must include a list of Medicare-participating home health agencies (HHAs) and skilled nursing facilities (SNFs) in the discharge plan for those patients for whom the plan indicates home health or post-hospital extended care services are required.

- “Extended care services” are defined at sections 1861(h) and (i) of the Social Security Act as items or services furnished in a skilled nursing facility (SNF).

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SNFs included on the list must be located in a geographic area that the patient or patient's representative indicated he/she prefers.

- For Home Health Agencies (HHAs) the list must consist of Medicare-participating HHAs that have requested the hospital to be listed and which serve the geographic area where the patient lives. Hospitals may expect the HHA to define its geographic service area when it submits its request to be listed.

During the discharge planning process the hospital must inform the patient of his/her freedom to choose among Medicare-participating post-hospital providers and must not direct the patient to specific provider(s) or otherwise limit which qualified providers the patient may choose among. Hospitals have the flexibility either to develop their own lists or to print a list of skilled nursing facilities and home health agencies in the applicable geographic areas from the CMS websites, Nursing Home Compare (www.medicare.gov/NHcompare) and Home Health Compare (www.medicare.gov/homehealthcompare). If hospitals develop their own lists, they are expected to update them at least annually. (69 FR 49226, August 11, 2004)

For Information – Not Required/Not to be Cited

Hospitals may also refer patients and their families to the Nursing Home Compare and Home Health Compare websites for additional information regarding Medicare-certified skilled nursing facilities and home health agencies, as well as Medicaid-participating nursing facilities.

The data on the Nursing Home Compare website include an overall performance rating, nursing home characteristics, performance on quality measures, inspection results, and nursing staff information.

Home Health Compare provides details about every Medicare-certified home health agency in the country. Included on the website are quality indicators such as managing daily activities, managing pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned hospital care.

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The hospital might also refer the patient and their representatives to individual State agency websites, Long-Term Care Ombudsmen Program, Protection and Advocacy Organizations, Citizen Advocacy Groups, Area Agencies on Aging, Centers for Independent Living, and Aging and Disability Resource Centers for additional information on long term care facilities and other types of providers of post-hospital care. Having access to the information found at these sources may assist in the decision making process regarding post-hospital care options.

If the patient is enrolled in a managed care insurance program that utilizes a network of exclusive or preferred providers, the hospital must make reasonable attempts, based on information from the insurer, to limit the list to HHAs and SNFs that participate in the insurer's network of providers.

If the hospital has a disclosable financial interest in a HHA or SNF on a patient's list, or an HHA or SNF on the list has a disclosable financial interest in the hospital, these facts must also be stated on the list provided to the patient. Surveyors are not expected to know the requirements for a disclosable financial interest under Part 420, Subpart C, but hospitals are expected to know and comply with these requirements, and to identify for the surveyor whether there are such disclosable financial interests between the hospital and any specific HHAs or SNFs to which they refer/transfer patients.

When the patient or the patient's family has expressed a preference, the hospital must attempt to arrange post-hospital care with an HHA or SNF, as applicable, which meets these preferences. If the hospital is unable to make the preferred arrangement, e.g., if there is no bed available in the preferred SNF, it must document the reason the patient's preference could not be fulfilled and must explain that reason to the patient.

Survey Procedures §482.43(c)(6), §482.43(c)(7) & §482.43(c)(8):

- Review a sample of cases of patients discharged to HHAs or SNFs to determine if, when applicable, the hospital provided the patient with lists of Medicare-participating HHAs or SNFs. In making this determination:
 - Is there documentation of a list of multiple HHAs or SNFs being provided (including electronically) to the patient? If not, is there documentation for an acceptable rationale for providing only one option, e.g., the patient's home is

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included in the service area of only one Medicare-participating HHA that requested to be included on hospital lists, or there is only one Medicare-participating SNF in the area preferred by the patient?

- Ask to see examples of lists of HHAs and SNFs provided to patients prior to discharge.
- Ask the hospital if it has any disclosable financial interests in any HHA or SNF on its lists, or if an HHA or SNF has a disclosable financial interest in the hospital. If yes, is this stated clearly on the lists?
- Interview staff members involved with the discharge planning process. Ask them to describe how patient preferences are taken into account in the selection of post-hospital HHA or SNF services.
 - Ask the hospital to identify current patients for whom HHA or SNF services are planned. Interview the patient or the patient's family to ask them:
 - Were they presented with a list of HHAs or SNFs, as applicable, to choose from?
 - Did the hospital emphasize their freedom of choice?
 - Did the hospital arrange for their referral/transfer to an HHA or SNF reflecting their preferences? If not, did the hospital explain why their choice was not feasible?
 - If applicable, were they made aware of disclosable financial interest?

A-0837

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(d) Standard: Transfer or Referral

The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

Interpretive Guidelines §482.43(d)

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The hospital must take steps to ensure that patients receive appropriate post-hospital care by arranging, as applicable, transfer to appropriate facilities or referrals to follow-up ambulatory care services.

“Appropriate facilities, agencies, or outpatient services” refers to entities such as skilled nursing facilities, nursing facilities, home health agencies, hospice agencies, mental health agencies, dialysis centers, suppliers of durable medical equipment, suppliers of physical and occupational therapy, physician offices, etc. which offer post-acute care services that address the patient’s post-hospital needs identified in the patient’s discharge planning evaluation. The term does not refer to non-healthcare entities, but hospitals also are encouraged to make appropriate referrals to community-based resources that offer transportation, meal preparation, and other services that can play an essential role in the patient’s successful recovery.

“Appropriate facilities” may also include other hospitals to which a patient is transferred for follow-up care, such as rehabilitation hospitals, long term care hospitals, or even other short-term acute care hospitals.

Necessary medical information must be provided not only for patients being transferred, but also for those being discharged home, to make the patient’s physician aware of the outcome of hospital treatment or follow-up care needs. This is particularly important since the increasing use of hospitalists in the inpatient hospital setting means the patient’s physician may have had no interaction with the patient throughout the hospital stay. When the hospital provides the patient’s physician with necessary medical information promptly, among other things, this provides an opportunity for the patient’s physician to discuss with the hospital care team changes to the patient’s preadmission medication regimen or other elements of the post-discharge care plan about which the physician may have questions. Facilitating opportunities for such communication and dialogue enhances the likelihood of better patient outcomes after discharge.

The “medical information” that is necessary for the transfer or referral includes, but is not limited to:

- Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;

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- Brief description of hospital course of treatment;
- Patient's condition at discharge, including cognitive and functional status and social supports needed;
- Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);
- List of allergies (including food as well as drug allergies) and drug interactions;
- Pending laboratory work and test results, if applicable, including information on how the results will be furnished;
- For transfer to other facilities, a copy of the patient's advance directive, if the patient has one; and
- For patients discharged home:
 - Brief description of care instructions reflecting training provided to patient and/or
 - If applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date and time.
 - If applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.

The regulation requires transfer or referral “along” with necessary medical information. In the case of a patient being transferred to another inpatient or residential health care facility, the necessary information must accompany the patient to the facility. However, in the case of a patient discharged home who is being referred for follow-up ambulatory care, the transmittal of the information to the patient's physician may take place up to 7 days after discharge or prior to the first appointment for ambulatory care services that may have been scheduled, whichever comes first. If the patient's physician is not yet able to

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accept the information electronically from the hospital, the hospital may provide the information to the patient with instructions to give this information to the physician at their next appointment.

For Information – Not Required/Not to be Cited

Scheduling of follow-up appointments for ambulatory care services by the hospital prior to discharge has been found to be an effective tool to ensure prompt follow-up and reduce the likelihood of a preventable readmission. This follow-up visit shortly after discharge provides an opportunity for the patient to address any issues or concerns experienced after the inpatient stay. It also provides an opportunity for the primary care physician or practitioner to review and reinforce the post-hospital plan of care with the patient, for rehabilitation therapy to begin in a timely manner, to clarify any concerns related to medication reconciliation or other adjustments to the patient's pre-hospital regimen, etc.

It is recognized that hospitals have certain constraints on their ability to accomplish patient transfers and referrals:

- They must operate within the constraints of their authority under State law;
- A patient may refuse transfer or referral; or
- There may be financial barriers limiting a facility's, agency's, or ambulatory care service provider's willingness to accept the patient. In such cases the hospital does not have financial responsibility for the post-acute care services. However, hospitals are expected to be knowledgeable about resources available in their community to address such financial barriers, such as Medicaid services, availability of Federally Quality Health Centers, Area Agencies on Aging, etc. and to take steps to make those resources available to the patient. For example, in most states hospitals work closely with the Medicaid program to expedite enrollment of patients eligible for Medicaid.

Survey Procedures §482.43(d)

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- Review a sample of records for discharged patients who had a discharge plan to determine if:
 - For patients discharged home:
 - Necessary medical information was sent to a practitioner with which the patient has an established relationship prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first;
 - For patients without an established relationship with a practitioner, information was provided on potential primary care providers, such as health
 - For patients transferred to another inpatient facility, was necessary medical information ready at time of transfer and sent to the receiving facility with the patient?
 - When applicable, there is documentation in the medical record of providing the results of tests, pending at time of discharge, to the patient and/or post-hospital provider of care?

A-0843

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§483.43(e) Standard: Reassessment

The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

Interpretive Guidelines §483.43(e)

The hospital must reassess the effectiveness of its discharge planning process on an ongoing basis. Since the QAPI CoP at §482.21 requires the QAPI program to be hospital-wide, the discharge planning reassessment process is considered an integral component of the overall hospital QAPI program.

The hospital must have a mechanism in place for ongoing reassessment of its discharge planning process. The reassessment process must include a review of

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discharge plans in closed medical records to determine whether they were responsive to the patient's post-discharge needs. One indicator of the effectiveness of the discharge plan is whether or not the discharge was followed by a preventable readmission. Accordingly, hospitals are expected to track their readmission rates and identify potentially preventable readmissions.

Typically readmissions at 7, 15, 30 days, or even longer, after discharge are tracked by analysts studying readmissions to short-term acute care hospitals. Hospitals must choose at least one interval to track. Since there are National Quality Forum-endorsed readmissions measures that use a 30-day interval, and since such measures are permitted by law to be used by CMS for payment-related purposes, it might be prudent for a hospital to track its 30-day readmissions rate, but other intervals are permissible. It is understood that information on post-discharge admissions to other hospitals may not be readily available to hospitals, but all hospitals are expected to track readmissions to their own hospital, and to do so on an ongoing basis, i.e., at least quarterly. Hospitals may employ various methodologies to identify potentially preventable readmissions. There are proprietary products that, for example, use claims data to identify such cases. Hospitals are expected to document their methodology for tracking their readmissions rates.

Once the hospital has identified potentially preventable readmissions, it is expected to conduct an in-depth review of the discharge planning process for a sample of such readmissions (at least 10% of potentially preventable readmissions, or 15 cases/quarter, whichever is larger is suggested but not required) in order to determine whether there was an appropriate discharge planning evaluation, discharge plan, and implementation of the discharge plan.

Hospitals are also expected to follow up on trends identified through analysis of their readmissions, such as a concentration of readmissions related to post-surgical infections, discharges from a particular service or unit, discharges to a particular extended care facility or home health agency, discharges with the same primary diagnosis on the first admission, etc. Such clustering or concentration may identify areas requiring more follow-up analysis and potential remedial actions.

Having identified factors that contribute to preventable readmissions, hospitals are expected to revise their discharge planning and related processes to address these

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factors. Consistent with the requirements under the QAPI CoP, the hospital's governing body, medical leadership and administrative leadership are all expected to ensure that identified problems are addressed, with further ongoing reassessment to achieve improvement.

Survey Procedures §482.43(e)

- Review hospital policies and procedures to determine whether the discharge planning process is reassessed on an ongoing basis, i.e., at least quarterly.
 - Does the hospital's discharge planning reassessment policy include tracking and analysis of readmissions?
 - Do staff know how to obtain data on readmissions that enables them to review the discharge plans for the initial admission? Ask them to identify medical records for patients who were readmitted and to show you the documentation of the review of the discharge planning process for the initial admission.
 - Does the assessment of readmissions include an evaluation of whether the readmissions were potentially preventable?
 - Is there evidence of in-depth analysis of a sample of discharge plans in cases where preventable readmissions were identified?
- Is there evidence that the hospital took action to address factors identified as contributing to preventable readmissions?