The IMPACT Act and CMS Proposed Changes to Discharge Planning

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Speaker

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468 (Call with questions, No emails)
- sdill1@columbus.rr.com

2

IMPACT Act

- The IMPACT Act is a federal law that has been passed which will affect all hospitals including CAHs
- A patient is scheduled for a total hip and asks which of the following post-care setting has the best outcomes and how much does it cost?
  - Discharge home with home health care, inpatient rehab, LTC hospital or the SNF advertised as a rehab center
- What do you tell the patient?
- Lack of comparable information across the different settings made it difficult for policymakers and providers to figure out the most appropriate setting

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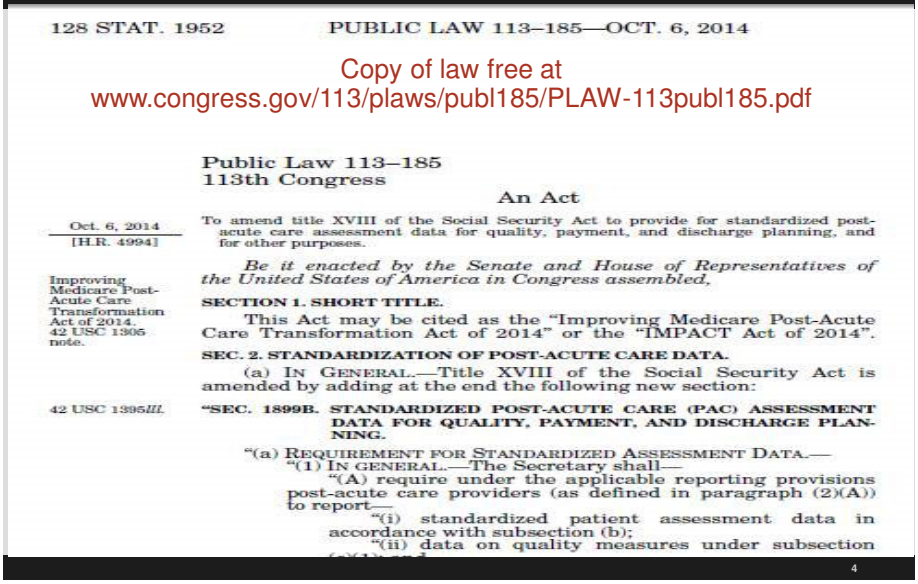
IMPACT Act



128 STAT. 1952 PUBLIC LAW 113–185—OCT. 6, 2014

Copy of law free at
www.congress.gov/113/plaws/publ185/PLAW-113publ185.pdf

Public Law 113–185
113th Congress

An Act

Oct. 6, 2014
[H.R. 4994]

To amend title XVIII of the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Improving Medicare Post-Acute Care Transformation Act of 2014. 42 USC 1305 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Medicare Post-Acute Care Transformation Act of 2014" or the "IMPACT Act of 2014".

SEC. 2. STANDARDIZATION OF POST-ACUTE CARE DATA.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

42 USC 1395lll.

"SEC. 1899B. STANDARDIZED POST-ACUTE CARE (PAC) ASSESSMENT DATA FOR QUALITY, PAYMENT, AND DISCHARGE PLANNING.

"(a) REQUIREMENT FOR STANDARDIZED ASSESSMENT DATA.—
"(1) IN GENERAL.—The Secretary shall—
"(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—
"(i) standardized patient assessment data in accordance with subsection (b);
"(ii) data on quality measures under subsection

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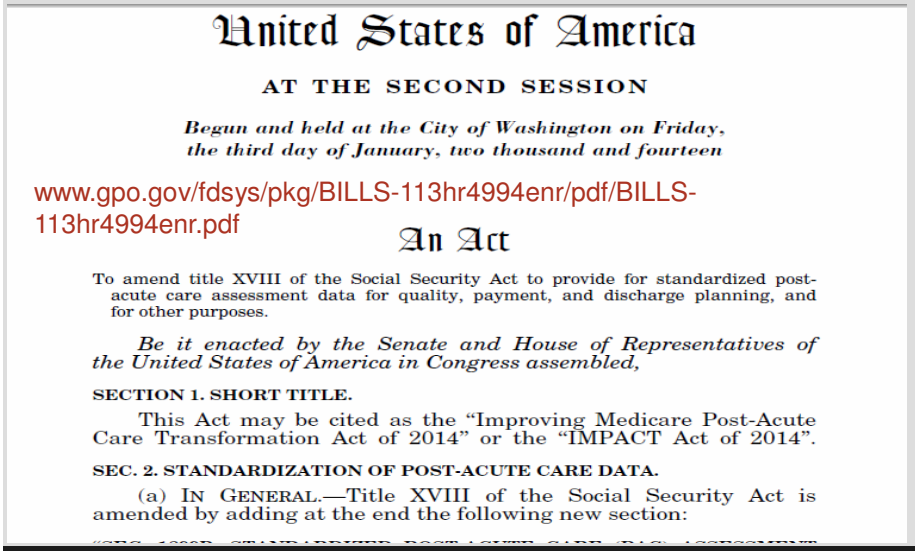
IMPACT ACT 19 Pages



United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Friday, the third day of January, two thousand and fourteen

www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf

An Act

To amend title XVIII of the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning, and for other purposes.

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SEC. 2. STANDARDIZATION OF POST-ACUTE CARE DATA.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

5

The Four PACs

- The Impact Act affects four post-acute care facilities (PACs)
  - Long-Term Care Hospitals (LTCHs),
  - Skilled Nursing Facilities (SNFs),
  - Home Health Agencies (HHAs) and
  - Inpatient Rehabilitation Facilities (IRFs).

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IMPACT Act

- Signed by the President on October 7, 2014
- Stands for "Improving Medicare Post-Acute Care Transformation Act of 2014"
- Wants to standardize the information collected between the **four** post-acute care providers (PACs)
  - Wants data to be interoperable so as to allow exchange of data and information between the PACs
- Want to improve quality of care across the provider settings and reduce readmissions
- Wanted to improve hospital and discharge planning

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Why the IMPACT Act was Passed

- Wants to improve post-acute care (PAC) since 42% of discharged beneficiaries to PACs from hospitals
- Wants to create an assessment tool to have information hospitals and post-acute care facilities would need
- Lack of comparable information across the different settings made it difficult for policymakers and providers to figure out the most appropriate setting
  - It is **home health, LTC hospital, SNF, or inpatient rehab**
- Need information for payment reform also
- CMS has a time line of major deliverables

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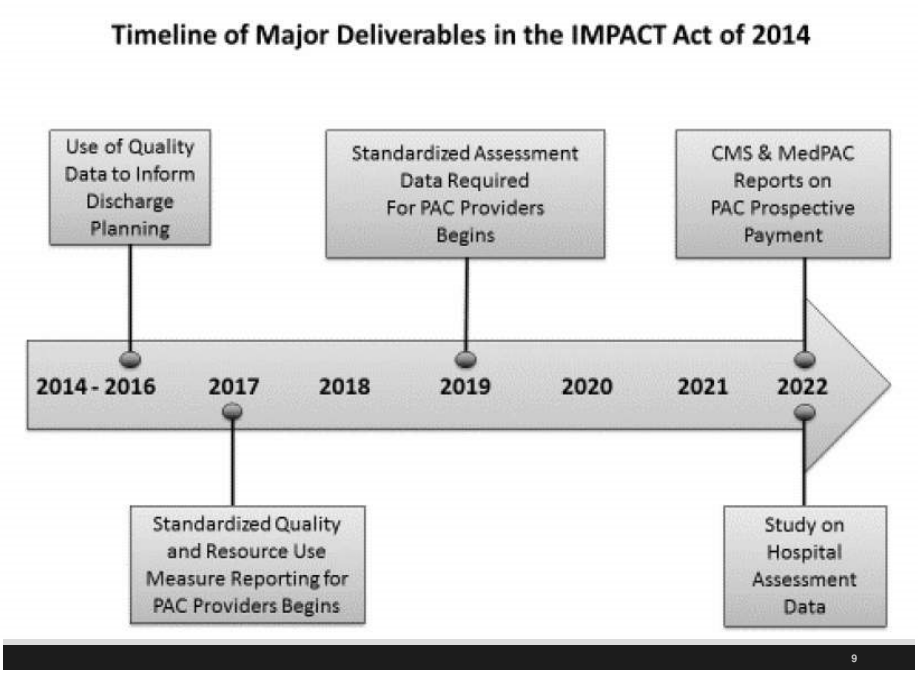

Why the IMPACT Act was Passed

- Want to better monitor and improve quality of care across the provider settings & outcomes
- Wanted to use to reform payment such as neutral or bundle payments
- So post-acute providers have to report standardized data
- Protects beneficiary by giving them choice and access to care
- CMS has a website on the IMPACT Act

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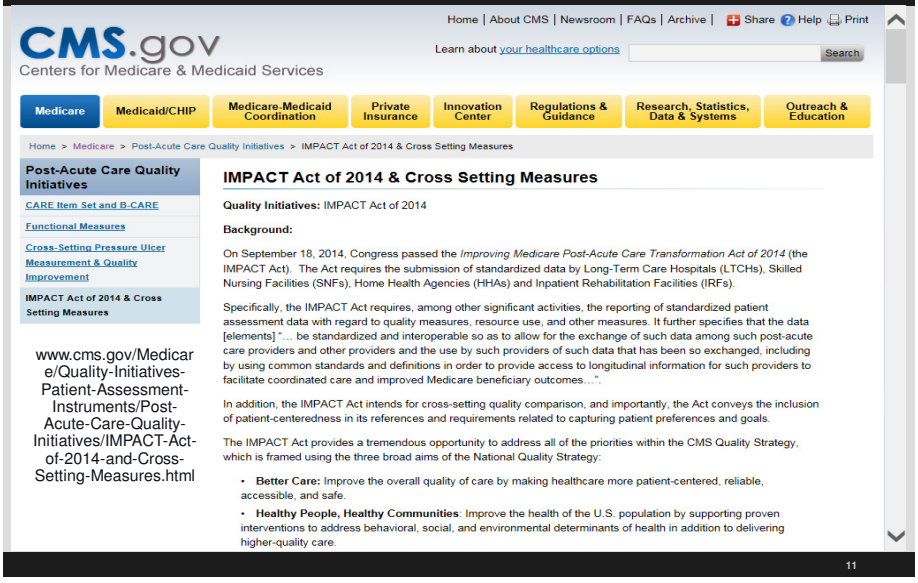
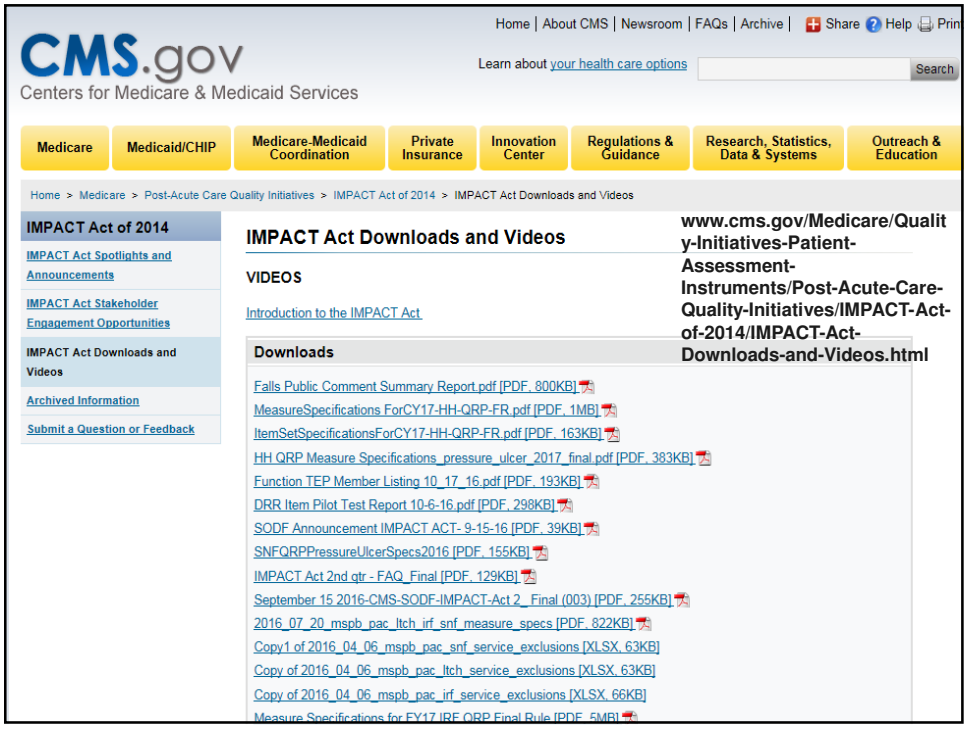
CMS Website on IMPACT Act

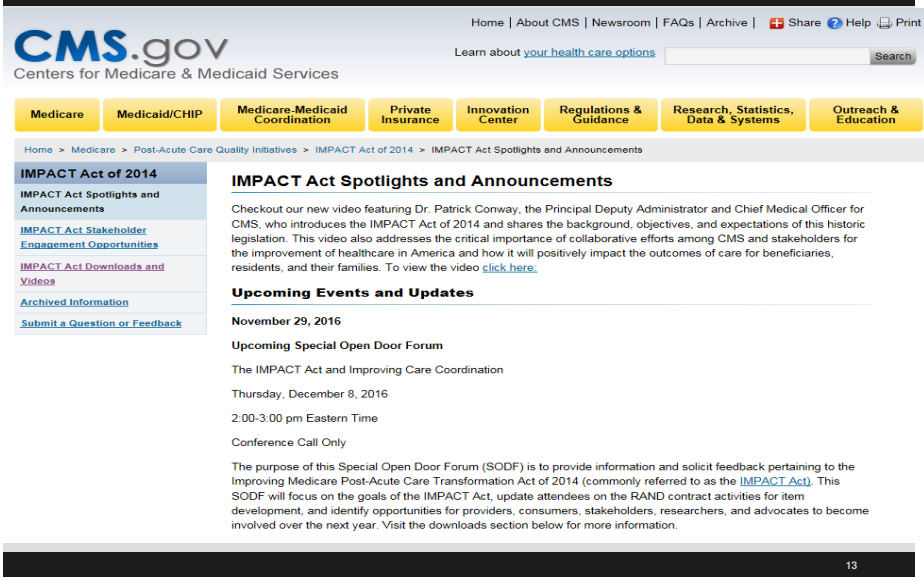


www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html



www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html

CMS Resources on the Impact Act



Definition of PAC Assessment Instruments

Defines PAC assessment instruments and 4 different payment systems:

1) Outcome and Assessment Information Set (OASIS) and HH (home health) PPS payment system or prospective payment system
2) The Minimum Data Set (MDS) and SNF PPS
3) The IRF-Patient Assessment Instrument (IRF-PAI) and IRF PPS (Inpatient Rehab Facility)
4) LTCH-Continuity Assessment and Record and Evaluation Data Set (LTCH-CARE) and LTC PPS

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Standardize 5 Patient Assessments

- The IMPACT ACT talked about standardizing the following information on patient assessments:
- Functional status, such as mobility and self care at admission and before discharge
- Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia
- Special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and TPN

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Standardize Patient Assessments

- Medical conditions and co-morbidities, such as DM, CHF, and pressure ulcers
- Impairments, such as incontinence and an impaired ability to hear, see, or swallow
- Other categories deemed necessary and appropriate by the Secretary
  - Claims data will be aligned with the standardized patient assessment data
- So hospitals and PACs will need to change their admission assessment forms to collect this data
  - RN does admission assessment and could collect this data

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Five Quality Measures to be Reported

- Functional status, cognitive function, and changes in function and cognitive function
- Skin integrity and changes in skin integrity
- Medication reconciliation
- Incidence of major falls
- Accurately communicating the existence of and providing for the transfer of health information and care preferences from a hospital to another provider
  - A PAC is a post-acute care provider such as home health agency, LTC, inpatient rehab, or LTC hospital

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Reporting of Quality Measures

Reporting of Quality Measures. To the extent possible, the Secretary shall require reporting of such new quality measures through the PAC assessment instruments.

Table 1: Timeline for New Quality Domains*

Quality Domains	HHAs	SNFs	IRFs	LTCHs
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Patient Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018

*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above.

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Patient Assessment Data Inpatient Hospitals

- Requires inpatient hospitals, CAH and PPS-exempt cancer hospitals to submit standardized patient assessment data by October 1, 2018
- Standardized patient assessment data shall be submitted no less than one time per admission
- Data shall include:
  - Medical condition, functional status, cognitive function, living situation, access to care at home, and any other indicators necessary for assessing patient need

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Patient Assessment Data HHA IRF LTC

- The measures shall address, at a minimum, the following quality domains:
- 1) Functional status and changes in function
- 2) Skin integrity and changes in skin integrity
- 3) Medication reconciliation
- 4) Incidence of major falls and
- 5) Patient preference regarding treatment and discharge options

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Reporting of Quality Measures

- Using common standards and definitions will help providers coordinate care and improve Medicare patient outcomes
- Besides the reporting from the five quality measure domains using the standardized assessment data
  - The Act requires the development and reporting of measures pertaining to hospitalization, and discharge to the community

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Resource Use Measures

- There is also requirements for resource use measures
- The Secretary needs to specify resource use and other measurement date by October 1, 2016
- This must include at a minimum:
- 1) Medicare spending per beneficiary
- 2) Discharge to community and
- 3) Hospitalization rates of potentially preventable readmissions

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Resource Use Measures

- This will allow for comparison of the data across all four providers
- Maybe in the future when the patients asks about costs and outcomes in deciding where to go after their total knee, we will have data for them to base their decision on.
- CMS has specific information for each of the four facilities required to submit data on the specific quality measures
- ** Secretary to also develop plan to collect and access data on race and ethnicity

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Definition of PAC Assessment Instruments

- The standardized assessment builds on current tools
- Defines PAC assessment instruments as:
- 1) Outcome and Assessment Information Set (OASIS)
- 2) The Minimum Data Set (MDS)
- 3) The IRF-Patient Assessment Instrument (IRF-PAI) and
- 4) LTCH-Continuity Assessment and Record Evaluation (LTCH-CARE)

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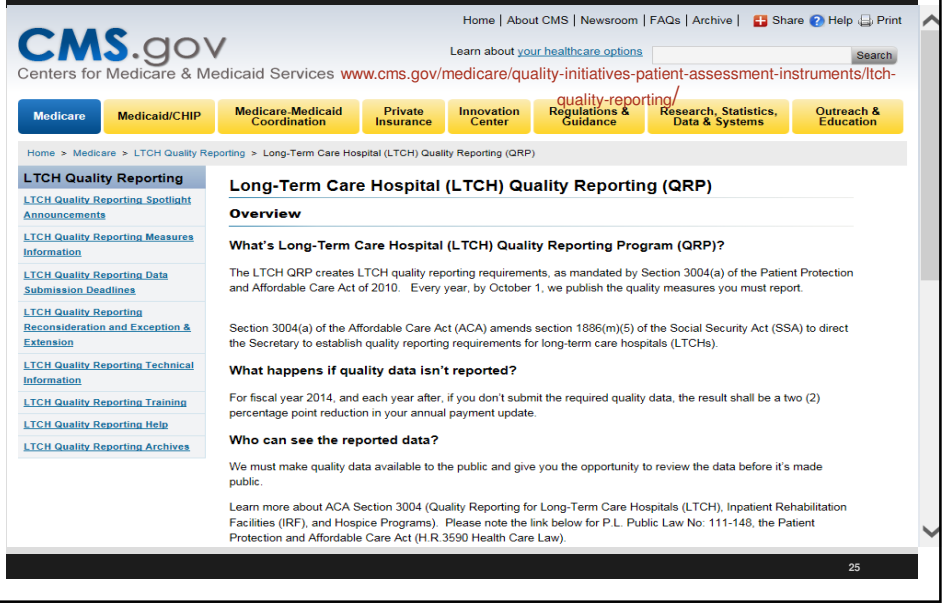
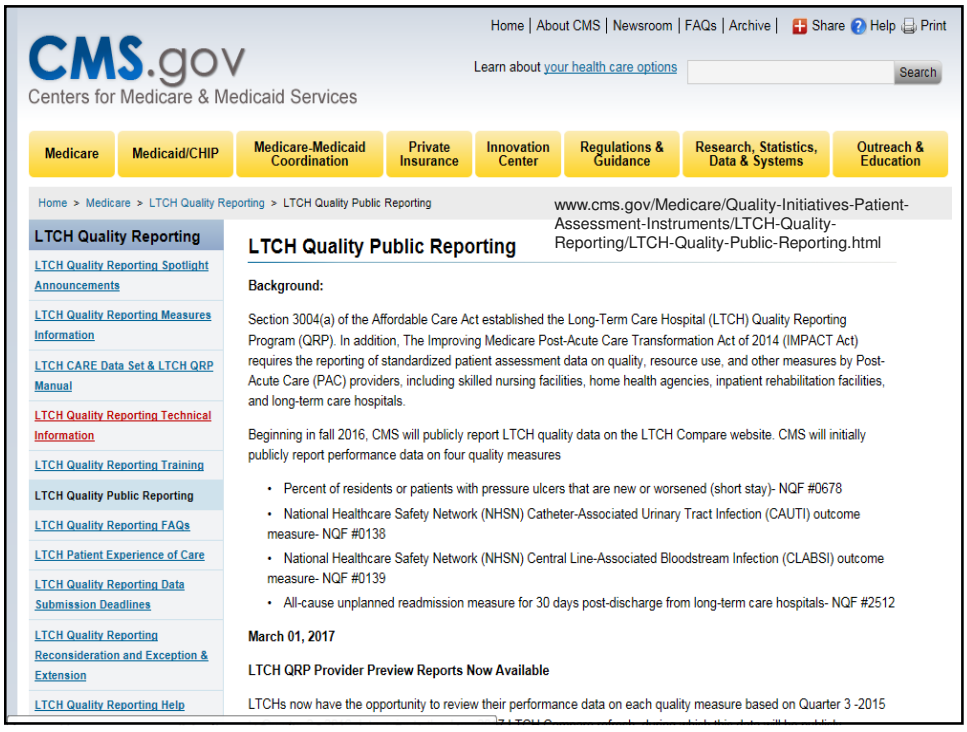
LTC Quality Reporting





Skilled Nursing Facilities SNF

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Inpatient Rehab Facilities (IRF)

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Home Health Agencies HHA

Home Health Revised 2018

Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies

A Rule by the Centers for Medicare & Medicaid Services on 01/13/2017

Site Feedback

PUBLISHED DOCUMENT

Start Printed Page 4504

ENHANCED CONTENT - SUBMIT PUBLIC COMMENT

This feature is not available for this document.

ACTION:

Final rule.

www.federalregister.gov/documents/2017/01/13/2017-00283/medicare-and-medicaid-program-conditions-of-participation-for-home-health-agencies?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email

SUMMARY:

This final rule revises the conditions of participation (CoPs) that home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. The requirements focus on the care delivered to patients by HHAs, reflect an interdisciplinary view of patient care, allow HHAs greater flexibility in meeting quality care standards, and eliminate unnecessary procedural

DOCUMENT DETAILS

Printed version: PDF

Publication Date: 01/13/2017

Agencies: Centers for Medicare & Medicaid Services

Dates: These regulations are effective on July 13, 2017.

Effective Date: 07/13/2017

Document Type: Rule

Document Citation: 82 FR 4504

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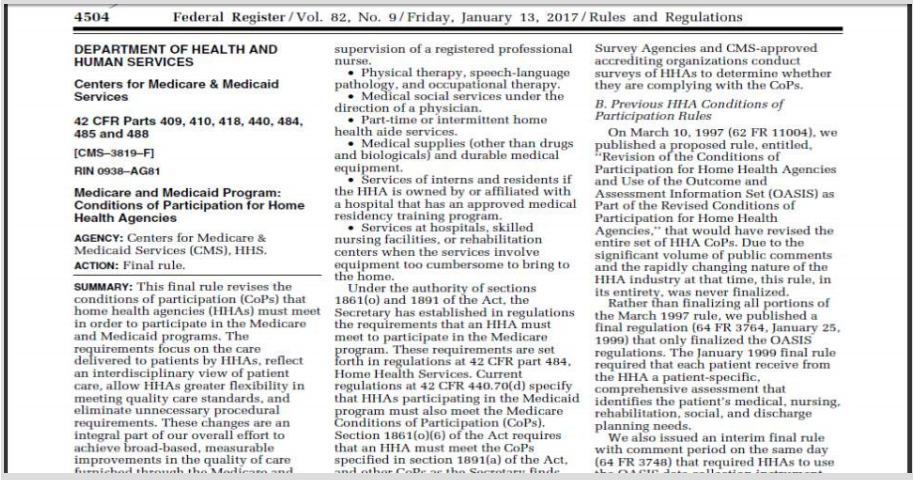
Home Health Revised 2017 PDF 88 Pages



4504 Federal Register / Vol. 82, No. 9 / Friday, January 13, 2017 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 418, 440, 484, 485 and 488

[CMS–3819–F]

RIN 0938–AG81

Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises the conditions of participation (CoPs) that home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. The requirements focus on the care delivered to patients by HHAs, reflect an interdisciplinary view of patient care, allow HHAs greater flexibility in meeting quality care standards, and eliminate unnecessary procedural requirements. These changes are an integral part of our overall effort to achieve broad-based, measurable improvements in the quality of care

supervision of a registered professional nurse.

- Physical therapy, speech-language pathology, and occupational therapy.
- Medical social services under the direction of a physician.
- Part-time or intermittent home health aide services.
- Medical supplies (other than drugs and biologicals) and durable medical equipment.
- Services of interns and residents if the HHA is owned by or affiliated with a hospital that has an approved medical residency training program.
- Services at hospitals, skilled nursing facilities, or rehabilitation centers when the services involve equipment too cumbersome to bring to the home.

Under the authority of sections 1861(o) and 1891 of the Act, the Secretary has established in regulations the requirements that an HHA must meet to participate in the Medicare program. These requirements are set forth in regulations at 42 CFR part 484, Home Health Services. Current regulations at 42 CFR 440.70(d) specify that HHAs participating in the Medicaid program must also meet the Medicare Conditions of Participation (CoPs). Section 1861(o)(6) of the Act requires that an HHA must meet the CoPs specified in section 1891(a) of the Act,

Survey Agencies and CMS-approved accrediting organizations conduct surveys of HHAs to determine whether they are complying with the CoPs.

B. Previous HHA Conditions of Participation Rules

On March 10, 1997 (62 FR 11004), we published a proposed rule, entitled, "Revision of the Conditions of Participation for Home Health Agencies and Use of the Outcome and Assessment Information Set (OASIS) as Part of the Revised Conditions of Participation for Home Health Agencies," that would have revised the entire set of HHA CoPs. Due to the significant volume of public comments and the rapidly changing nature of the HHA industry at that time, this rule, in its entirety, was never finalized.

Rather than finalizing all portions of the March 1997 rule, we published a final regulation (64 FR 3764, January 25, 1999) that only finalized the OASIS regulations. The January 1999 final rule required that each patient receive from the HHA a patient-specific, comprehensive assessment that identifies the patient's medical, nursing, rehabilitation, social, and discharge planning needs.

We also issued an interim final rule with comment period on the same day (64 FR 3748) that required HHAs to use

www.gpo.gov/fdsys/pkg/FR-2017-01-13/pdf/2017-00283.pdf?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email

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What Does This New Law Mean?

- It will mean more work for the four PAC providers
- Failure to comply would result in payment reductions
- These changes could eventually result in a different billing structure which could include site neutral payments or bundling
- Providers will need to create a process to capture these quality measures
- This would include redoing forms to capture the assessment criteria

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What Does This New Law Mean?

- This would include documentation of the patient's preferences and goals
- Medication reconciliation must be implemented and many facilities found this to be more time consuming then originally realized
- The secretary will make confidential feedback reports to providers so stayed tuned
- The law requires reports to Congress from MedPAC and DHHS after reviews of the PAC assessment data for consideration in future payment reforms

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Improving **M**edicare **P**ost-**A**cute **C**are **T**ransformation Act of 2014 **IMPACT** Act

Resources from CMS www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html

Centers for Medicare & Medicaid Services

Special Open Door Forum on the Improving Medicare Post-Acute Care Transformation Act of 2014 IMPACT Act

October 27, 2015

CMS Resources Impact Act

IMPACT Act Spotlights and Announcements

Checkout our new video featuring Dr. Patrick Conway, the Principal Deputy Administrator and Chief Medical Officer for CMS, who introduces the IMPACT Act of 2014 and shares the background, objectives, and expectations of this historic legislation. This video also addresses the critical importance of collaborative efforts among CMS and stakeholders for the improvement of healthcare in America and how it will positively impact the outcomes of care for beneficiaries, residents, and their families. To view the video click here:

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/Spotlights-and-Announcements-.html

Upcoming Events and Updates

September 30, 2016

August 11, Chicago, IL, IMPACT Act Presentation Materials Now Available

On August 11, 2016, CMS delivered a presentation in Chicago, IL about the IMPACT Act and Assessment Data Element Standardization and Interoperability. A link to the video recording of this presentation can be accessed on YouTube. Further information can be found on the IRF QRP Training webpage or LTCH QRP Training webpage.

September 22, 2016

IMPACT Act Cross-Setting Quality Measure: Falls with Major Injury - Comments due October 14

Public comments are due October 14 on a cross-setting post-acute care measure under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) to meet the domain of incidence of major falls, for application in home health. CMS seeks comments on:

Project Objectives:

- Introduce falls with major injury data elements for capturing data for a falls with major injury measure in the incidence of major falls domain for home health patients
- Refine measure specifications
- Identify setting-specific needs/concerns/barriers for capturing falls with major injury information using the data elements
- Gather feedback on importance, feasibility, usability and potential impact of adding falls with major injury data elements for quality measurement as new items to the OASIS item set
- Identify additional guidance required for the implementation in home health

Visit the Public Comment webpage for more information.

AHA 14 Page Comment Letter

American Hospital Association

800 10th Street, N\
Two CityCenter, S\
Washington, DC 2\
(202) 638-1100 Pho\
www.aha.org

January 4, 2016

http://src.bna.com/bS9

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

Re: CMS 3317-P, Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (80, No. 212, Nov. 3, 2015).

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services'

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Discharge Planning History and Worksheet

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Discharge Planning History

- The current discharge planning requirements in the regulations (482.43) were first published on December 13, 1994
- The regulations were last updated on August 11, 2004 (69 FR 49268)
- First, CMS published proposed and then final regulations in the Federal Register
- Next, CMS adds interpretive guidelines
- These are helpful so surveyors and hospitals understand what the regulation means

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Discharge Planning History

- CMS issues 39 page memo of interpretive guidelines on May 17, 2013 and final transmittal July 19, 2013
- Completely revised the discharge planning interpretive guidelines to reflect transition literature to reduce readmissions
- Includes advisory practices to promote better patient outcomes and called **blue boxes**
- Reorganized all the standards and a number of tags were eliminated
  - The prior 24 standards have been consolidated into 13
- Now amending them again

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Discharge Planning Rewritten

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-32- HOSPITAL

DATE: May 17, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

- ***Discharge Planning Guidance Revised:*** SOM Hospital Appendix A has been revised to update the guidance for the discharge planning Condition of Participation (CoP).
- ***Advisory Boxes:*** Included in the updated interpretive guidelines are "blue boxes," to display advisory practices to promote better patient outcomes. The information found in these advisory boxes is **not** required for hospital compliance but only resurce information or references for process improvement.
- ***Automated Survey Processing Environment (ASPEN) Tags:*** ASPEN Tags for discharge planning CoPs have been reorganized. A number of tags were eliminated. These changes were made in 2012.

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Discharge Planning Transmittal July 19, 2013

CMS Manual System
Pub. 100-07 State Operations
Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 87 **Date: July 19, 2013**

SUBJECT: Revised Appendix A, Interpretive Guidelines for Hospitals, Condition of Participation: Discharge Planning.

I. SUMMARY OF CHANGES: Clarification is provided for the provisions of 42 CFR 482.43, concerning discharge planning. Several "Tags" within this CoP guidance have a been consolidated, but there are no changes to the regulatory text.

NOTES:

Tag A-0808 is deleted. Content combined with Tag A-0806
Tag A-0809 is deleted. Content combined with Tag A-0806
Tag A-0817 is deleted. Content combined with Tag A-0818
Tag A-0822 is deleted. Content combined with Tag A-0820
Tag A-0824 is deleted. Content combined with Tag A-0823
Tag A-0825 is deleted. Content combined with Tag A-0823
Tag A-0826 is deleted. Content combined with Tag A-0823
Tag A-0827 is deleted. Content combined with Tag A-0823
Tag A-0828 is deleted. Content combined with Tag A-0823
Tag A-0829 is deleted. Content combined with Tag A-0823
Tag A-0830 is deleted. Content combined with Tag A-0823
Tag A-0831 is deleted. Content combined with Tag A-0823
Exhibit XX is deleted, renamed Exhibit 353 and moved with other SOM Exhibits

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CMS Hospital Worksheets History

- First, October 14, 2011 CMS issues a 137 page memo in the survey and certification section
- After 3 pilots, the final worksheets were published November 26, 2014
- Addresses **discharge planning,** infection control, and QAPI
- Discharge planning worksheet will be revised again to reflect the changes in the discharge planning standards
- CMS mentions will not use this one during the time before the final interpretive guidelines are issued

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Final 3 Worksheets QAPI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

REF: S&C: 15-12-Hospital

DATE: November 26, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

SUBJECT: Public Release of Three Hospital Surveyor Worksheets

Memorandum Summary

- ***Three Hospital Surveyor Worksheets Finalized***: The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.
- ***Final Worksheets Made Public:*** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.

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Discharge Planning P&P

Section 2 Discharge Planning – Policies and Procedures

Elements to be assessed		Surveyor Notes
2.1 Implementation of discharge planning policies and procedures for inpatients:		
2.1a For every inpatient unit surveyed is there evidence of applicable discharge planning activities?	☐ Yes ☐ No	
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	☐ Yes ☐ No	
NOTE: If no for either 2.1a or 2.1b the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to identification of patients needing discharge planning, 42 CFR 482.43(a) (Tag A-0800); discharge planning evaluation, 42 CFR 482.43(b) (Tag A-0806); and/or developing and implementing the discharge plan, 42 CFR 482.43(c) (Tag A-0818)		
2.2 Does the discharge planning process apply to certain categories of outpatients?	☐ Yes ☐ No	
If yes, check all that apply: ☐ Same day surgery patients ☐ Observation patients who are not subsequently admitted ☐ ED patients who are not subsequently admitted ☐ Other		
2.3 Is a discharge plan prepared for each inpatient?	☐ Yes, skip to question 2.8 ☐ No, go to question 2.4	

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Proposed Changes in CMS Discharge Planning in 2017

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Discharge Planning Proposed Changes

- October 30, 2015 CMS proposes to revise the hospital discharge planning standards again
  - Published in FR November 3, 2015 http://federalregister.gov/a/2015-27840
- Includes hospitals, CAH, LTC hospitals, inpatient rehab, and home health agencies
- To bring them into closer alignment with current practices and to reduce unnecessary readmissions
- To implement the requirements of the IMPACT Act- Improving Medicare Post-Acute Care Transformation

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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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-P]

RIN 0938-AS59

https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-27840.pdf

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

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CMS Proposed Discharge Planning

FEDERAL REGISTER

Vol. 80 Tuesday,
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www.gpo.gov/fdsys/pkg/FR-2015-11-03/pdf/2015-27840.pdf

Part IV

Department of Health and Human Services

Centers for Medicare and Medicaid Services
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; Proposed Rule

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CMS Issues a Press Release

e Database > Press releases > 2015 Press releases items > Discharge Planning Proposed Rule Focuses on Patient Preferences

Discharge Planning Proposed Rule Focuses on Patient Preferences

Date 2015-10-29

Title Discharge Planning Proposed Rule Focuses on Patient Preferences

Contact go.cms.gov/media

Discharge Planning Proposed Rule Focuses on Patient Preferences

Today, the Centers for Medicare & Medicaid Services (CMS) proposed to 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 changes would modernize the discharge planning requirements by: bringing them into closer alignment with current practice; helping to improve patient quality of care and outcomes; and reducing avoidable complications, adverse events, and readmissions.

The proposed rule would also implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which will improve consumer transparency and beneficiary experience during the discharge planning process. The IMPACT Act requires hospitals, critical access hospitals, and certain post-acute care providers to use data on both quality and resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

"CMS is proposing a simple but key change that will make it easier for people to take charge of their own health care. If this policy is adopted, individuals will be asked what's most important to them as they choose the next step in their care – whether it is a nursing home or home care," said CMS Acting Administrator Andy Slavitt. "Policies like this put real meaning behind the words consumer-centered health care."

www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-10-29.html

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Improved Discharge Planning

- CMS states this will help to improve quality of care and outcomes
- It would reduce complications, adverse events, and help to prevent readmissions
- Hospitals will be required to use data to assist patients during discharge planning process
  - Must take into consideration patient's goals and patient preferences
- To improve transparency for Medicare patients during discharge planning process

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Proposed Revised Discharge Planning

- Requires the secretary of HHS to assist patients with discharge planning from inpatient to post-acute care
- Secretary to revise hospital CoPs to incorporate measures into the discharge planning process
- To address patient preferences and goals of care
- The discharge planning regulations were developed to implement the IMPACT ACT
  - The 4 PACs are required to develop a discharge plan based on goals, patient preferences and needs

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Hospital CoPs on Discharge Planning

The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Manual updated more frequently now
  - Many changes since 1986
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **survey procedures** [2]
  - Hospitals should check this website once a month for changes

[1]www.gpoaccess.gov/fr/index.html [2]www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

Location of CMS Hospital CoP Manuals

Medicare State Operations Manual

Appendix

Email questions to CMS at hospitalscg@cms.hhs.gov

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

CMS Hospital CoP Manuals new address
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

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CoP Manual Also Called SOM

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 151, 11-20-15)

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

Transmittals for Appendix A

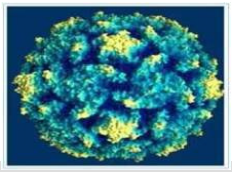
Survey Protocol

Introduction

Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 – Post-Survey Activities

Email questions
hospitalscg@cms.hhs.gov

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module



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Subscribe to the Federal Register

CMS Survey and Certification Website

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Survey Memos

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
Implementation Issues, Long-Term Care Regulatory Changes: Substandard Quality of Care (SQC) and Clarification of Notice before Transfer or Discharge Requirements	17-27-NH	2017-05-12	2017
Psychiatric Residential Treatment Facilities (PRTF) Frequently Asked Questions (FAQs)	17-28-PRTF	2017-05-12	2017
Notice of Proposed Regulation Changes to Requirements Related to Survey Team Composition and Investigation of Complaints	17-26-NH	2017-04-28	2017
Electronic Staffing Submission - Payroll-Based Journal Update	17-25-NH	2017-04-21	2017
Notice of Proposed Regulation Changes for Accrediting Organizations (AOs) Transparency and Termination Notices	17-24-ALL	2017-04-14	2017

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Resource from CMS 26 Pages

www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191522dl.pdf

Improving Hospital Discharge Planning for Elderly Patients

Sandra Potthoff, Ph.D., Robert L. Kane, M.D., and Sheila J. Franco

Hospital discharge planning has become increasingly important in an era of prospective payment and managed care. Given the changes in tasks, decisions, and environments involved, it is important to identify how to move such planning from an art to an empirically based decisionmaking process. The authors use a decision-sciences framework to review the state-of-the-art of hospital discharge planning and to suggest methods for improvement.

INTRODUCTION

For the older patient, the discharge from a hospital is a critical juncture, when decisions are made that may influence the rest of that person's life. Discharge planning is

patients into post-acute care (PAC); this care was paid for by Medicare but was not under PPS (Morrisey, Sloan, and Valvona, 1988; Neu, Harrison, and Heilbrunn, 1989; Neu and Harrison, 1988). Although the type of patients treated and the mix of PAC varied across home health care agencies, skilled nursing homes, and rehabilitation facilities, all three of these care modalities experienced substantial growth following the enactment of PPS (DesHarnais, Cheney, and Fleming, 1988; Guterman and Dobson, 1986; Gornick and Hall, 1988; Prospective Payment Assessment Commission, 1993). The acuity levels of nursing home care and home health care also increased (Shaughnessy and Kramer, 1990). Changes mandated by the Balanced

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Hospitals Discharge Planning

- Hospital must develop and implement a discharge planning process
- Must focus on patient goals and preferences
  - Can't just do the plan of care and present it
  - Needs patient's input and what they want
- Must prepare patients and their support person or caregivers to be active partners in their care after discharge
  - Be sure to ask patient if they have a patient advocate or support person or who will help care for them after leaving the hospital and record this in the medical record

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Hospitals Discharge Planning

- Must plan for the patient post-discharge care
  - Is the patient going to be able to return to home?
  - If the patient is going to be discharge to home will there need to be any modifications to the home, or equipment such as a walker or bedside commode, housekeeping services, transport to first appointment, rehab, physical therapy etc.
  - Is the patient going to need to go to a rehab center for a few weeks before going home?
  - * Remember hospital CoPs apply to LTCH & IRFs

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Hospitals Discharge Planning P&P

- Discharge planning P&P must meet the following:
- Must be in writing
- Be developed with input from hospital's MS (MEC) and nursing leadership
- Be developed with other relevant departments
  - This would include discharge planning and social workers
- Be reviewed by the board and reviewed periodically
  - Would want to have it in board minutes and have president of the board signature on the policy

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Re-evaluation of the Patient

- The discharge process must regularly reevaluate the patient's condition to identify any changes that would require modification of the discharge plan
- Hospitals may want to have process where discharge planners/social workers do a discharge planning evaluation on all inpatients
- Then they can do daily chart review to determine if any changes
- This would help hospitals to easily comply with the standards

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6 Hospitals Discharge Planning Apply to

- Who does the hospital discharge planning process apply to?
  - All inpatients
  - Outpatient observation patients
  - Same day surgery patients
  - Same day procedures for which anesthesia or moderate sedation is used
  - Specific emergency department patients
    - Those ED patient who are identified as needing one
  - Any other category of outpatients as recommended by MS and contained in the discharge P&P

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Hospital Discharge Planning Process

- The following are requirements of the DP process:
  - Must make sure discharge goals, preferences and needs of each patient are identified and result in the discharge plan
  - RN, SW, or other qualified person must coordinated the discharge needs evaluation and development of the discharge plan
  - Who is qualified to do this must be in the P&P
  - The hospital must begin to identify the anticipated discharge needs within **24 hours** after admission

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Hospital Discharge Planning Process

- The following are requirements of the DP process: (continued)
- The discharge planning process must be completed prior to discharge home
- It must also be completed before transfer to another facility unless emergency transfer
- If the patient's stay is less than 24 hours still need to make sure the discharge planning is done before discharge to home or transfer
  - It cannot unnecessarily delay the discharge or transfer

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Hospital Re-evaluation

- The discharge planning process MUST require regular re-evaluation of the patient's condition to identify changes that require modifications to the discharge plan
  - One way to do this would be to have discharge planner or SW do a discharge plan for 6 categories which include inpatients
  - Then they could check the chart daily to see if any changes in the conditions like a pulmonary emboli or DVT

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Hospital Discharge Planning Process

- The physician or practitioner responsible for the patient must be involved in the process of establishing the patient's goal of treatment
- This includes treatment preferences
- Must consider the support person or caregiver's capacity to perform the required care
- Must consider the patient's ability to do self care
- Must consider what care is available in the community including what care is available

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8 Things in Evaluating Patient Needs

- There are 8 things to consider in evaluating the patient's discharge needs:
  - So add to discharge planning evaluation form
- Admitting diagnosis
- Relevant co-morbidities and past medical and surgical history (DM, CHF, COPD, ESRD etc.)
- Post-discharge needs
- Readmission risk
- Relevant psychosocial history

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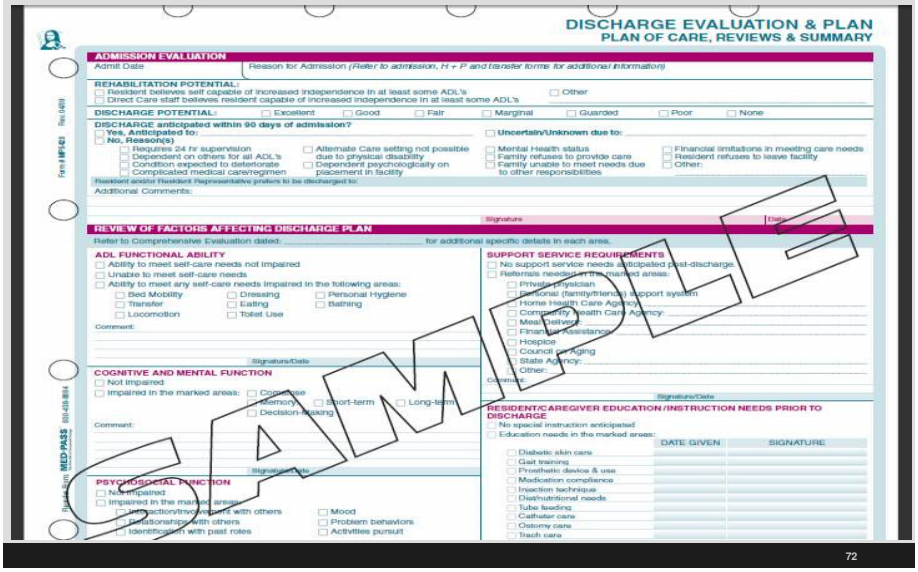
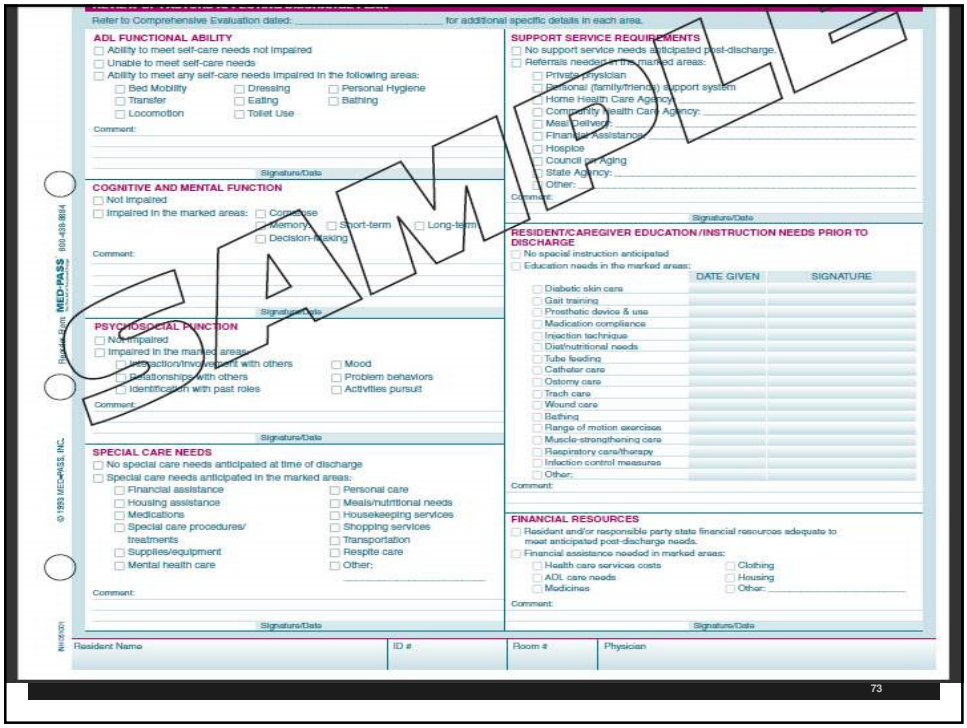
project BOOST
Better Outcomes by Optimizing Safe Transitions

The 8Ps:
Assessing Your Patient's Risk For Adverse Events After Discharge

Risk Assessment: 8P Screening Tool (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) ☐	☐ Assessment of need for psychiatric aftercare if not in place ☐ Communication with aftercare providers, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polypharmacy (≥5 more routine meds) ☐	☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all general and risk specific interventions ☐ Aftercare plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (absence of caregiver to assist with discharge and home care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers	
Prior hospitalization (non-elective, in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address bothersome symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

Discharge Evaluation & Plan





8 Things in Evaluating Patient Needs

- Patient goals and preferences
- Patient access to non-healthcare services and community based providers
- Communication needs
  - Language barriers
  - Diminished eyesight and hearing
  - Self reported literacy of patient or caregiver

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RARE Reducing Avoidable Readmissions

- There is a free resource known as RARE
- Stands for reducing avoidable readmissions effectively
- Has a gap analysis to enhance discharge planning
- Recognizes five key areas to reduce readmissions: comprehensive discharge planning, medication management, patient and family engagement, transition care support and communication
- Discusses best practices and strategies for improvement

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RARE Reducing Avoidable Readmissions

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RARE Reducing Avoidable Readmissions Effectively

Comprehensive Discharge Planning
Gap Analysis of Best Practices/Strategies for Improvement

Component	Best practice/Strategy	Present	Gap/Opportunity
Discharge Planning - Process	Conduct pre-discharge assessment of ability of patient/family to provide self-care (includes problem solving, decision making, early symptom recognition, and taking action, quality of life, depression and other cognitive and functional ability factors) Develop a comprehensive shared care plan using a shared decision making approach – consider patient values and preferences, social and medical needs Discharge summary and medication plan are complete and up to date Work with patient/family to prepare for the post discharge visit planning (goals, questions, concerns)		

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Content of a Discharge Plan

	advance directives as appropriate		
Discharge Planning – Content	Written discharge plan includes the following: • Reason for hospitalization • Medications to be taken post discharge, including, as appropriate, resumption of pre-admission medications. • Self-care activities such as diet, activity level or limitations, weight monitoring • DME/supplies that patient will need for care • Symptom recognition and management – what to do if patient has a question, a problem arises or condition changes, including of symptoms of which to notify health care provider • Coordination and planning for follow-up appointments • Coordination for follow up of test and studies for which confirmed results are not available at the time of discharge.		

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Hospital Discharge Planning Process

- The patient and caregiver/support person BOTH must be involved in the development of the discharge plan (new)
- They must be informed of the final plan
- The discharge plan MUST address the patient's goals and treatment preferences
  - Such as patient is having major foot surgery and wants to recover at home while physician prefers a rehab center (SNF)

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Hospital Discharge Planning Process

- Hospital must assist patient and their family in selecting a PAC provider
- This includes using and sharing data
- This includes, but is limited to, HHA, SNF, IRF, or LTCH data on quality measures and resource use measures
  - Data must be relevant to the patients goals and treatment preference
- The discharge plan must be included in the patient's medical records

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Evaluation and Discharge Plan

- The evaluation of the patient's need and the resulting discharge plan must be documented
- It must be completed timely
- It must be based on the patient's goals and preferences
- It must based on the patient's strengths and needs and contain all relevant information
- Must be done so arrangements for post-hospital care can be made to avoid delay

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Hospital Discharge Planning Process

- Hospital must assess its discharge planning process on a regular basis
- The assessment must be ongoing
- There must be a periodic review of a sample of discharge plans
- This must include those who were readmitted within 30 days
- Want to make sure the plans were responsive to the patients needs post-discharge

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AHRQ Resources On Hospital Discharge

Re-engineering the Hospital Discharge: An Example of a Multifaceted Process Evaluation

David Anthony, VK Chetty, Anand Kartha, Kathleen McKenna, Maria Rizzo DePaoli, Brian Jack

www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety/vol2/Anthony.pdf

Abstract

Introduction: The transfer of patient care from the hospital team to primary care and other providers in the community at the time of discharge is a high-risk process characterized by fragmented, nonstandardized, and haphazard care that leads to errors and adverse events. The development of interventions to improve the discharge process requires a detailed evaluation of the process by a multidisciplinary team. **Methods:** Using the resources of the Boston University–Morehouse College of Medicine AHRQ Developmental Center for Patient Safety Research (funded by the Agency for Healthcare Research and Quality), multidisciplinary teams have been assembled to identify and address the sources of error at discharge. To better understand the current hospital discharge process, the researchers have applied a battery of epidemiologic and quality control methods taken from industry. These include probabilistic risk assessment, process mapping, qualitative analyses, failure mode and effects analysis, and root cause analysis. The researchers describe each of these methods and discuss their experience with them, displaying concrete tools that have arisen from their application. **Conclusions:** A detailed, multifaceted process analysis has provided us with powerful insight into the many patient safety issues surrounding the discharge process. The generalizable methods described here have produced the re-engineering of the discharge process, allowing for the planning of a clinical trial and significant improvements in patient care.

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AHRQ Hospital Guide to Reducing Readmissions

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AHA Guide to Reducing Readmissions

www.hpoe.org/Reports-HPOE/readmissions1.2010.pdf

Health Care Leader Action Guide to Reduce Avoidable Readmissions

January 2010

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So What's in Your Discharge Planning P&P?

Section 9 Subject 9.1	Clinical Policies Admissions, Transfers, and Discharges	11/01/92 06/10/05 04/11/03	-Originated -Reviewed w/ changes -Reviewed w/o changes
Policy 9.1.14	**Patient Discharge Planning**	Nursing Service	-Author

Patient Discharge Planning

Audience	The information in this document is intended for all healthcare workers involved in discharge planning for patients and their families.
Policy	The patient's needs pertaining to post-discharge care will be assessed upon admission. A multidisciplinary team that includes the physician, registered nurse, and care manager, together with the other members of the healthcare team, will perform the assessment. A plan to meet these needs will be developed, and interventions to meet specific discharge planning goals will be designed. The plan will be monitored and revised as necessary throughout the hospital stay.
Needs Assessment Factors	Actual and potential discharge planning needs of the patient/family will be assessed on the basis of the following criteria: □ the level at which the patient and family or other caregiver understands the patient's medical condition and the reason for hospitalization □ the patient/caregiver's stated expectations

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Hospital Discharge Instructions

- Discharge instructions must be provided at time of discharge for **ALL** patients now
  - To the patient and support person and use teach back
  - To the PAC or supplier
- Discharge instructions must include 5 things:
  - Instructions to be used as home as identified in the discharge plan
  - Written information on the warning signs and symptoms when patient must seek immediate care
    - Such as post-MI patient is told if chest pain reoccurs to call 911 or immediately call the physician

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Teach Back Toolkit

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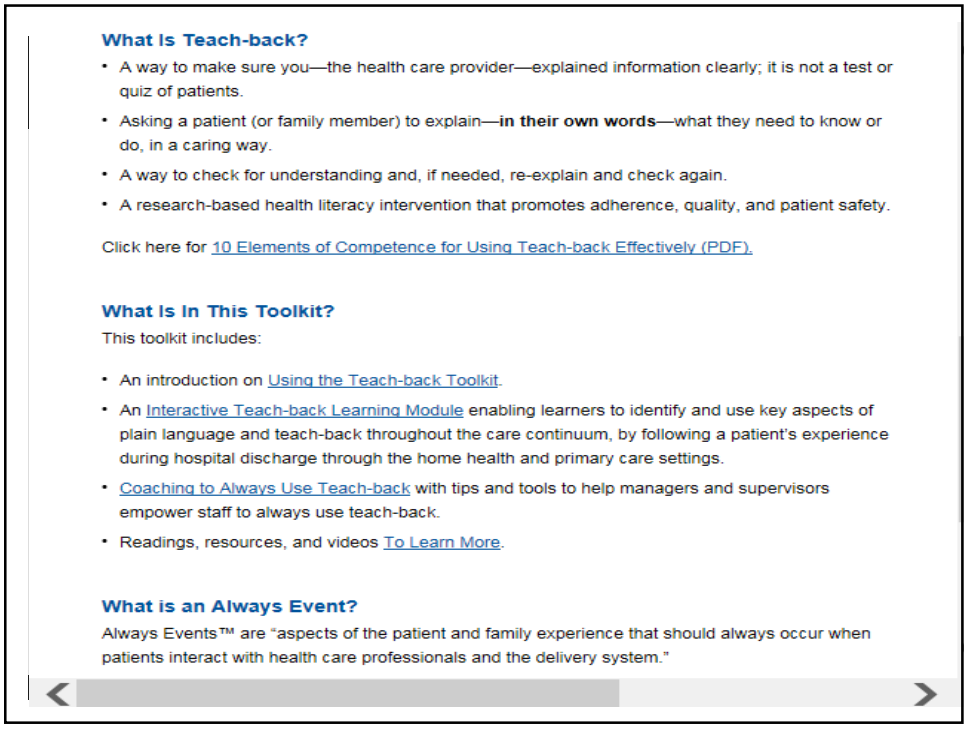

What Is Teach-back?

- A way to make sure you—the health care provider—explained information clearly; it is not a test or quiz of patients.
- Asking a patient (or family member) to explain—**in their own words**—what they need to know or do, in a caring way.
- A way to check for understanding and, if needed, re-explain and check again.
- A research-based health literacy intervention that promotes adherence, quality, and patient safety.

Click here for 10 Elements of Competence for Using Teach-back Effectively (PDF).

What Is In This Toolkit?

This toolkit includes:

- An introduction on Using the Teach-back Toolkit.
- An Interactive Teach-back Learning Module enabling learners to identify and use key aspects of plain language and teach-back throughout the care continuum, by following a patient's experience during hospital discharge through the home health and primary care settings.
- Coaching to Always Use Teach-back with tips and tools to help managers and supervisors empower staff to always use teach-back.
- Readings, resources, and videos To Learn More.

What is an Always Event?

Always Events™ are "aspects of the patient and family experience that should always occur when patients interact with health care professionals and the delivery system."

Hospital 5 Discharge Instructions

- Discharge instructions must include: (continued)
  - Prescription and OTC medications
    - Include name, indication, dose, along with any significant risk and **side effects** of each drug
  - Reconciliation of all discharge medication
    - Reconcile with pre-hospital medications including prescribed and OTC
  - Written instructions on follow-up care, appointments, pending tests, contact information, including phone number of follow up providers

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Sample Form Follow Up Appointments

What is my main medical problem?

Chest Pain

When are my appointments?

Wednesday, August 8 at 11:30 a.m.	Thursday, August 16 at 3:20 p.m.	Wednesday September 12 at 9:00 a.m.
Dr. Mark Avery	Dr. Anita Jones	Dr. Lin Wu
Primary Care Provider (Doctor)	Rheumatologist	Cardiologist
100 Main St, 2nd Floor	100 Pleasant Rd, Suite 105	100 Park Rd, Suite 504
Anytown, ST	Anytown, ST	Anytown, ST
For a Followup appointment	For your arthritis	To check your heart
Office Phone #:	Office Phone #:	Office Phone #:
(555) 555-5555	(555) 555-6666	(555) 555-4444

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Outstanding Labs or Tests

Outstanding Labs or Tests

Are any lab tests/studies pending? ☐ yes ☐ no ☐ unknown

PENDING LAB TEST/STUDIES

Lab test/ study name	Date done	Name of clinician to review/location	Day/Date subject will see clinician to discuss results?
1.		Same as PCP	Same as PCP
2.			
3.			

Some tests have been done while you have been in the hospital, but the results are not yet ready. A (test/study name) was done on (date of test/study). (Name of PCP) will review the results and discuss them with you during your appointment.

Depending on the results of your lab test(s)/studies, your doctor might adjust your treatment. We just talked about your scheduled appointment with (name of PCP). It is very important that you see your doctor on (date/time to see PCP) to find out if anything needs to be done or changed as a result of these tests. Again, if there is anything you don't understand or you are having trouble making an appointment, please call me. If I am not there, leave a message and we will call you back.

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Hospital Must Send PCP Following

- The hospital must send the following information to the physician or practitioner responsible for follow up
  - A copy of the discharge instructions and discharge summary within **48 hours**
    - Hospital may want to consider having physician or practitioner immediately dictate these at time of discharge
    - Then Health Information Management needs to get them into the hands of the physician or practitioner

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Hospital Must Send PCP Following

- Pending test results within 24 hours of availability
- Secretary may specify additional information
- The hospital MUST establish a post-discharge follow-up process
  - Studies show the timing of the first post-hospital visit is tied to the readmission rate
  - Many hospitals call the patient after discharge
  - Some hospitals allow the patient to call with any questions
  - Some patients may get a follow up home visit

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Patient Transfers and 21 Things

- Transfer of patient to another health care facility:
- Must send necessary medical record information
- Will want to make sure your **transfer form** or continuity form includes all the required elements so may need to revise
- Medical record information on the transfer form must contain:
  - Sex, DOB, race, ethnicity, preferred language, contact information of responsible practitioner, advance directives, course of illness, procedures, diagnoses, lab tests and results of pertinent lab and other diagnostic testing,

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Patient Transfers 21 Things

- Medical record information on the transfer form must contain: (continued)
  - All known allergies, including medication allergies, immunizations, smoking status, vital signs; unique device identifier for a patient's implantable device,
  - All special instructions or precautions for ongoing care, patient's goals and treatment preferences
  - All other necessary information including a copy of the discharge instructions and discharge summary
  - Reconciliation of discharge medications, social support, functional status assessment, psychosocial assessment including cognitive function, consults, behavioral health issues

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Transfer Form Preamble

- Does not require a specific transfer form
- But needs to include required elements
- Many requirements in current CoPs on what needs to be in the form along with revisions
- CMS aligned these data elements in common clinical data set published October 16, 2015
- This is why they are requiring things such as race, ethnicity, preferred language, advance directives, etc.
  - These are also required by TJC

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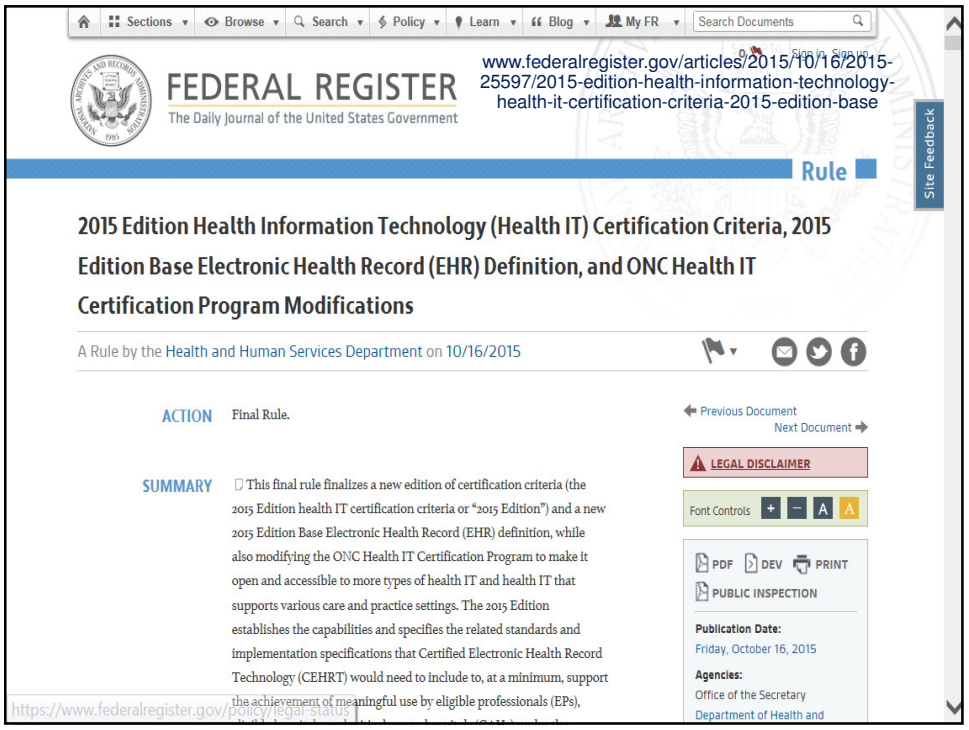

Medication Reconciliation Preamble

- CMS suggests use generic and proprietary (brand) names for each medication
- May need to include patient and caregiver/support person in reconciling medications
- Create a list for patient when discharged
- Consider how patients would obtain their post-discharge medications such as identify a pharmacy
  - Patients may not realized they need to get a prescription filled to continue medication started in hospital
  - Inform in advance of discharge and consider if patient has prescription drug coverage and check state's PDMP

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Sample Medication Form

MEDICINES

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many (or how much) do I take?	How do I take this medicine?
 Morning	Blood pressure	PROCARDIA XL NIFEDIPINE 90 mg	1 pill	By mouth
	Blood pressure	HYDROCHLOROTHIAZIDE 25 mg	1 pill	By mouth
	Blood pressure	CLONIDINE HCl 0.1 mg	3 pills	By mouth
	Cholesterol	LIPITOR ATORVASTATIN CALCIUM 20 mg	1 pill	By mouth
	Stomach	PROTONIX PANTOPRAZOLE SODIUM 40 mg	1 pill	By mouth
	Heart	ASPIRIN EC 325 mg	1 pill	By mouth
	To stop smoking	NICOTINE 14 mg/24 hour	1 patch	On skin
	Then, after 4 weeks use →	NICOTINE 7 mg/24 hour	1 patch	On skin

3

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Medication List From RED

What medicines do I need to take?

Each day, follow this schedule:

Morning Medicines			
Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

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AHRQ Medications at Transitions

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MARQUIS Medication Reconciliation

103

Requirements for PAC Services

- Patients discharged home or for HHA, IRF, LTCH or SNF
  - In addition to the above
  - Must include in the discharge plan a list of these four that are available to the patient
  - Includes ones that serve that geographical area
  - Home health agencies must request to be listed by the hospital as available
  - The list includes one indicated and appropriate as determined by the discharge plan

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Requirements for PAC Services

- If patient is in managed care then make patient aware of need to verify which ones are in the network
- Hospital must document that the list was presented to the patient
- Hospital must inform the patient of their freedom of choice among Medicare providers when possible
- Hospital can not specify or limit qualified providers
- Discharge plan must disclose financial interests

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What Does this Mean?

- The reporting requirements mean more work
- Failure to report can cause payment reduction
- Sets the stage for payment changes
- Will impact fee for service beneficiaries, Medicare Managed care patients and private insurance payors who typically follow Medicare standards
- Put system in place to capture this information
- Changes assessment tools to capture this information

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What Does this Mean?

- Hospitals will need to rewrite P&P to comply
- Hospitals will need to rewrite the transfer form to ensure all 21 items are included
- Hospital will need to revise process to collect the five required data measurements
- Hospitals will need to revise forms to collect the five assessment requirements
- Hospitals will need to train staff and providers
- Will need to get discharge instructions and discharge summary to PCP within 48 hours

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What Does this Mean?

- Hospitals will need to revise discharge planning evaluation form
- Hospital will need to ensure that the medication reconciliation process is followed
- Hospitals will need to make sure that the side effects of medication prescribed and over the counter meds include side effects
- Will need to make sure discharge instructions are in writing and include the required five elements
- May need to hire more social workers especially for evenings or weekends so evaluate and fund

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Resources

- There are many good resources available
- CMS also mentions a number of resources in the Federal Register
- CMS mentions several resources on discharge planning and preventing readmission on their website
- RED or The Re-Engineered Discharge Toolkit
- Hospital Guide to Reducing Medicaid Readmissions
- Health Literacy Universal Precautions Toolkit etc.
  - www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

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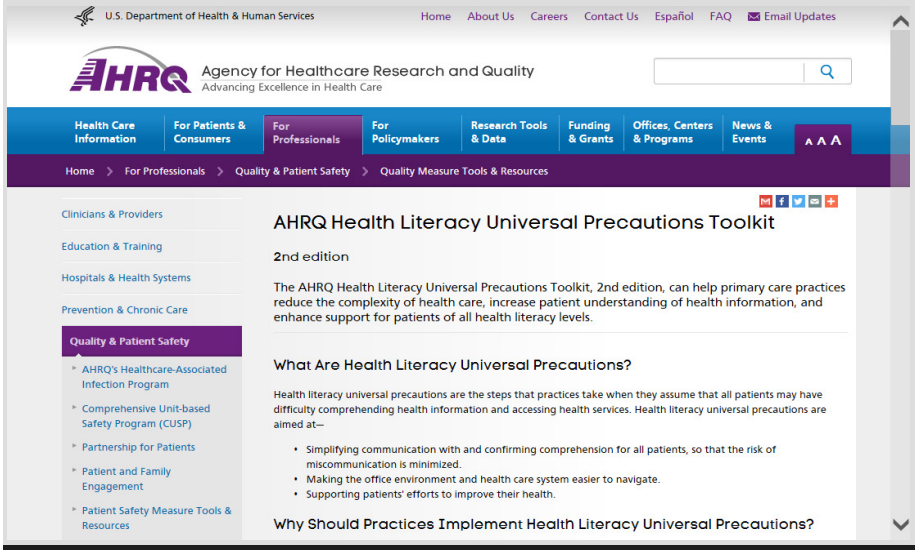
AHRQ Literacy Toolkit



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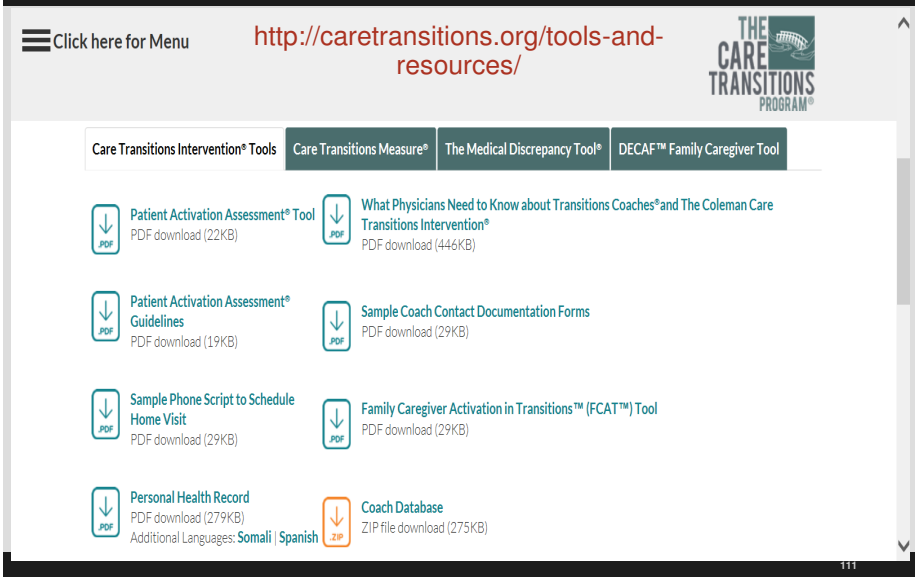
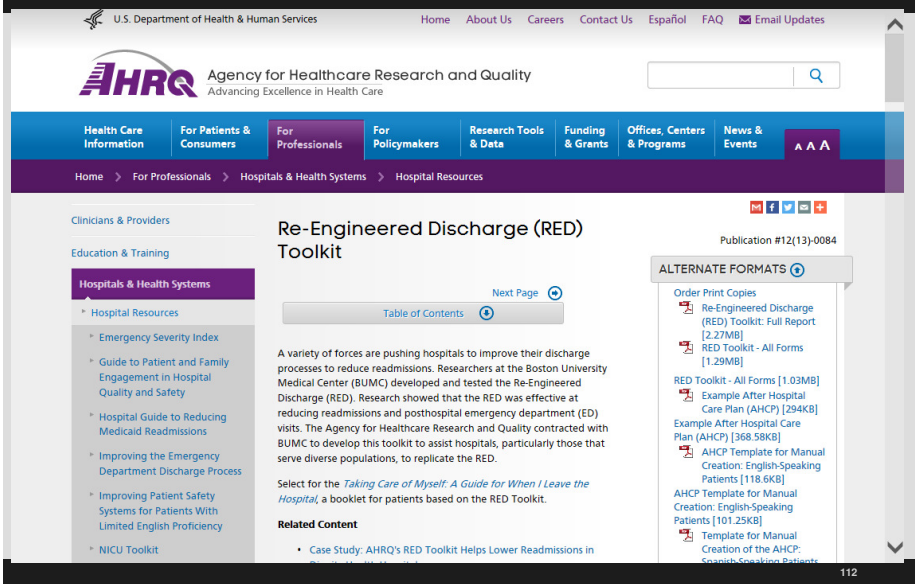
Care Transition Tools



AHRQ RED Toolkit and Forms



Written Discharge Instructions

Noncardiac Chest Pain

Noncardiac chest pain is pain that is not caused by a heart problem.

www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

- If your chest pain gets different or worse, call your doctor.
- Take your medicines as prescribed.
- See your doctor and ask questions.

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Project RED

http://www.bu.edu/fammed/projectred/index.html

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Role of Caregivers in RED

Tool 7: Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge[1]

Carol Levine and Jennifer Rutberg, United Hospital Fund
Brian Jack MD and Ramon Cancino MD, Boston University School of Medicine

Purpose of This Tool

http://www.bu.edu/fammed/projectred/Project%20RED%20Revised%20Toolkit%209-2012/REDTool7FamilyCaregiversUnitedHospital%20Fund.pdf

Patients who benefit from the Re-Engineered Discharge (RED) frequently rely on family members or friends to help them manage their health at home. While families are mentioned in other tools, this tool is different; it targets family caregivers as a critical element in the success of the discharge plan. This tool systematically reviews the challenges they face and the support and training they need from staff in the hospital and beyond.

It is often assumed that the person at the bedside is the family caregiver. But that may not be the case. Identifying the family caregiver—or caregivers, if there is more than one—is an important first step.

We use the term "family caregivers" to refer to individuals who are related by:

- Birth, marriage, or commitment

AND

- Who take on responsibilities for providing various kinds of assistance to the patient. In addition to the emotional support that is the mainstay of family life, family caregivers manage medications, coordinate care, take care of financial matters, and provide personal care, skilled

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34 Safe Practices for Better Healthcare

http://www.qualityforum.org/Publications/2009/03/Safe_Practices_for_Better_Healthcare%e2%80%932009_Update.aspx

SAFE PRACTICE 15: DISCHARGE SYSTEMS

The Objective

Ensure that effective transfer of clinical information to the patient and ambulatory clinical providers occurs at the time of discharge from healthcare organizations.

The Problem

The transfer of patient care from a hospital to primary care or other community providers has been characterized as an unsystematic, non-standardized, fragmented process that creates high risk for adverse events postdischarge.

The frequency of high rates of low health literacy; lack of coordination in the hand-off from the hospital to community care; gaps in social supports; and other limitations place patients at high risk for adverse events. [Anthony, 2005] Many adverse events lead to subsequent rehospitalizations. There is controversy about whether rehospitalization rates

adverse events. [Levinson, 2008] A study conducted in 2003 directly measured adverse events postdischarge and concluded that 19 percent of patients experience adverse events; of these, 6 percent had preventable adverse events, and 6 percent had ameliorable adverse events. It has been reported that the readmission and mortality of seniors after acute-care hospital admissions may be much higher than previously presumed. [Boutwell, 2008; Denham, 2009]

The preventability of many of these events could have been increased by implementing simple strategies at discharge. [Forster, 2003] Of the postdischarge adverse events, 66 percent were adverse drug events caused by antibiotics (38 percent), corticosteroids (16 percent), cardiovascular drugs (14 percent), analgesics (10 percent), and anticoagulants (8 percent). [Forster, 2003] The discharge process must effectively address the patient's needs for continuing care and treatment and must effectively communicate this information to patients and responsible caregivers in a timely fashion. [Note 15-1; Note 15-2; Note 15-3; Greenwald, 2007] As part of this process, hospitals should

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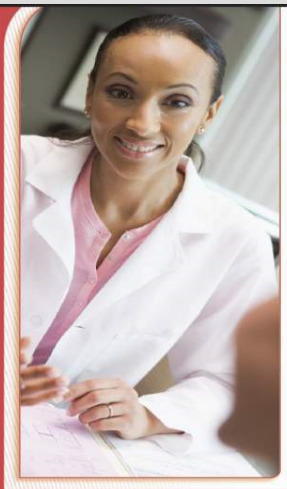
CMS Discharge Planning Medicare Learning



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning Process

Medicare-participating acute care hospitals/post-acute care facilities must identify patients who need or have requested a discharge plan at an early stage of their hospitalization. The discharge planning process must be thorough, clear, comprehensive, and understood by acute care hospital/post-acute care facility staff.

The physician may make the final decision as to whether a discharge plan is necessary. If a physician requests a discharge plan, you must develop such plan, even if the interdisciplinary team determines that it is not necessary (as applicable).

Depending on the patient's needs, discharge planning may be completed by personnel in multiple disciplines who have specific expertise. You may designate discharge planning responsibilities to appropriate qualified personnel such as registered nurses, social workers, or other qualified personnel. These individuals should have:

- Discharge planning experience;
- Knowledge of social and physical factors that affect functional status at discharge; and
- Knowledge of appropriate community services and facilities that can meet the patient's post-discharge clinical and social needs.

Discharge Planning 3

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Discharge-Planning-Booklet-ICN908184.pdf

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CMS DP Checklist for Patients

For Information– Not Required/Not to be Cited

Providing a discharge planning tool to patients and their family or other support persons may help to reinforce the discharge plan. Use of the tools may encourage patients' participation in developing the plan as well as provide them an easy-to-follow guide to prepare them for a successful transition from the hospital. The tool should be given to patients on admission, reviewed throughout their stay, and updated prior to discharge.

Examples of available tools include:

- *Medicare's "Your Discharge Planning Checklist," (available at http://www.medicare.gov/publications/pubs/pdf/11376.pdf)*
- *Agency for Healthcare, Research and Quality's (AHRQ) "Taking Care of Myself: A Guide For When I Leave the Hospital," (available at http://www.ahrq.gov/qual/goinghomeguide.pdf)*
- *Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient Toolkit" (available at http://www.patientsafety.org/page/transtoolkit/).*

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CMS Discharge Checklist

- CMS website recommends the discharge planning team use a checklist to make transfer more efficient
- It is available at www.medicare.gov
- Previously research showed the value of hospital discharge planners using a discharge checklist
- We need to dictate the discharge summary immediately when the patient is discharged
- We need to document that it is in the hands of the family physician and within 48 hours
  - Make sure PCP has it before first appointment

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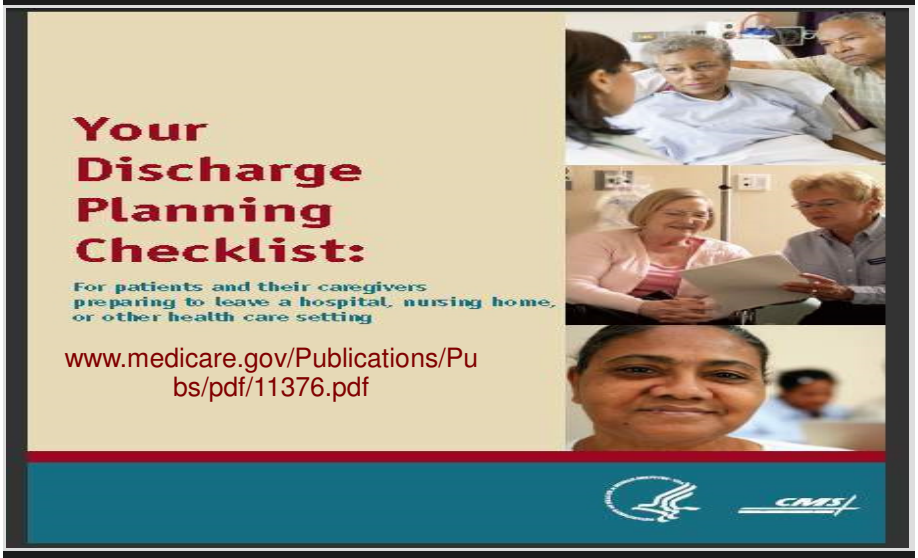
CMS Your Discharge Planning Checklist



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NAME: _____

Reason for admission: _____

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver are important members of the planning team. A caregiver is a family member or friend who may be helping you after discharge. Below is a checklist of important things you and your caregiver should know to prepare for discharge.

Instructions:

- Use the checklist early and often during your stay.
- Talk to your doctor and the staff (for example, a discharge planner, social worker, or nurse) about the items on the checklist.
- Check the box next to each item when you and your caregiver complete it. ☑
- Use the notes column to write down important information like names and phone numbers.
- Skip any items that don't apply to you.

ACTION ITEMS	NOTES
What's Ahead?	
☐ Ask where you will get care after discharge. Do you have options? Be sure you tell the staff what you prefer.	
☐ If a family member or friend will be helping you after discharge, write down the name and phone number.	
Your Condition	
☐ Ask the staff about your health condition and what you can do to help yourself get better.	
☐ Ask about problems to watch for and what to do about them. Write down a name and phone number to call if you have problems.	

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www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/goinghomeguide.pdf

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Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient – Toolkit Introduction

Hospital discharge is a time during which patients and families are at their most vulnerable. There is so much information they need to know, just when they may be least able to absorb, remember and act on it.

It is vital for members of the healthcare team to help patients leave the hospital with confidence, giving them the tools and information they need to make a smooth transition to their next destination. This toolkit, *Taking Charge of your Healthcare: Your Path to Being an Empowered Patient*, provides you with these tools.

Hospital discharge is not an event; it is a process. It is a process that takes time and should be started upon admission, if not sooner. Healthcare providers should give the tools in *Taking Charge of your Healthcare: Your Path to Being an Empowered Patient* to patients and families as soon as possible. Plan time to discuss their contents and answer any questions, recognizing you may need more than one conversation to ensure understanding and readiness for discharge.

At the heart of safe discharge is clear communication and education for patients and families. Patients and families need to know:

- The importance of prompt follow-up care
- What to expect and what to do when they leave the hospital
- How to plan for their immediate and longer-term needs

www.patientsafety.org/page/transtoolkit/

Patients also need to be empowered to talk to their healthcare providers when they feel intimidated, and they need practical strategies for getting the most out of conversations with members of the healthcare team.

Healthcare providers know that patients' and families' feelings of fear, anxiety, insecurity and uncertainty, combined with their compromised medical conditions, make communication and understanding especially difficult precisely when their understanding is so essential. *Taking Charge of your Healthcare: Your Path to Being an Empowered Patient* is designed to help providers help patients during this critical time.

Patients know they don't feel well. They or their family members who accompany them on their care journey may recognize that they could use some help in working with the healthcare team to contribute to the safety and effectiveness of the process. This toolkit will help both groups achieve the safety they desire.

Elements of the toolkit are:

- **Staying Safe When You Leave the Hospital**, a journal-like bi-fold booklet that guides patients and family members to collect their thoughts and ask the right questions. By using this tool, they will have what they need to know and do before leaving the hospital in an easy to use and update format. A cover page allows for the patient to record their thoughts and keep them private. *If you have the capability to print two-sided, a print friendly version is available here.*
- **Talking to Your Doctor or Nurse**, a handy list that gives patients and their advocates advice and tips for making the most of their conversations with their doctor or nurse, wherever such conversations occur.
- **The Emotional Side of Healthcare: Six Tips for Talking to Your Doctor** , a trifold brochure presenting six strategies for coping with conversations that often feel stressful for patients and families. This can also serve as a reminder or educational tool for healthcare team members to raise their sensitivity to the emotional realities patients bring with them as they talk to their doctor or nurse.
- **The Emotional Side of Healthcare: Six Tips for Talking to Your Doctor**, a condensed poster version of the brochure that lists the six tips for easy reference. A version highlighting the healthcare team is also included. Lastly this poster is being made available in bright colors (doctor and team versions) for posting in open patient areas and staff lounges.
- **Communicating with Patients and Families for Smooth, Safe Transitions**, this short document explains how patients and families often feel during this stressful time, and how healthcare providers can open lines of communication. It can be used by hospital training personnel to lay a foundation for understanding if the toolkit is rolled out organization wide.
- **Glossary of Terms**, listing of words our patient advisors suggested would be helpful for consumers to help them understand terms that

Critical Access Hospitals CAHs

CAH Provisions of Care

- Must have discharge planning (DP) P&P
- Must develop and implement an effective DP process
- Must be consistent with patient goals and preferences
- Need to make an effective transition to post-discharge care
- P&P must be developed with input from nursing leadership, professional staff, and other relevant departments
- Be approved by the board

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CMS CoP Manual Also Called SOM Manual

State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 165, 12-16-16)

Transmittals for Appendix W

INDEX

Survey Protocol

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_Appendixtoc.pdf

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CAH Discharge P&P

- P&P must be in writing
- Discharge planning applies to same groups; inpatients, observation, same day surgery, specific ED patients, and other outpatients recommended by MS
- Discharge planning process must make sure discharge goals, preferences, and needs of patients are identified and in discharge plan
- RN, SW, or qualified person must coordinate
  - Policy must include who is qualified

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CAH Discharge P&P

- CAH must identify goals, preferences, and discharge needs within 24 hours after admission
- If discharge is in less than 24 hours must make sure it is done timely and does not delay the patient's discharge or transfer to another facility
- Must regularly re-evaluate patient for changes
- If changes then update the discharge plan
- PCP must be involved in establishing goals of care and treatment

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CAH Discharge Process

- Must assess patient ability to do self care
- Must assess if caregiver can do care
- Must assess if follow up from a community based provider, LTC or residential facility to include same things as discussed previously
  - Admitting diagnosis, co-morbidities, readmission risk, communication needs, psychosocial history, etc.
- Same freedom of choice and to give patient the list
- Must document discharge plan and evaluation of patient's discharge needs

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CAH Psych and Behavioral Health Patients

- CMS mentions that they believe CAH need to improve their focus on psychiatric and behavioral health patients
- This includes patients with substance use disorders
- Believe CAHs often overlook the special discharge planning needs of these patients
- Consider options of tele-behavioral health services
- Identify community services or establish partnerships with others; Aging and Disability Resource Centers, Area Agencies on Aging, Substance Abuse Mental Health Admin, Centers for Independent Living etc.

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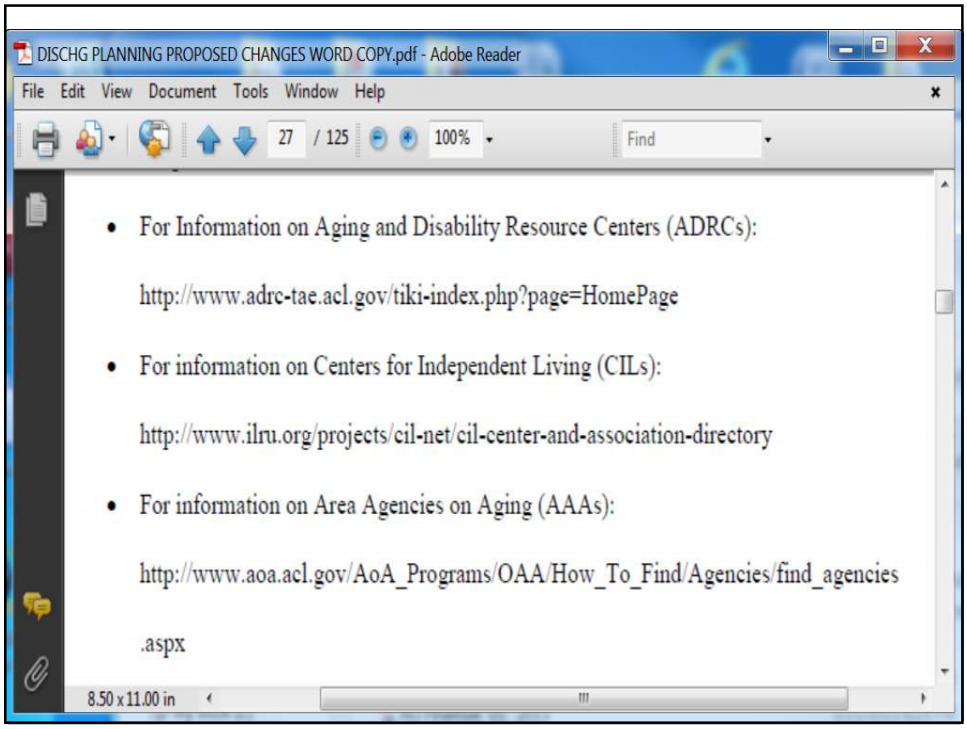

CAH Discharge Process

- Must include discharge plan in medical record
- Must assess the discharge planning process with periodic review of discharge plans, etc.
- Same requirements for discharge instructions
- Same requirements to get a copy of instructions and discharge summary to PCP within 48 hours
- Same with pending tests to PCP within 24 hours
- Transfer form must include the same 21 things

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Home Health Services

Home Health Discharge Planning

- HHA must develop and implement an effective discharge planning process
- It must focus on preparing patients to be active partners in their post-discharge care
- Needs to reduce factors that can lead to readmission
- Must ensure discharge goals, preferences and needs of each patient is identified and in discharge plan
- Must include in the patient's discharge plan

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HHA Discharge Planning Process

- Must re-evaluation patient to identify any changes
- If changes need to modify discharge plan
- PCP responsible for home health plan of care and must be involved in ongoing process
- Must consider patient capability to perform the care
- Patient and caregiver must be involved in developing the discharge plan
- If patient transferred to another HHA or sent to LTCH, SNF, or IRF must help patient pick one by sharing data including quality measures

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HHA Discharge Planning Process

- Must timely document evaluation of patient's discharge needs and plan
- Discharge plan must be in the clinical record
- Must discuss evaluation with the patient
- HHA must send necessary information to PCP or receiving facility
- Long list of information that must be contained- same 21 things plus any information to ensure a safe transition of care
  - Allergies, smoking, VS, race, dx, ethnicity, advance directives, etc.
- Note that CMS has proposed changes to HHA CoPs in 2014

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CMS Proposed Changes HHA CoPs

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HHA Proposed Changed Revised

- The 2014 proposed changes specified the content of the discharge summary or transfer summary
  - Note Revised CoPs in FR January 2017 which go into effect in 2018
- The IMPACT Act that requires HHAs to take into account quality measures etc and to consider patient preferences
- Because of this and efforts to update the discharge planning and discharge summary requirements, CMS is revising the previously proposed discharge or transfer summary
- Added change of having patient as an active partner in the post-discharge care

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Home Health Revised 2017

Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies

A Rule by the Centers for Medicare & Medicaid Services on 01/13/2017

Site Feedback

PUBLISHED DOCUMENT

Start Printed Page 4504

ENHANCED CONTENT - SUBMIT PUBLIC COMMENT

This feature is not available for this document.

ACTION:

Final rule.

www.federalregister.gov/documents/2017/01/13/2017-00283/medicare-and-medicaid-program-conditions-of-participation-for-home-health-agencies?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email

SUMMARY:

This final rule revises the conditions of participation (CoPs) that home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. The requirements focus on the care delivered to patients by HHAs, reflect an interdisciplinary view of patient care, allow HHAs greater flexibility in meeting quality care standards, and eliminate unnecessary procedural

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Document Type: Rule

Document Citation: 82 FR 4504

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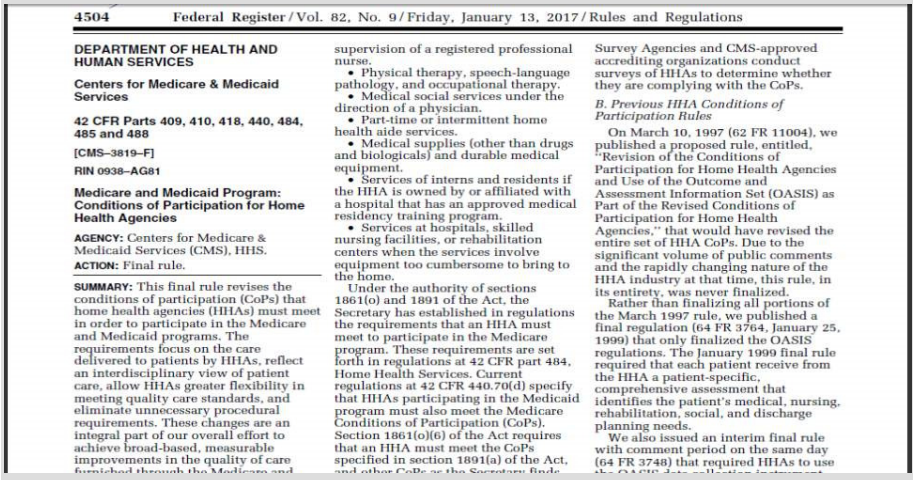
Home Health Revised 2017 PDF 88 Pages



4504 Federal Register / Vol. 82, No. 9 / Friday, January 13, 2017 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 418, 440, 484, 485 and 488

[CMS–3819–F]

RIN 0938–AG81

Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises the conditions of participation (CoPs) that home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. The requirements focus on the care delivered to patients by HHAs, reflect an interdisciplinary view of patient care, allow HHAs greater flexibility in meeting quality care standards, and eliminate unnecessary procedural requirements. These changes are an integral part of our overall effort to achieve broad-based, measurable improvements in the quality of care

supervision of a registered professional nurse.

- Physical therapy, speech-language pathology, and occupational therapy.
- Medical social services under the direction of a physician.
- Part-time or intermittent home health aide services.
- Medical supplies (other than drugs and biologicals) and durable medical equipment.
- Services of interns and residents if the HHA is owned by or affiliated with a hospital that has an approved medical residency training program.
- Services at hospitals, skilled nursing facilities, or rehabilitation centers when the services involve equipment too cumbersome to bring to the home.

Under the authority of sections 1861(o) and 1891 of the Act, the Secretary has established in regulations the requirements that an HHA must meet to participate in the Medicare program. These requirements are set forth in regulations at 42 CFR part 484, Home Health Services. Current regulations at 42 CFR 440.70(d) specify that HHAs participating in the Medicaid program must also meet the Medicare Conditions of Participation (CoPs). Section 1861(o)(6) of the Act requires that an HHA must meet the CoPs specified in section 1891(a) of the Act,

Survey Agencies and CMS-approved accrediting organizations conduct surveys of HHAs to determine whether they are complying with the CoPs.

B. Previous HHA Conditions of Participation Rules

On March 10, 1997 (62 FR 11004), we published a proposed rule, entitled, "Revision of the Conditions of Participation for Home Health Agencies and Use of the Outcome and Assessment Information Set (OASIS) as Part of the Revised Conditions of Participation for Home Health Agencies," that would have revised the entire set of HHA CoPs. Due to the significant volume of public comments and the rapidly changing nature of the HHA industry at that time, this rule, in its entirety, was never finalized.

Rather than finalizing all portions of the March 1997 rule, we published a final regulation (64 FR 3764, January 25, 1999) that only finalized the OASIS regulations. The January 1999 final rule required that each patient receive from the HHA a patient-specific, comprehensive assessment that identifies the patient's medical, nursing, rehabilitation, social, and discharge planning needs.

We also issued an interim final rule with comment period on the same day (64 FR 3748) that required HHAs to use

www.gpo.gov/fdsys/pkg/FR-2017-01-13/pdf/2017-00283.pdf?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email

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Current HHA CoPs

State Operations Manual

Appendix B - Guidance to Surveyors: Home Health Agencies

(Rev. 11, 08-12-05)

Part I – Investigative Procedures

Subpart A - General Provisions

§484.1 Basis and Scope

§484.2 Definitions

§484.4 Personnel Qualifications

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf

Subpart B - Administration

§484.10 Condition of Participation: Patient Rights

§484.10(a) Standard: Notice of Rights

§484.10(b) Standard: Exercise of Rights and Respect for Property and Person

§484.10(c) Standard: Right to be Informed and to Participate in Planning Care and Treatment

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Questions and Important Things

- So does your patient know their diagnosis?
- Can they list their medications?
- Do they know why they are taking them and the major side effects?
- Can they explain their follow up plan?
- Can the patient articulate their treatment preferences and goals of care?
- Don't forget to use interpreters when indicated and don't forget the issue of low health literacy

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Questions and Important Things

- In preamble of federal register, CMS recommends providers check their state's prescription drug monitoring program
  - During evaluation of relevant co-morbidities along with past medical and surgical history
  - These are designed to monitor for suspected abuse or diversion
- Don't forget any state specific laws on this
  - Massachusetts and Rhode Island mandate the use of a universal transfer form
  - American Medical Directors Association has one also

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AMDA Universal Transfer Form

Universal Transfer Form

AMDA has developed and recommends the use of the Universal Transfer Form (UTF) to facilitate the transfer of necessary patient information from one care setting to another. Patient transfers are fraught with the potential for errors stemming from the inaccurate or incomplete transfer of patient information. Use of the UTF can help to minimize the occurrence of such errors by ensuring that patient information is transmitted fully and in a timely fashion.

Patient's name: _____ Patient Identifier #: _____
Setting Discharged from: _____ Patient's date of birth: _____
Setting Discharged to: _____ Patient's gender Male: _____ Female: _____
Attending physician in setting discharged from: _____
Admission date: / / Discharge date: / /

A. Admitting diagnosis: _____

B. Other diagnoses from this admission:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

C. Current diagnoses prior to admission:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

www.amda.com/tools/universal_transfer_form.pdf

D. Surgical procedures and endoscopies during admission (include name of physician who performed the procedure) None __ Physician name: _____
1. _____ Date/results _____ (may attach)
2. _____ Date/results _____ (may attach)
3. _____ Date/results _____ (may attach)

E. Laboratory values (please record most recent results, with date)

WBC	/ /	_____	BUN	/ /	_____
Hgb	/ /	_____	Creatinine	/ /	_____
Na+	/ /	_____	CL	/ /	_____

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Current List of Required Information

The "medical information" that is necessary for the transfer or referral includes, but is not limited to:

- *Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;*
- *Brief description of hospital course of treatment;*
- *Patient's condition at discharge, including cognitive and functional status and social supports needed;*
- *Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);*
- *List of allergies (including food as well as drug allergies) and drug interactions;*
- *Pending laboratory work and test results, if applicable, including information on how the results will be furnished;*
- *For transfer to other facilities, a copy of the patient's advance directive, if the patient has one; and*
- *For patients discharged home:*
  - *Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);*

The End! Questions??

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468 (Call with questions, No emails)
- sdill1@columbus.rr.com

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LTC

- Proposed discharge planning requirements for SNFs are addressed in the proposed rule "Medicare and Medicaid Programs; Reform for Long Term Care Facilities
- 80 FR 42167, July 16, 2015
- Copy at www.federalregister.gov/articles/2015/07/16/2015-17207/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

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LTC

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