



*HFMA would like to thank Melinda Hancock and Dixon Hughes Goodman for sharing this summary of the discharge planning proposed rule with HFMA's membership.*

### **Discharge Planning CMS Proposal**

Published in the Federal Register on Nov. 3, 2015, with a 60-day comment period.  
<https://www.federalregister.gov/articles/2015/11/03/2015-27840/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals>

The Centers for Medicare & Medicaid Services (CMS) proposes to modernize the discharge planning requirements to improve patient care, reduce complications, and avoid readmissions. They are also proposing to implement the discharge planning requirements of the Improving Medicare Post-Acute Transformation Act of 2014 (IMPACT Act 2014) that requires hospitals and post-acute care settings to take into account quality measures and access to information for a well-informed patient. An estimated one-third of re-hospitalizations might be avoided with improved comprehensive transitional care from the hospital to the community per the proposed rule.

The current discharge planning requirement within the Conditions of Participation 482.43 (c)(3) states only that a hospital must arrange for the initial implementation of the patient's discharge. The proposed rule has specific revisions to this within six areas outlined below.

Specific changes include

- (1) Design: propose to require that the discharge planning process be specified in writing and be reviewed and approved initially, and then routinely reviewed by the hospital's governing body.
- (2) Applicability:
  - a. All inpatients and outpatients
    - i. These outpatients include observation patients, patients undergoing surgery or other same day surgery where anesthesia or moderate sedation is used, and emergency patients who have been identified by a practitioner as needing a discharge plan.
  - b. Others as defined and approved by the governing body
- (3) Discharge planning process:

- a. Early in the stay: within 24 hours of admission or registration
- b. Proposed changes would require that the discharge plan be tailored to the unique goals, preferences, and needs of the patient, and, therefore, “discharge planning for patients is a process that involves the consideration of the patient's unique circumstances, treatment preferences, and goals of care, and not solely a documentation process.”
- c. Would “require that a registered nurse, social worker, or other personnel qualified in accordance with the hospital's discharge planning policy, coordinate the discharge needs evaluation and the development of the discharge plan.”
- d. Would “require that the hospital's discharge planning process ensure an ongoing patient evaluation throughout the patient's hospital stay or visit to identify any changes in the patient's condition that would require modifications to the discharge plan”
- e. Propose that the “practitioner responsible for the care of the patient be involved in the ongoing process of establishing the patient's goals of care and treatment preferences that inform the discharge plan, just as they are with other aspects of patient care during the hospitalization or outpatient visit.”
- f. Propose that “the hospital consider the availability of caregivers and community-based care for each patient, whether through self-care, follow-up care from a community-based provider, care from a caregiver/support person(s), care from post-acute health care facilities or, in the case of a patient admitted from a long-term care or other residential care facility, care in that setting.”
- g. Would require hospitals to “consider the patient's or caregiver's capability and availability to provide the necessary post-hospital care. As part of the on-going discharge planning process, hospitals would identify areas where the patient or caregiver/support person(s) would need assistance, and address those needs in the discharge plan in a way that takes into account the patient's goals and preferences. In addition, we encourage hospitals to consider potential technological tools or methods, such as telehealth.”
- h. Propose to “consider the availability of and access to non-health care services for patients, which may include home and physical environment modifications including assistive technologies, transportation services, meal services or household services (or both), including housing for homeless patients.”
- i. “Propose that hospitals must consider the following in evaluating a patient's discharge needs, including but not limited to:
  - i. Admitting diagnosis or reason for registration;
  - ii. Relevant co-morbidities and past medical and surgical history;
  - iii. Anticipated ongoing care needs post-discharge;
  - iv. Readmission risk;
  - v. Relevant psychosocial history;

- vi. Communication needs, including language barriers, diminished eyesight and hearing, and self-reported literacy of the patient, patient's representative or caregiver/support person(s), as applicable;
- vii. Patient's access to non-health care services and community-based care providers; and
- viii. Patient's goals and treatment preferences."
- j. "Propose a new requirement at § 482.43(c)(6) that the patient and the caregiver/support person(s), be involved in the development of the discharge plan and informed of the final plan to prepare them for post-hospital care. Hospitals should integrate input from the patient, caregiver/support person(s) whenever possible."
- k. Propose "to require that the patient's discharge plan address the patient's goals of care and treatment preferences and documented as such."
- l. Propose to "require that hospitals assist patients, their families, or their caregivers/support persons in selecting a PAC provider by using and sharing data that includes but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. Furthermore, the hospital would have to ensure that the PAC data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences."
- m. Would "require that the hospital assess its discharge planning process on a regular basis. We propose to require that the assessment include ongoing review of a representative sample of discharge plans, including patients who were readmitted within 30 days of a previous admission, to ensure that they are responsive to patient discharge needs. This evaluation will assist hospitals to improve the discharge planning process."

**(4) Discharge to Home**

- a. "Discharge instructions must be provided at the time of discharge to patients, or the patient's caregiver/support person (s), (or both) who are discharged home or who are referred to PAC services."
  - i. Recommend that hospitals consider the use of "teach-back" during discharge planning and upon providing discharge instructions to the patient
- b. "Proposing that practitioners/facilities (such as a HHA or hospice agency and the patient's PCP), receive the patient's discharge instructions at the time of discharge if the patient is referred to follow up PAC services."
- c. "Propose a new requirement that the discharge instructions include written information on the warning signs and symptoms that patients and caregivers should be aware of with respect to the patient's condition."
- d. "Propose to require that the patient's discharge instructions include all medications prescribed and over-the-counter for use after the patient's discharge from the hospital. This should include a list of the

name, indication, and dosage of each medication along with any significant risks and side effects of each drug as appropriate to the patient. Furthermore, we propose a new requirement at § 482.43(d)(2)(v) that the patient's medications would be reconciled."

- e. "Written instructions, in paper or electronic format (or both), would be provided to the patient, and that the instructions would document follow-up care, appointments, pending and/or planned diagnostic tests, and any pertinent telephone numbers for practitioners that might be involved in the patient's follow-up care or for any providers/suppliers to whom the patient has been referred for follow-up care. The choice of format of the instructions should be based on patient and caregiver needs, preferences, and capabilities."
- f. "Propose at § 482.43(d)(3) to require that the hospital send the following information to the practitioner(s) responsible for follow up care, if the practitioner has been clearly identified:
  - i. A copy of the discharge instructions and the discharge summary within 48 hours of the patient's discharge;
  - ii. Pending test results within 24 hours of their availability;
  - iii. All other necessary information as specified in proposed § 482.43(e)(2)."
- g. Require, for patients discharged to home, that the hospital must establish a post-discharge follow-up process.

(5) Transfer of Patients to Another Facility: overall goal is efficiency and patient safety.

- a. "Propose, at the minimum, the following information to be provided to a receiving facility:
  - Demographic information, including but not limited to name, sex, date of birth, race, ethnicity, and preferred language;
  - Contact information for the practitioner responsible for the care of the patient and the patient's caregiver/support person(s);
  - Advance directive, if applicable;
  - Course of illness/treatment;
  - Procedures;
  - Diagnoses;
  - Laboratory tests and the results of pertinent laboratory and other diagnostic testing;
  - Consultation results;
  - Functional status assessment;
  - Psychosocial assessment, including cognitive status;
  - Social supports;
  - Behavioral health issues;
  - Reconciliation of all discharge medications with the patient's pre-hospital admission/registration medications (both prescribed and over-the-counter);
  - All known allergies, including medication allergies;

- Immunizations;
- Smoking status;
- Vital signs;
- Unique device identifier(s) for a patient's implantable device(s), if any;
- All special instructions or precautions for ongoing care, as appropriate;
- Patient's goals and treatment preferences; and
- All other necessary information to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.
- In addition to these proposed minimum elements, necessary information must also include a copy of the patient's discharge instructions, the discharge summary, and any other documentation that would ensure a safe and effective transition of care, as applicable.”

b. “Propose that the requirement and the timeframe for communicating necessary information for patients being transferred to another healthcare facility remain the same as in the current requirement. That is, hospitals would continue to be required to provide this information at the time of the patient's discharge and transfer to the receiving facility.”

(6) Requirements for Post-Acute Services:

- a. “Proposing that for patients who are enrolled in managed care organizations, the hospital must make the patient aware that they need to verify the participation of HHAs or SNFs in their network. If the hospital has information regarding which providers participate in the managed care organization's network, it must share this information with the patient. The hospital must document in the patient's medical record that the list was presented to the patient. The patient or their caregiver/support persons must be informed of the patient's freedom to choose among providers and to have their expressed wishes respected, whenever possible. The final component of the retained provision would be the hospital's disclosure of any financial interest in the referred HHA or SNF. However, this section would be revised to include IRFs and LTCHs.”
- b. Home Health Discharge Planning:
  - i. “HHAs develop and implement an effective discharge planning process that focuses on preparing patients and caregivers/support person(s) to be active partners in post-discharge care, effective transition of the patient from HHA to post-HHA care, and the reduction of factors leading to preventable readmissions.”
  - ii. “Propose to establish a new standard, “Discharge planning process,” to require that the HHA's discharge planning process ensure that the discharge goals, preferences, and needs of each

patient are identified and result in the development of a discharge plan for each patient. In addition, we propose to require that the HHA discharge planning process require the regular re-evaluation of patients to identify changes that require modification of the discharge plan.”

- iii. Would “require that the physician responsible for the home health plan of care be involved in the ongoing process of establishing the discharge plan.”
- iv. “Propose to require that the discharge plan address the patient's goals of care and treatment preferences.”
- v. “For those patients that are transferred to another HHA or who are discharged to a SNF, IRF, or LTCH, we propose to require that the HHA assist patients and their caregivers in selecting a PAC provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures.”
- vi. Proposed to “require that the evaluation of the patient's discharge needs and discharge plan be documented and completed on a timely basis, based on the patient's goals, preferences, and needs, so that appropriate arrangements are made prior to discharge or transfer.” This must be documented in the record.
- vii. Required information to be sent to receiving facility’

c. Critical Access Hospital Discharge Planning

- i. Currently, there is no Condition of Participation discharge planning requirement. Acknowledge that Critical Access Hospitals (CAH) may have limited availability of health care resources in a rural environment and limited post-acute options.
- ii. Propose to “require that all inpatients and certain categories of outpatients be evaluated for their discharge needs and that the CAH develop a discharge plan. We also propose to require that the CAH provide specific discharge instructions, as appropriate, for all patients”
- iii. Very similar to IPPS requirements and propose five standards for all inpatients and certain outpatients, and develop discharge instructions for all patients.
  - 1. Design: same as acute
  - 2. Applicability: same as acute
  - 3. Discharge planning process:
    - a. Require a RN, social worker, or other personnel qualified in accordance with policy
    - b. Within 24 hours of admission or registration
    - c. Regular re-evaluation that requires modification based on changes of the patient condition
    - d. Patient must be involved

- e. Consider caregiver and capability to perform required care as well as community-based care
- f. Consider availability of non health care services (housing, meals, transportation, household services)
- g. Must consider the following in evaluating discharge needs but not limited to:
  - i. Admitting diagnosis
  - ii. Relevant co-morbidities and past medical history
  - iii. Anticipated ongoing care post discharge
  - iv. Readmission risk
  - v. Relevant psychosocial history
  - vi. Communication needs
  - vii. Access to non-health care needs
  - viii. Patient goals and preferences
- h. In selecting a PAC, must provide quality measures and resource use measures and document such
- i. Evaluation must be documented in medical record
- j. CAH must assess discharge planning process through periodic review of representative sample of 30 day readmission

4. Discharge to Home: same as acute except offering some flexibility to CAH as to appropriate time and mechanism for the follow-up process post discharge.

5. Transfer of Patients to Another Health Care Facility: same as acute

### **Cost Estimates:**

Hospitals: It is estimated that the one-time costs for these new requirements would be \$3,424 per hospital for 4,900 hospitals for a total one time cost of \$17M.

They estimate that only 5 percent of emergency department (ED) visits would need a discharge plan and 5 percent of hospital outpatient visits would need one. Therefore, the estimate is 5 minutes per patient and \$107 million annually.

Home Health Agencies: It is estimated that the new requirements first would have a one-time cost of \$2,816 per HHA for a total of \$34 million and would add \$21,710 per HHA or \$259 million annually for the 10 minutes per patient needed to comply. Then the discharge summary part would add 2.5 minutes per patient for administrative staff, adding \$1,984 per HHA or \$24 million annually. Therefore, the one-time cost is \$34 million and ongoing is \$283 million

Critical Access Hospitals: It is estimated that the one-time costs would be \$5,271 per CAH or \$7 million and the ongoing costs would add \$4,518 per CAH or \$6 million annually.

This proposed rule is economically significant as it eclipses the \$100M threshold.