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VNAA Summary: Discharge Planning Proposed Rule

On Thursday, October 29, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a proposed regulation that would revise the discharge planning requirements for hospitals, including long-term care and inpatient rehabilitation facilities, critical access hospitals (CAHs), and home health agencies (HHAs).[1],[2] These updates are based in part on the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which required that post-acute care providers, hospitals and critical access hospitals take into account quality, resource use, and other measures in the discharge planning process. CMS estimates that the provisions in the rule will cost $454 million to implement during the first full year of implementation. Of that amount, CMS estimates that home health agencies will incur $34 million in one-time costs and $283 million in recurring annual costs. In publishing this proposed regulation, CMS has withdrawn the proposed discharge summary content requirements published in the October 9, 2014 proposed rule updating the home health conditions of participation.[3] Major provisions of the rule are summarized below. Given the importance of hospital discharge planning processes to HHA's work, we include a summary of the hospital requirements as well.

Comments on the regulation are due to CMS 60 days from the date of publication in the Federal Register (publication pending).

Hospital Discharge Planning

CMS proposes to revise the existing requirements for hospital discharge planning with six new standards:

> **(1) Design:** CMS proposes to require that hospitals develop a discharge planning process in consultation with medical staff, nursing leadership, and other pertinent services and that the process be specified in writing and reviewed and approved by the hospital's governing body.
>
> **(2) Applicability:** CMS proposes to require that the discharge planning process apply to all inpatients, as well as certain categories of outpatients, including, but not limited to patients

[1] "Medicare and Medicaid Programs; Revisions to the Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" (Publication in the Federal Register Pending)
[2] Updated discharge planning requirements for skilled nursing facilities were included in a prior proposed regulation released in July 2015 ("Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities" (80 FR 42167, July 16, 2015)).
[3] "Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies" (79 Federal Register 61164, October 9, 2014)

Tel: 571-527-1520 | Fax: 571-527-1521 | 2121 Crystal Drive, Suite 750, Arlington, VA 22202 | www.vnaa.org

receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, emergency department patients who have been identified by a practitioner as needing a discharge plan, and any other category of outpatient as recommended by the medical staff, approved by the governing body, and specified in the hospital's discharge planning policies and procedures.

(3) Discharge planning process: CMS proposes to require that hospitals implement a discharge planning process that begins within 24 hours after admission or registration and identifies the anticipated post-discharge goals, preferences, and needs of the patient. The proposed regulation would require that a registered nurse, social worker, or other qualified personnel as identified in the hospital's discharge planning policy coordinate the discharge needs evaluation and development of the discharge plan.

CMS proposes for hospitals to involve the patient and caregiver in the development of the discharge plan and consider a number of factors when evaluating a patient's discharge needs, including:

- Admitting diagnosis or reason for registration;
- Relevant co-morbidities and past medical and surgical history;
- Anticipated ongoing care needs post-discharge;
- Readmission risk;
- Relevant psychosocial history;
- 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;
- Patient's access to non-health care services and community-based care providers; and
- Patient's goals and treatment preferences.

CMS emphasizes several elements for hospitals' consideration, including the availability of caregivers (factoring in the caregiver's capability and availability to provide care), community-based care providers, and access to non-health care services, e.g., social services and supports. CMS recommends that providers use their state's Prescription Drug Monitoring Program (PDMP) when evaluating a patient's past medical history.

CMS also proposes revisions to the requirement that hospitals assist patients and their caregivers, in selecting a post-acute care provider. In compliance with the IMPACT Act, CMS proposes that hospitals provide patients with quality and resource use information to help in selecting a post-acute care provider. CMS notes that because standardized quality and resource use measures as required by the IMPACT Act are not yet available, providers should use other sources of information on post-acute care provider quality, such as the Nursing Home and Home Health Compare websites. Hospitals are also directed to consider patient goals of care and treatment preferences when presenting post-acute care provider options.

(4) Discharge to home: In this section, CMS proposes updates to requirements regarding discharge instructions for individuals who are returning to their residence or other community-based settings who require follow-up care. CMS proposes that hospitals provide discharge instructions at the time of discharge to patients who are discharged home or who are referred to post-acute care. CMS also proposes that hospitals share the discharge instructions with practitioners/facilities (e.g., HHA, hospice agency) at the time of discharge if the patient is referred to their services. Finally, hospitals must establish a post-discharge follow-up process.

CMS proposes specific components to be included in the discharge instructions, including: information on warning signs and symptoms that patients and caregivers should be aware of and what to do if such a situation arises. Hospitals would also need reconcile all prescription and over-the-counter medications and provide an accurate and complete post-discharge medication list.

CMS also proposes to revise the requirements for communicating necessary information to the practitioner(s) responsible for follow-up care, if the practitioner is known, including:

- 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 as specified in in the regulations.

(5) Transfer of patient to another health care facility: CMS proposes to update requirements related to information sharing between hospitals and facilities receiving discharged patients. In addition to a copy of the patient's discharge instructions and the discharge summary, CMS proposes that the following information be provided to the receiving facility at a minimum:

- 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.

(6) Requirements for post-acute care services: CMS proposes to require hospitals to tell patients enrolled in managed care organizations that they need to verify whether an HHA or SNF is in-network or provide that information directly to the patient if the hospital has it.

Home Health Agency Discharge Planning

CMS proposes to establish a new §484.58 related to discharge planning with the following components:

Discharge planning process: CMS proposes to require that HHAs develop and implement a discharge planning process that prepares patients and their caregivers for post-discharge care, facilitates effective transition of patients to post-HHA care, and reduces factors leading to preventable readmissions. The discharge planning process must ensure that the patient's goals for care, preferences, and needs are identified and reflected in the discharge plan, including taking into account the availability and capabilities of caregivers to perform required care. The physician responsible for the home health plan of care would be required to be involved in the establishment of the discharge plan. HHAs would also be required to regularly reevaluate patients for any changes that would require modification of the discharge plan.

With respect to discharges and transfers, HHAs would be required to assist patients and their caregivers in selecting another post-acute care provider by using quality and resource use data. Pending the availability of IMPACT Act data, HHAs, like hospitals, would be expected to rely on available quality information, such as that provided through CMS' Compare websites.

Timeliness and documentation requirements: While CMS proposes to require that the discharge plan is documented and completed on a timely basis, the specific timeframe would be left to the HHAs to develop. HHAs would be required to document the evaluation resulting in the discharge plan in the clinical record and discuss the evaluation with the patient or the patient's representative.

Content of discharge and transfer summaries: Similar to the proposal for hospitals, CMS proposes to establish a new standard for content of discharge and transfer summaries. The information must include, at a minimum:

- Demographic information, including but not limited to name, sex, date of birth, race, ethnicity, and preferred language;
- Contact information for the physician responsible for the home health plan of care;
- 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.

To the extent one or more of these elements does not apply to the patient, the HHA must include an appropriate notation, such as "N/A."

Critical Access Hospital Discharge Planning

CMS proposes nearly identical requirements for discharge planning for CAHs as it does for other hospitals (see above). The exception is that CMS does not propose to require a standard for "Requirements for post-acute care services" for CAHs.

Anticipated Impact on Home Health Agencies

CMS anticipates that implementation of this proposed rule will cost HHAs in aggregate $34 million to develop a discharge planning process and $283 million annually to develop and send the discharge summary. CMS used the following assumptions in developing the impact statement:

- **Discharge planning process:** CMS estimates that compliance with this provision would require eight hours of time from each a physician ($187/hourly), a registered nurse ($67/hourly), and an administrator ($98/hourly) for a total of 24 hours or $2,816 per HHA.
- **Discharge or transfer summary content:** CMS estimates that compliance with this provision would require 10 minutes per patient. Of those 10 minutes, CMS estimates that 2 minutes would be covered by a physician, 3 minutes by a social worker ($52/hourly), and 5 minutes by an RN. The average estimated annual cost for an HHA would be approximately $21,710 per HHA.
- **Sending discharge or transfer summaries:** CMS estimates that an office employee of an HHA would spend 2.5 minutes per patient sending the discharge summary to the patient's next source of care, resulting in an estimated $1,984 per average HHA.