DISCHARGE PLANNING

Requirements of the Final Rule

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OVERVIEW

Objectives & Applicability

Patient Rights

Hospitals & Critical Access Hospitals

- IMPACT Act
- Discharge planning COPs

Home Health Agencies

- IMPACT Act
- Discharge planning COPs

Other Considerations

- Compliance with fraud and abuse laws, EMTALA
- Meaningful access and effective communication
- Culturally and linguistically appropriate services
- Inclusion of caregivers

QUESTIONS

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OBJECTIVES

Today's rule is huge step to providing patients with the ability to make healthcare decisions that are right for them and gives them transparency into what used to be an opaque and confusing process.

By demystifying the discharge planning process, we are improving care coordination and making the system work better for patients.

Patients will now no longer be an afterthought; they'll be in the driver's seat, playing an active role in their care transitions to ensure seamless coordination of care.

Seema Verma, CMS Administrator

OBJECTIVES

This final rule empowers patients to be active participants in the discharge planning process and complements efforts around interoperability that focus on the seamless exchange of patient information[.]

This final rule also implements **discharge planning requirements** which will give patients and their families access to information that will help them to make informed decisions about their post-acute care, while addressing their goals of care and treatment preferences, which may ultimately reduce their chances of being re-hospitalized.

84 Fed. Reg. 51836 (Sept. 30, 2019) (emphasis added)

OBJECTIVES

Patient Participation	Empower patients to participate in discharge planning
Informed Decisions	Ensure patients have access to information about care options
Patient Focused	Focus discharge planning on patient goals and treatment preferences
Information Exchange	Improve information exchange between healthcare settings

APPLICABILITY

Hospitals

- Short-Term Acute-Care Hospitals
- Rehabilitation Hospitals
- Psychiatric Hospitals
- Children's Hospitals
- Cancer Hospitals

Critical Access Hospitals ("CAH")

Post-Acute Care Settings

- Home Health Agencies ("HHA")

APPLICABILITY

November 2019

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

PATIENT RIGHTS

PATIENT RIGHTS: Hospitals

Patient has the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame.

The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

42 CFR § 482.13(d)(2)

PATIENT RIGHTS: Key Takeaways

- ✓ Accept verbal and written requests by the patient for records.
- ✓ Include discharge planning documents and other current records available.
- ✓ Communicate with patients to determine preferred format; if no preference, hospital has flexibility to decide.
- ✓ Beware: some state laws may impose stricter requirements.

HOSPITALS
and
CRITICAL ACCESS HOSPITALS

IMPACT Act

Discharge Planning COPs

IMPACT ACT

The hospital/CAH must assist patients, their families, or the patient's representatives in selecting a post-acute care 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. The hospital/CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

42 CFR § 482.43(a)(8)

42 CFR § 485.642(a)(8)

IMPACT ACT: Key Takeaways for Hospitals and CAHs

- ✓ Be available to discuss and answer questions from patients and caregivers about post-discharge options and needs.
- ✓ Document in the medical record that the post-acute care data on quality and resource use measures were shared with the patient and used to assist the patient during the discharge planning process.
- ✓ Use reasonable efforts to provide information that is currently available.
- ✓ Avoid claims of patient steering by
  - Presenting objective data specific to patient's goals of care;
  - Presenting all PAC providers available to the patient;
  - Allowing patient choice;
  - Documenting interactions in the record.

DISCHARGE PLANNING COPs

Hospital Rules

- 42 CFR § 483.43

CAH Rules

- 42 CFR § 485.642
- 42 CFR § 485.635(a)(3)(viii) – policies & procedures

New Rules – Sections 482.43, 485.642	Old Rules - Section 482.43
The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.	Must have in effect a discharge planning process that applies to all patients.
The hospital's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning. . . (a)	The hospital must identify, at an early stage of hospitalization, patients likely to suffer adverse health consequences upon discharge if no adequate discharge planning. (a)
. . . and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician. (a)	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. (b)(1)

New Rules – Sections 482.43, 485.642	Old Rules - Section 482.43
Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge. (a)(1)	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. (b)(5)
A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services. (a)(2)	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. (b)(3)
The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative). (a)(3)	The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf. (b)(6)

New Rules – Sections 482.43, 485.642	Old Rules - Section 482.43
Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient. (a)(4)	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. (c)(2) The hospital must arrange for the initial implementation of the patient's discharge plan.(c)(3)
Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel. (a)(5)	A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation. (b)(2) 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. (c)(1)
The hospital's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (a)(6)	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. (c)(4)

New Rules – Sections 482.43, 485.642	Old Rules - Section 482.43
The hospital must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post- discharge needs. (a)(7)	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. (e)
SEE IMPACT ACT SLIDES: (a)(8)	As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. (c)(5)
The hospital must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care. (b)	

HOSPITAL ONLY – Section 482.43(c)

For those patients discharged home and referred for HHA services or transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, the following requirements apply, in addition to those set out at paragraphs (a) and (b) of this section:

(1) The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs 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, IRF, or LTCH, in the geographic 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 post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.
- (ii) For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization’s network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient’s managed care organization, it must share this with the patient or the patient’s representative.
- (iii) The hospital must document in the patient’s medical record that the list was presented to the patient or to the patient’s representative.

HOSPITAL ONLY – Section 482.43(c)

(2) The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post- discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.

(3) 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.

HOSPITAL & CAH: Key Takeaways

- ✓ Maintain policies and procedures for post-acute care planning.
- ✓ Ensure discharge planning process.
  - focuses on patient’s goals and treatment preferences.
  - includes the patient/caregiver as active participant.
- ✓ Ensure discharge plan.
  - is consistent with patient’s goals and treatment preferences.
  - provides an effective transition to post-discharge care.
  - reduces factors leading to preventable hospital readmissions.
- ✓ Provide all necessary medical information to accepting facility, including goals and treatment preferences.
- ✓ Hospitals – add IRFs and LTCHs to list of facilities provided with discharge plan.

HOME HEALTH AGENCIES

IMPACT Act

Discharge Planning COPs

IMPACT ACT

HHAs must provide patients discharged to a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), or transferred to another HHA, relevant and applicable data about potential post-acute care providers, including quality and resource use measures. The HHA must send all necessary medical information regarding the patient's illness, treatment, and post-discharge goals, to the receiving facility. Thereafter, the HHA must comply with future requests for information from the patient or receiving facility or provider.

42 CFR § 484.58

IMPACT ACT: Key Takeaways for HHAs

- ✓ Present objective data on quality and resource use measures specifically applicable to the patient’s goals of care and treatment preferences.
- ✓ Include data on all available post-acute care providers.
- ✓ Prepare patients and caregivers for participation in post-discharge care to avoid readmissions.
- ✓ Existing requirements to maintain clinical records and provide records to post-acute providers remain in place.

DISCHARGE PLANNING COPs

HHA Rules

- 42 CFR § 484.58 (new)

Relevant existing rules:

- 42 CFR § 484.50
- 42 CFR § 484.55
- 42 CFR § 484.110

DISCHARGE PLANNING COPs: In Context

- Proposed adoption of new CoP at 42 CFR § 484.58 to inform patients and transition care from HHA to post-HHA.
- HHA's previously required to provide discharge summaries to follow-up care providers under 42 CFR § 484.110(a)(6).
- Rules adopted under the IMPACT ACT provide more detail about what is required within the discharge summary requirements of 42 CFR § 484.110(a)(6).

DISCHARGE PLANNING COPs: In Context

- The proposed rule for HHA discharge planning included seven subparts to § 484.58(a).
- The final rule only incorporated the requirements of proposed subpart 6 as the totality of § 484.58(a), based on concerns of burdens and practicality from commentators. 84 Fed. Reg. 51866 (Sept. 30, 2019).
- Proposed sections were analogous to hospital requirements; while not adopted, these proposals indicate what measures CMS and HHS may adopt in the future.

New Rule – Section 484.58(a)

Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care 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. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

New Rule – Section 484.58(b)(1)

Standard: Discharge or transfer summary content. (1) The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.

New Rule – Section 484.58(b)(2)

(2) The HHA must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner.

COPs: Key Takeaways

- ✓ Develop and implement an “effective” discharge planning process.
- ✓ Provide information for quality measures and resource use for post-acute care providers to which patient is discharged or transferred that are relevant to patient’s goals and treatment preferences.
- ✓ Ensure information provided to post-acute care provider complies with requirements of 42 CFR §§ 484.60 and 484.110.
- ✓ Provide all necessary medical information to accepting facility, including goals and preferences, and supply additional information as requested.

OTHER CONSIDERATIONS

OTHER CONSIDERATIONS

- Referrals.
  - Protecting against improper referrals to entity where referring hospital, CAH, or HHA has a financial interest.
  - Protecting against improper remuneration for a referral.
- Transfer concerns.
  - HIPAA and state law medical record protection laws regarding record transfer.
  - Concerns for transfers without significant planning time before discharge.

OTHER CONSIDERATIONS

- State documentation requirements that may be more restrictive than IMPACT Act and COP provisions.
- Needs for implementation and effective training of personnel by November 29, 2019.
- Updating written policies and procedures to document compliance.

OTHER CONSIDERATIONS

- EMTALA considerations for hospitals.
- Need to include patients and caregivers.
  - Patient participation and, for HHA's patient rights under 42 CFR § 484.50.
  - Compliance with meaningful access requirements of ACA Section 1557 and 42 CFR § 92.1 *et seq*.
  - Reduction and avoidance of potential claims.
- Potential effects on hiring and training practices.

IMPACT ACT: Resources

HHA Compare:
https://www.medicare.gov/homehealthcompare/search.html

IRF Compare:
https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

LTCH Compare:
https://www.medicare.gov/longtermcarehospitalcompare/

SNF Compare:
https://www.medicare.gov/nursinghomecompare/search.html

RESOURCES

- Final Rule, September 30, 2019, Federal Register

- CMS Press Release, September 26, 2019