Discharge Planning and Patient Follow-up

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Proposed Revisions to Discharge Planning Requirements for CAHs

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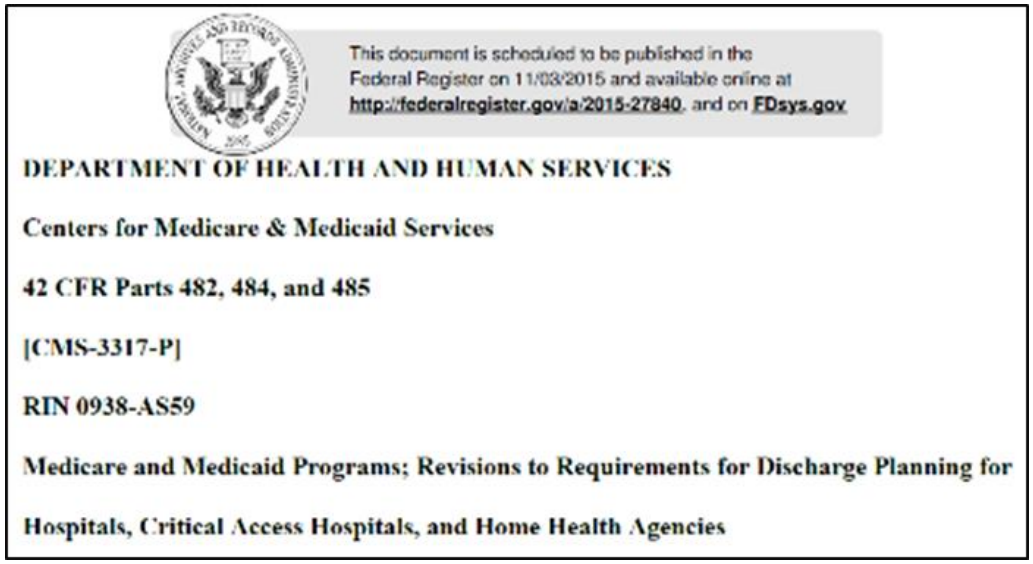

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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

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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.

Critical Access Hospital Discharge Planning

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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

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

Applicability

Critical Access Hospital Discharge Planning

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The discharge planning process must apply to:

- All inpatients
- Outpatients receiving observation services
- Outpatients undergoing surgery or other same day procedures for which anesthesia or moderate sedation are used
- 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
- 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

Discharge Planning Process

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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

Discharge Planning Process *Continued*

Critical Access Hospital Discharge Planning

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The CAH must consider:

- Caregiver/support person and community based care availability
- Patient's or caregiver's/support person's capability to perform required care including self-care
- Care from a support person(s)
- Follow-up care from a community based provider
- 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

Discharge Planning Process *Continued*

Critical Access Hospital Discharge Planning

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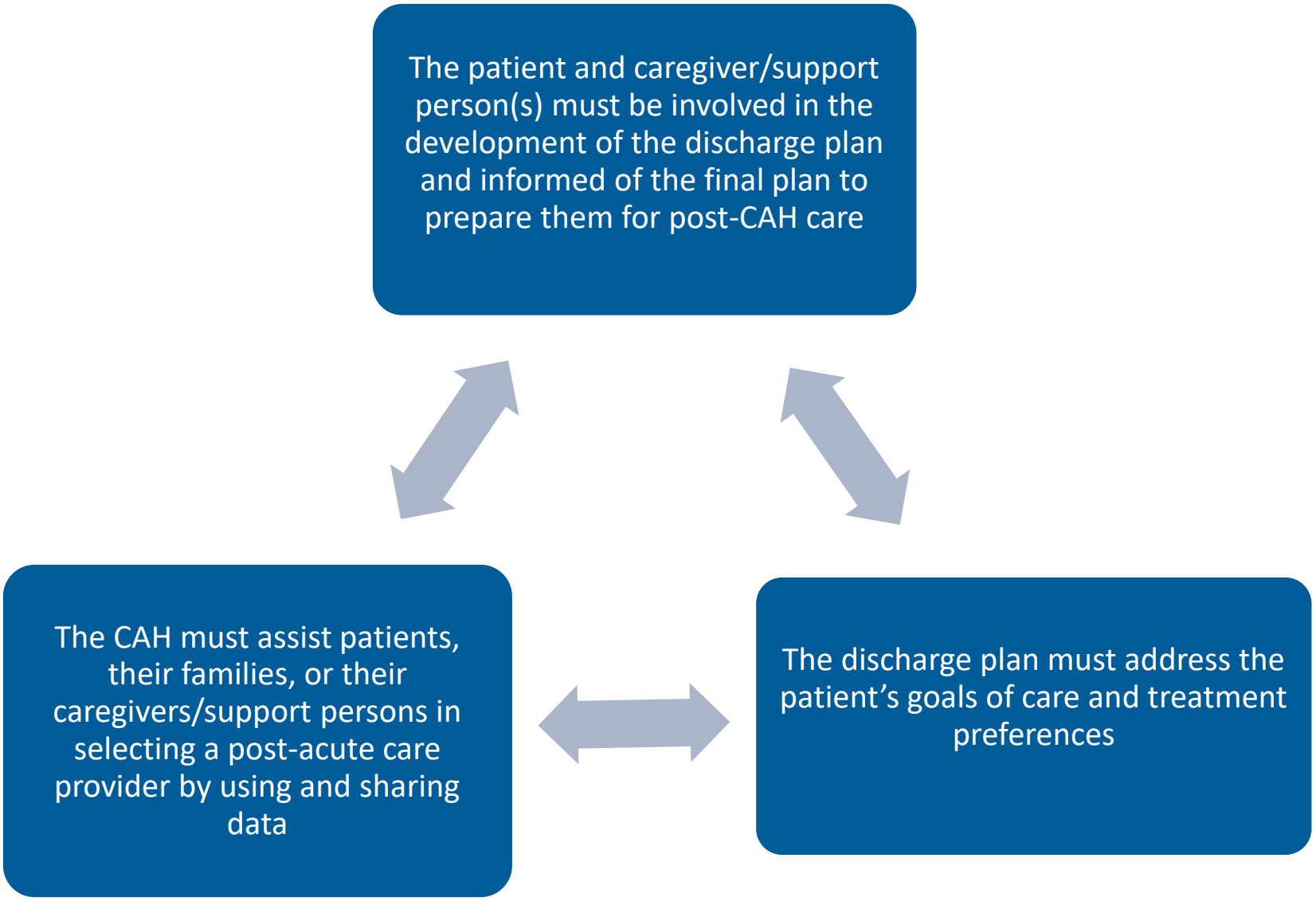

Discharge Planning Process *Continued*

Critical Access Hospital Discharge Planning

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- 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

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- 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

Discharge to Home *Continued*

Critical Access Hospital Discharge Planning

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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

Transfer to Another Health Care Facility

Critical Access Hospital Discharge Planning

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- The CAH must send necessary medical information to the receiving facility <u>at the time of transfer</u>

Recommendation- EDTC Format

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

Schuller, Kristin A., Szu-Hsuan Lin, Larry D. Gamm, and Nicholas Edwardson. "Discharge Phone Calls." *Journal for Healthcare Quality* 37.3 (2015): 163-72.

Importance of Discharge Planning

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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

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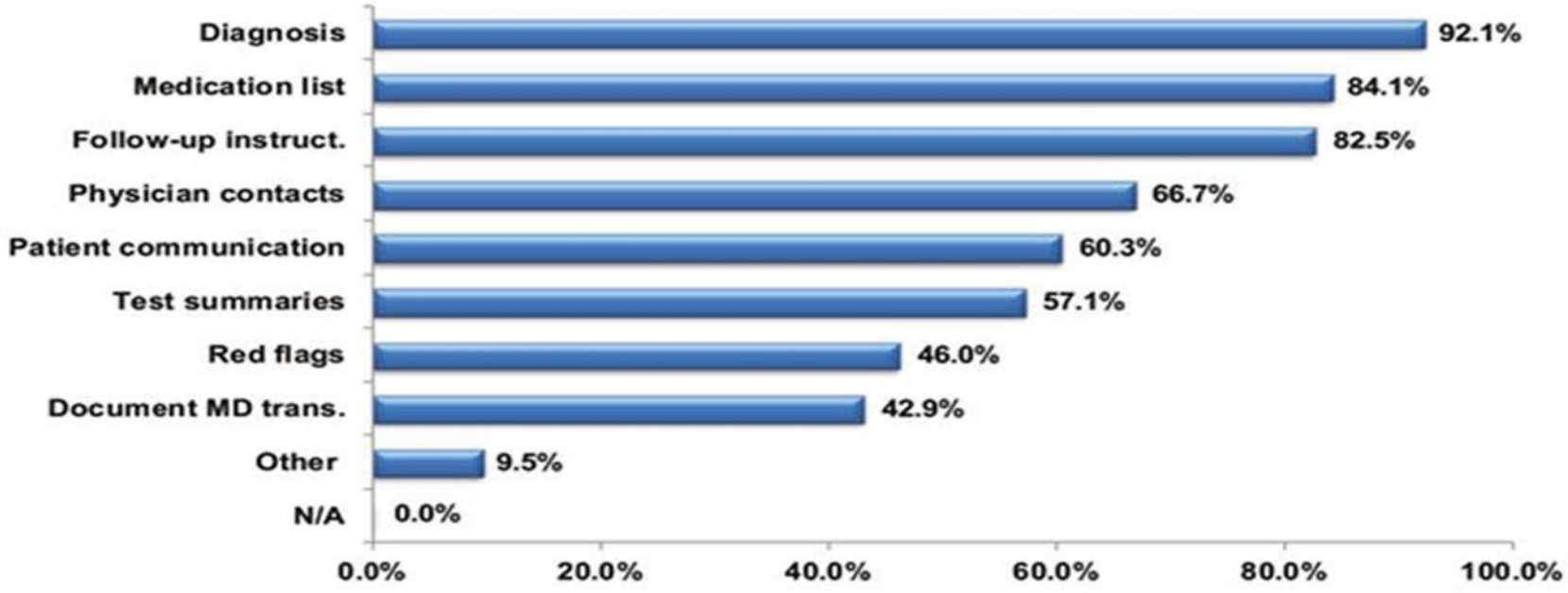
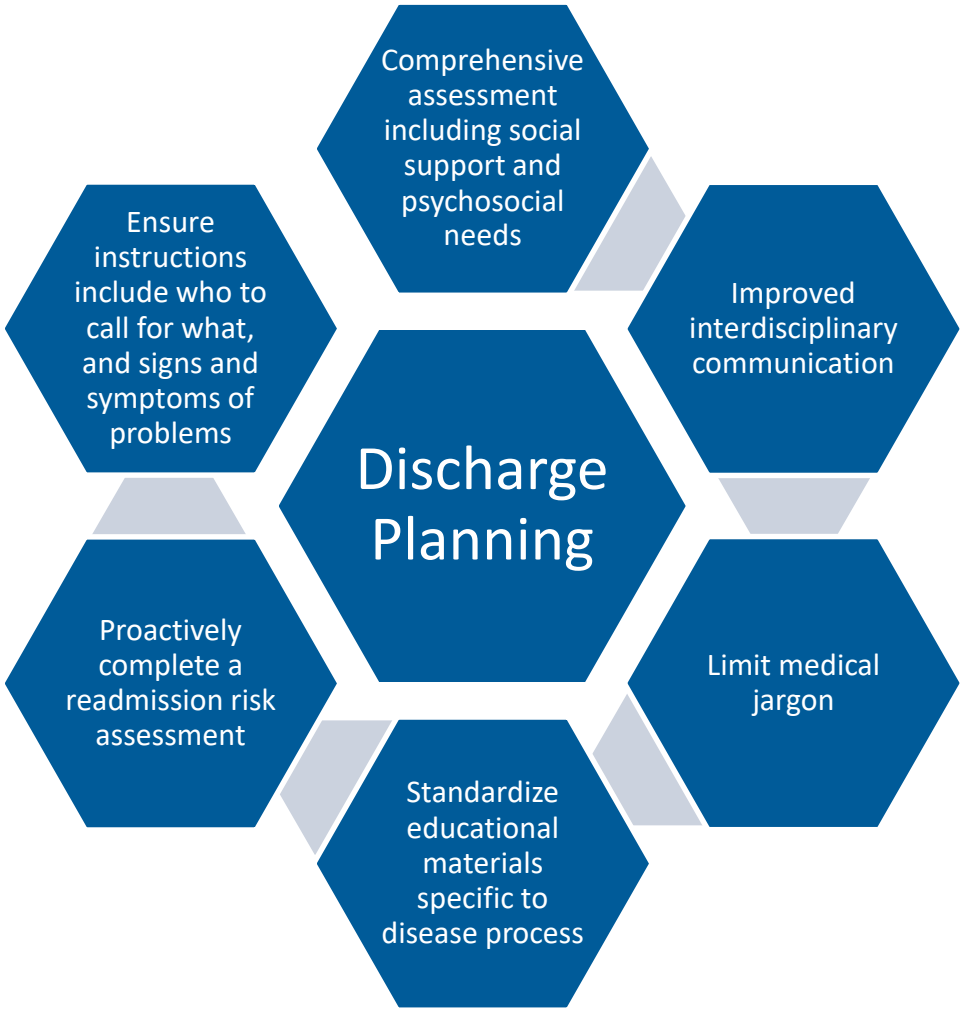
What Are the Top Components of a Discharge Summary?



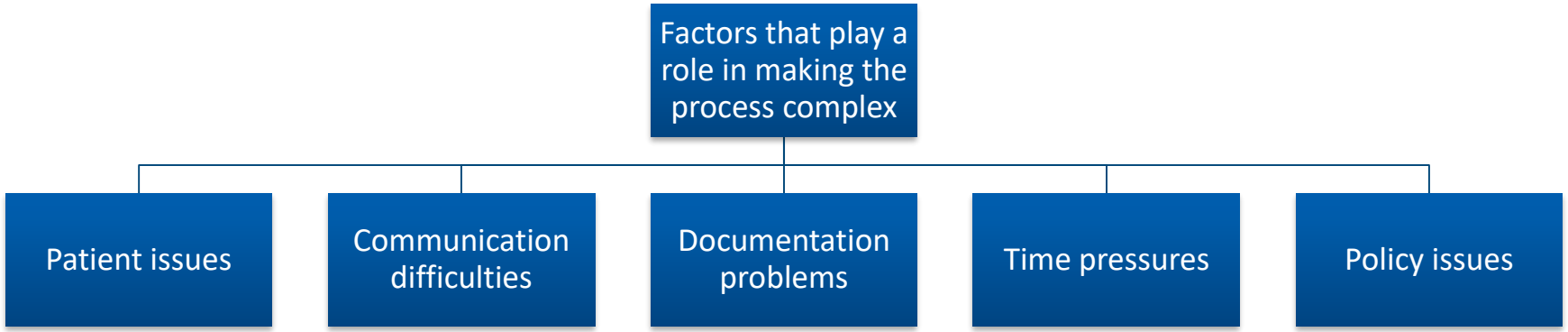
Source: 2015 Healthcare Benchmarks: Care Transitions Management
April 2015

Improving Discharge Planning



Adapted from: Schuller, Kristin A., Szu-Hsuan Lin, Larry D. Gamm, and Nicholas Edwardson. "Discharge Phone Calls." *Journal for Healthcare Quality* 37.3 (2015): 163-72.

What Makes Discharge Process Complex



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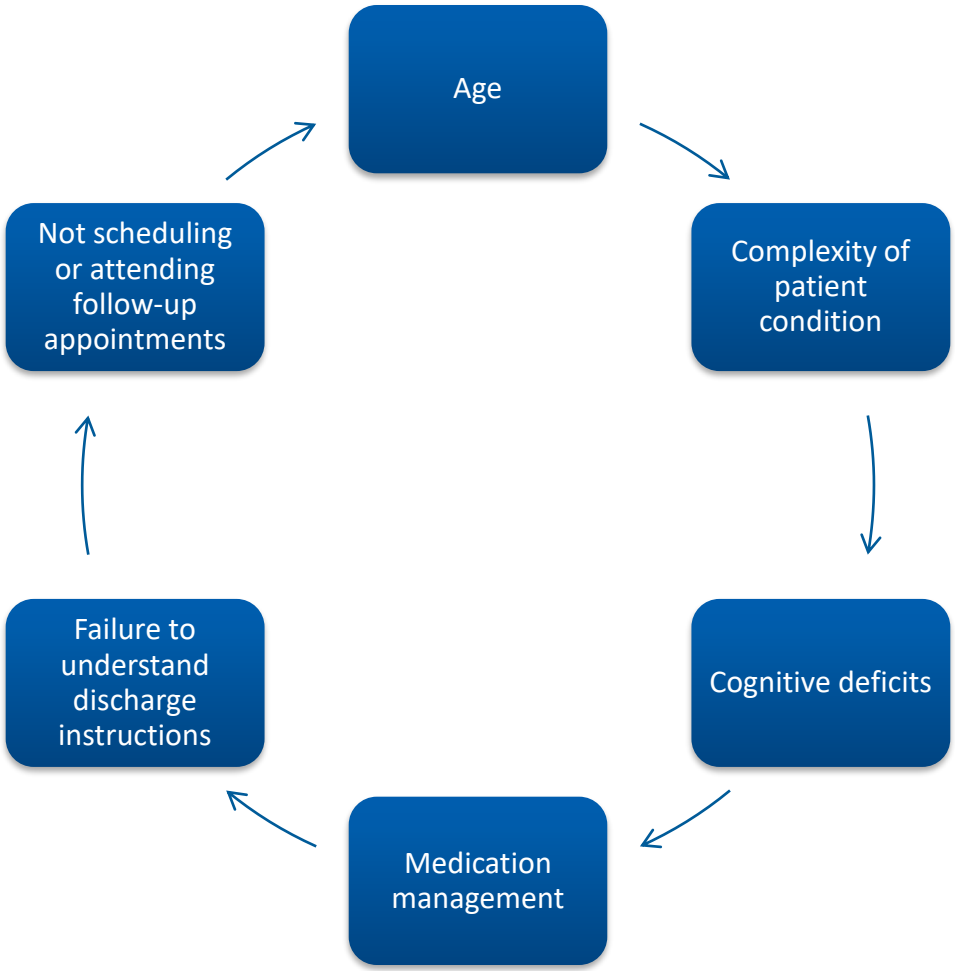
Patient Issues



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Communication Difficulties

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- ✓ 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

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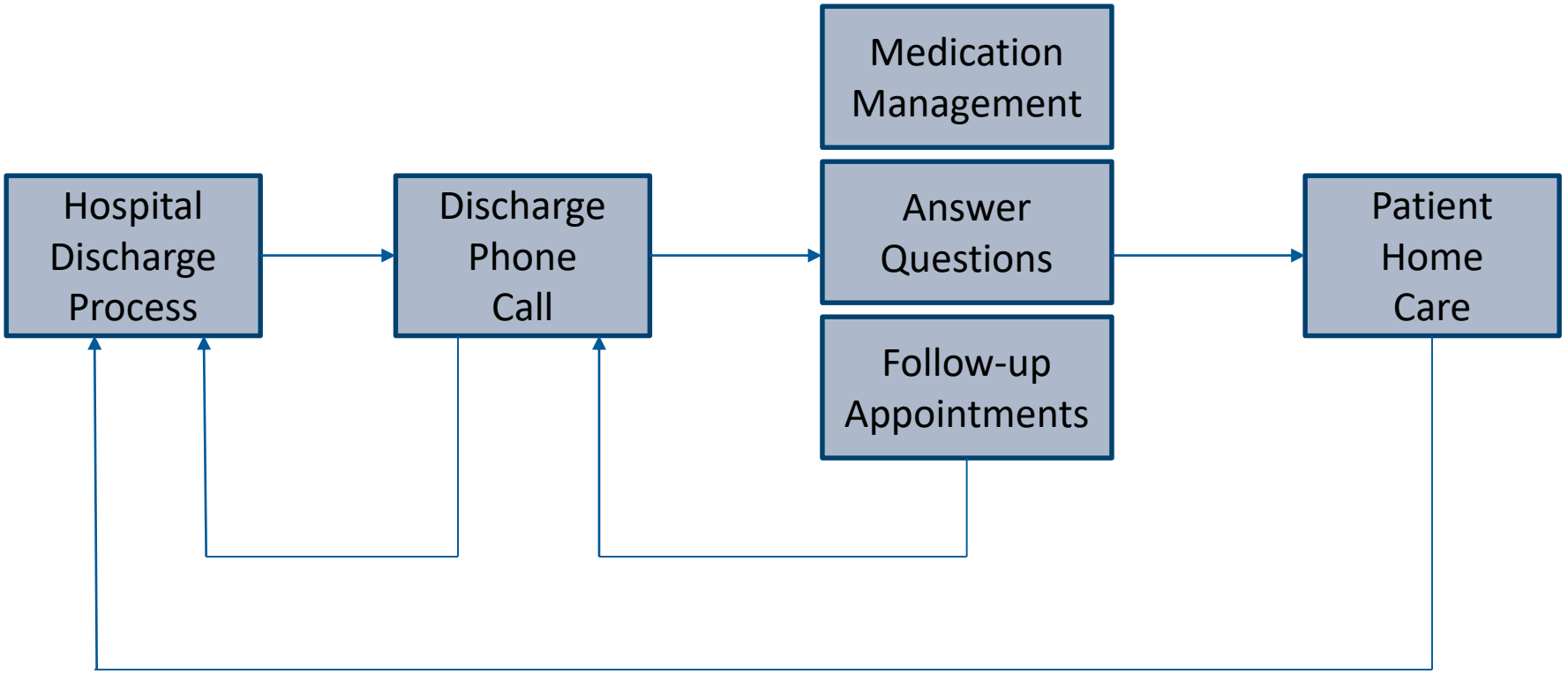
Model of Hospital Discharge Period using Discharge Phone Calls (DPCs)



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Purpose and Benefits of DPCs

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- ✓ 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

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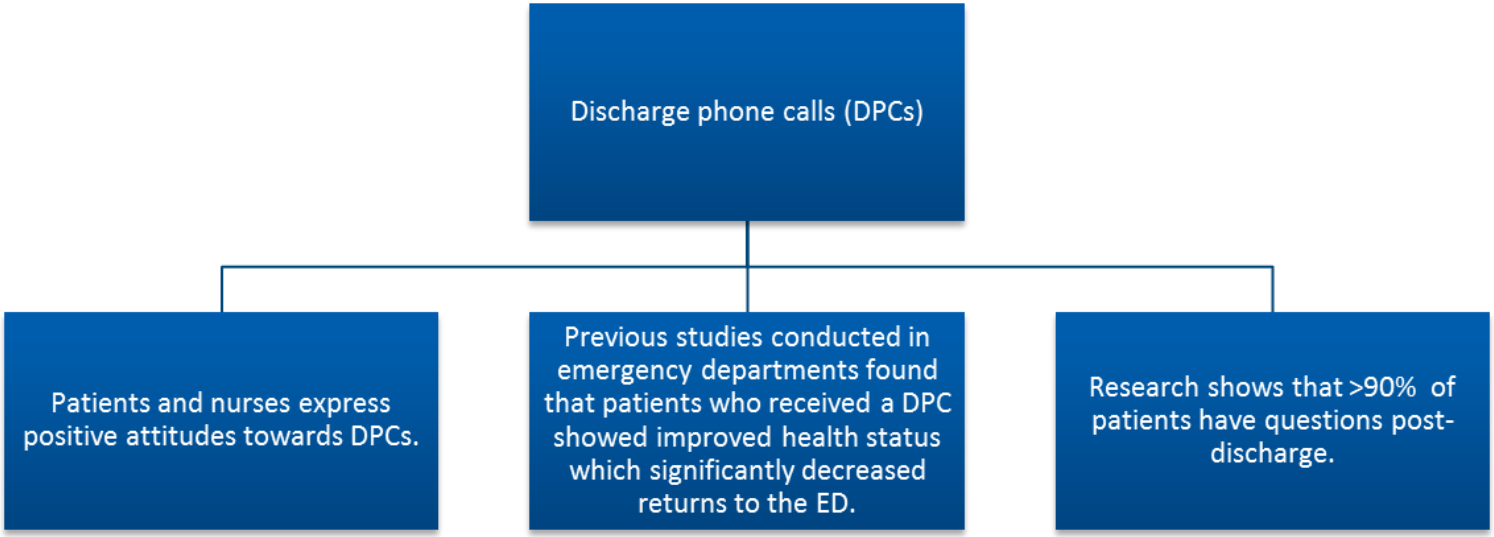
DPCs study shows…….



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Patient Problems Solved During DPCs

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Common Patient Problems	Problems During Transitional Period	How DPCs Helps Solve Problems
Medication Management	• Cannot afford medications	• Work on alternative medications
	• Has not filled medication	• Find out why
	• Does not understand how to take medications	• Solve the problem faster than waiting for them to be readmitted
	• Discharge without prescription	• Get the prescription to the patient
	• Do not have proper medical devices	• Discovers this faster and helps patient get proper devices

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Patient Problems Solved During DPCs

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Common Patient Problems	Problems During Transitional Period	How DPCs Helps Solve Problems
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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Patient Problems Solved During DPCs

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Common Patient Problems	Problems During Transitional Period	How DPCs Helps Solve Problems
Follow-up Appointments	• Forget about follow-up appointment • Did not receive follow-up appointment	• Reminds patients about appointments • Schedule appointments for patients

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