Discharge Planning and Patient Follow-up

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Proposed Revisions to Discharge Planning Requirements for CAHs

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-P]

RIN 0938-AS59

Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies

This document is scheduled to be published in the Federal Register on 11/03/2015 and available online at http://federalregister.gov/a/2015-27840, and on FDsys.gov

CMS 42 CFR Parts 482, 484, 485: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access hospitals, and Home Health Agencies, http://federalregister.gov/a/2015-27840
Proposed Rules

This proposed rule would revise the discharge planning requirements that Hospitals, including Long-Term Care Hospitals and Inpatient Rehabilitation Facilities, Critical Access Hospitals, and Home Health Agencies must meet in order to participate in the Medicare and Medicaid programs. The proposed rule would also implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014.
A Critical Access Hospital (CAH) must develop and implement an effective discharge planning process that focuses on preparing patients to participate in post-discharge care, planning for post-discharge care that is consistent with the patient’s goals for care and treatment preferences, effective transition of the patient from the CAH to post-discharge care, and the reduction of factors leading to preventable readmissions to a CAH or a hospital.
Design

Critical Access Hospital Discharge Planning

The discharge planning process policies and procedures must meet the following requirements:

1. Be developed with input from the CAH’s professional healthcare staff, nursing leadership as well as other relevant departments.
2. Be reviewed and approved by the governing body or responsible individual.
3. Be specified in writing.
Applicability
Critical Access Hospital Discharge Planning

The discharge planning process must apply to:

1. All inpatients
2. Outpatients receiving observation services
3. Outpatients undergoing surgery or other same day procedures for which anesthesia or moderate sedation are used
4. Emergency department patients identified in accordance with the CAH’s discharge planning policies and procedures by the emergency department practitioner responsible for the care of the patient as needing a discharge plan
5. Any other category of outpatients as recommended by the medical staff and specified in the CAH’s discharge planning policies and procedures approved by the governing body or responsible individual
Critical Access Hospital Discharge Planning

The CAH’s discharge planning process must 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.

- A registered nurse, social worker, or other personnel qualified in accordance with the CAH’s discharge planning policies must coordinate the discharge needs evaluation and development of the discharge plan.
- The CAH must begin to identify the anticipated goals, preferences, and discharge needs for each applicable patient within 24 hours after admission or registration.
- The CAH’s discharge planning process must require regular re-evaluation of patients to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
- The practitioner responsible for the care of the patient must be involved in the ongoing process of establishing the patient’s goals of care and treatment preferences that inform the discharge plan.
The CAH must consider:

1. Care from post-acute care facilities, or, in the case of a patient admitted from a long term care or other residential facility, care in that setting, as part of the identification of discharge needs.
2. Follow-up care from a community based provider.
3. Care from a support person(s).
4. Patient’s or caregiver’s/support person’s capability to perform required care including self-care.
5. Caregiver/support person and community based care availability.
The patient and caregiver/support person(s) must be involved in the development of the discharge plan and informed of the final plan to prepare them for post-CAH care.

The CAH must assist patients, their families, or their caregivers/support persons in selecting a post-acute care provider by using and sharing data.

The discharge plan must address the patient’s goals of care and treatment preferences.
The evaluation of the patient’s discharge needs and the resulting discharge plan must be documented and completed on a timely basis, based on the patient’s goals, preferences, strengths, and needs, so that appropriate arrangements for post-CAH care are made before discharge to avoid unnecessary delays in discharge.

The CAH must assess its discharge planning process. 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.
Discharge to Home
Critical Access Hospital Discharge Planning

• Discharge instructions must be provided at the time of discharge

The discharge instructions must include, but are not limited to:

• Instruction on post-hospital care
• Written information on warning signs and symptoms that may indicate the need to seek immediate medical attention
• Prescriptions and over-the-counter medications that are required after discharge
• Reconciliation of all discharge medications with the patient’s pre-hospital admission/registration medications
• Written instructions in paper and/or electronic format regarding the patient’s follow-up care, appointments, pending and/or planned diagnostic tests, and pertinent contact information
The CAH must send the following information to the practitioner(s) responsible for follow-up care, if the practitioner is known and has been clearly identified:

- A copy of the discharge instructions and the discharge summary within 48 hours of the patient’s discharge
- Pending test results within 24 hours of their availability
- All other necessary information

The CAH must establish a post-discharge follow-up process
The CAH must send necessary medical information to the receiving facility at the time of transfer.
Successful Discharge

Discharge Process
• A transitional period when the patient’s care is shifted from the hospital to the home. A time that can be stressful and unsatisfying for the patient.

Discharge Planning
• Crucial component in continuity of care from hospital to home
  • Informs patient of their illness
  • Medication use including names, dosing schedule, possible side effects
  • Treatment plan
  • Offers time for questions and concerns
  • If patient’s needs are unmet during the post-discharge period, there is a higher rate of negative health outcomes, care complications, and readmission rates

Importance of Discharge Planning

Essential for timely discharge of patients, accurate medication information, communication of instructions for self-care

Ease patient’s transition of care from hospital to home that can reduce re-hospitalizations and improve health outcomes

Approximately 20% of discharged patients experience some type of adverse event

What Are the Top Components of a Discharge Summary?

- Diagnosis: 92.1%
- Medication list: 84.1%
- Follow-up instructions: 82.5%
- Physician contacts: 66.7%
- Patient communication: 60.3%
- Test summaries: 57.1%
- Red flags: 46.0%
- Document MD trans.: 42.9%
- Other: 9.5%
- N/A: 0.0%

Source: 2015 Healthcare Benchmarks: Care Transitions Management
April 2015
Improving Discharge Planning

- Comprehensive assessment including social support and psychosocial needs
- Improved interdisciplinary communication
- Limit medical jargon
- Standardize educational materials specific to disease process
- Proactively complete a readmission risk assessment
- Ensure instructions include who to call for what, and signs and symptoms of problems

What Makes Discharge Process Complex

Factors that play a role in making the process complex

- Patient issues
- Communication difficulties
- Documentation problems
- Time pressures
- Policy issues

Patient Issues

Age

Not scheduling or attending follow-up appointments

Complexity of patient condition

Failure to understand discharge instructions

Cognitive deficits

Medication management

Communication Difficulties

- Information dissemination and documentation
- Number/variety of provides, groups, agencies involved in discharge process
- Transfer documentation and information
- Lack of community support such as family support, shortage of community resources, access to primary care
- Lack of support for discharge planning improvement from staff members
- Increased patient-to-nurse ratios
- Shortened average length of stay
  - Less time for physicians/nurses to meet with patients to discuss discharge needs

Model of Hospital Discharge Period using Discharge Phone Calls (DPCs)

Purpose and Benefits of DPCs

✓ Provides patients opportunity to ask questions that arise after discharge about their post-discharge care
  • Patients/caretakers confused about use of medications
  • Need of personal care at home
  • Need of social services
✓ Patients perceive DPCs as a good monitor of their recovery progress
✓ Can be an effective method to improve follow-up care of elder patients after discharge from Emergency Room
✓ Scheduling and/or reminders of follow-up appointments
✓ For the hospital, DPCs provides feedback about quality of care

DPCs study shows......

Discharge phone calls (DPCs)

- Patients and nurses express positive attitudes towards DPCs.
- Previous studies conducted in emergency departments found that patients who received a DPC showed improved health status which significantly decreased returns to the ED.
- Research shows that >90% of patients have questions post-discharge.

## Patient Problems Solved During DPCs

<table>
<thead>
<tr>
<th>Common Patient Problems</th>
<th>Problems During Transitional Period</th>
<th>How DPCs Helps Solve Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Management</td>
<td>• Cannot afford medications</td>
<td>• Work on alternative medications</td>
</tr>
<tr>
<td></td>
<td>• Has not filled medication</td>
<td>• Find out why</td>
</tr>
<tr>
<td></td>
<td>• Does not understand how to take medications</td>
<td>• Solve the problem faster than waiting for them to be readmitted</td>
</tr>
<tr>
<td></td>
<td>• Discharge without prescription</td>
<td>• Get the prescription to the patient</td>
</tr>
<tr>
<td></td>
<td>• Do not have proper medical devices</td>
<td>• Discovers this faster and helps patient get proper devices</td>
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| Patient Questions       | • Have questions about their medical care  
|                         | • Have problems after discharge      
|                         | • Too proud to ask questions         
|                         | • Do not listen to discharge instructions because they just want to go home  
|                         | • Do not understand their medical care | • Allows patients to ask questions and get answers  
|                         |                                     | • Catches problems before they become serious  
|                         |                                     | • May be easier for patients to ask questions over the phone than in person  
|                         |                                     | • Patients get a second chance to hear the instructions when they are not in a rush  
|                         |                                     | • Provides re-education |
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<td>Follow-up Appointments</td>
<td>• Forget about follow-up appointment • Did not receive follow-up appointment</td>
<td>• Reminds patients about appointments • Schedule appointments for patients</td>
</tr>
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