Discharge Planning: New Regulations Proposed.

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

§482.43 Condition of participation: Discharge planning.

The hospital must develop and implement an effective discharge planning process that focuses on the patient’s goals and preferences and prepares patients and their caregivers/support person(s), to be active partners 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 hospital to post-discharge care, and the reduction of factors leading to preventable hospital readmissions.

(a) Standard: Design. The discharge planning process must meet the following requirements:

(1) Be developed with input from the hospital’s medical staff, nursing leadership as well as other relevant departments;
(2) Be reviewed and approved by the governing body; and
(3) Be specified in writing.

(b) Standard: Applicability. 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 hospital’s discharge planning policies and procedures by the emergency department practitioner responsible for the care of the patient as needing a discharge plan; and
(5) Any other category of outpatients as recommended by the medical staff and specified in the hospital’s discharge planning policies and procedures approved by the governing body.

(c) Standard: Discharge planning process. The hospital’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 in accordance with paragraph (b) of this section.

(1) A registered nurse, social worker, or other personnel qualified in accordance with the hospital’s discharge planning policies must coordinate the discharge needs evaluation and development of the discharge plan.
(2) The hospital must begin to identify the anticipated discharge needs for each applicable patient within 24 hours after admission or registration, and the discharge planning process is completed prior to discharge home or transfer to another facility and without unduly delaying the patient’s discharge or transfer.

On November 3, 2015 the US Centers for Medicare and Medicaid Services (CMS) announced proposed new regulations for discharge planning in hospitals, long-term care hospitals (LTCH), inpatient rehabilitation facilities, critical access hospitals (CAH) and home health agencies (HHA).

The new regulations are not mandatory at this time. CMS is accepting public comments until January 6, 2016. CMS must consider the public comments it receives before issuing new regulations in final mandatory form.

Theoretically it is still possible that after the public-comment process CMS will alter the proposed regulations substantially before issuing them as mandatory or not issue them at all.

We have placed CMS’s Federal Register announcement on our website at http://www.nursinglaw.com/CMS110315.pdf

We have also included here verbatim the new regulations that CMS proposes to apply to hospitals.

For other providers the proposed new requirements can be found toward the end of the Federal Register announcement following the proposed new regulations for hospitals.

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If the patient’s stay is less than 24 hours, the discharge needs for each applicable patient must be identified and the discharge planning process completed prior to discharge home or transfer to another facility and without unnecessarily delaying the patient’s discharge or transfer.

(3) The hospital’s discharge planning process must require regular reevaluation 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.

(4) 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.

(5) The hospital must consider caregiver/support person and community based care availability and the 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 practitioners and facilities, or, in the case of a patient or other residential facility, care in that setting, as part of the identification of discharge needs. The hospital 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.

(6) 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-hospital care.

(7) The discharge plan must address the patient’s goals of care and treatment preferences.

(8) The hospital must assist the patients, their families, or the patient’s representative 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 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.

(9) 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-hospital care are made before discharge to avoid unnecessary delays in discharge.

(i) The discharge plan must be included in the patient’s medical record. The results of the evaluation must be discussed with the patient or patient’s representative.

(ii) All relevant patient information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the patient’s discharge or transfer.

(10) 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.

(d) Standard: Discharge to home. (1) Discharge instructions must be provided at the time of discharge to:

(i) The patient and/or the patient’s caregiver/support person(s), and

(ii) The post-acute care provider or supplier, if the patient is referred to post-acute care services.

(2) The discharge instructions must include, but are not limited to the following:

(i) Instruction on post-hospital care to be used by the patient or the caregiver/support person(s) in the patient’s home, as identified in the discharge plan;

(ii) Written information on warning signs and symptoms that may indicate the need to seek immediate medical attention. This must include written instructions on what the patient or the caregiver/support person(s) should do and who they should contact if these warning signs or symptoms present;

(iii) Prescriptions and over-the-counter medications that are required after discharge, including the name, indication, and dosage of each drug, along with any significant risks and side effects of each drug as appropriate to the patient;

(iv) Reconciliation of all discharge medications with the patient’s prehospital admission/registration medications (both prescribed and over-the-counter); and

(v) 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, including telephone numbers, for any practitioners involved in follow-up care or for any providers/suppliers to whom the patient has been referred for follow-up care.

(3) The hospital must send the following information to the practitioner(s) responsible for follow up care, if the practitioner is known and 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 §482.43(e)(2).

(4) The hospital must establish a post-discharge follow-up process.

(e) Standard: Transfer of patients to another health care facility. (1) The hospital must send necessary medical information to the receiving facility at the time of transfer.

(2) Necessary medical information must include:

(i) Demographic information, including but not limited to name, sex, date of birth, race, ethnicity, preferred language;

(ii) Contact information for the practitioner responsible for the care of the patient, as described at paragraph (b)(4) of this section, and the patient’s caregiver(s)/support person(s), if applicable;

(iii) Advance directive, if applicable;

(iv) Course of illness/treatment;

(v) Procedures;

(vi) Diagnoses;

(vii) Laboratory tests and the results of pertinent laboratory and other diagnostic testing;

(viii) Consultation results;

(ix) Functional status assessment;

(x) Psychosocial assessment, including cognitive status;

(xi) Social supports;

(xii) Behavioral health issues;

(xiii) Reconciliation of all discharge medications with the patient’s prehospital admission/registration medications (both prescribed and over-the-counter);

(xiv) All known allergies, including medication allergies;

(xv) Immunizations;

(xvi) Smoking status;

(xvii) Vital signs;

(xviii) Unique device identifier(s) for a patient’s implantable device(s), if any;

(xix) All special instructions or precautions for ongoing care, as appropriate;

(xx) Patient’s goals and treatment preferences; and

(xxi) All other necessary information including a copy of the patient’s discharge instructions, the discharge summary and any other documentation as applicable, to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.

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