

The IMPACT Act and CMS Proposed Changes to Discharge Planning



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Speaker



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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,

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:

“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

Improving
Medicare Post-
Acute Care
Transformation
Act of 2014.
42 USC 1395
note.

42 USC 1395III.

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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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SECTION 1. SHORT TITLE.

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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:

“SEC. 1862. STANDARDIZED POST-ACUTE CARE DATA REQUIREMENTS”

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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

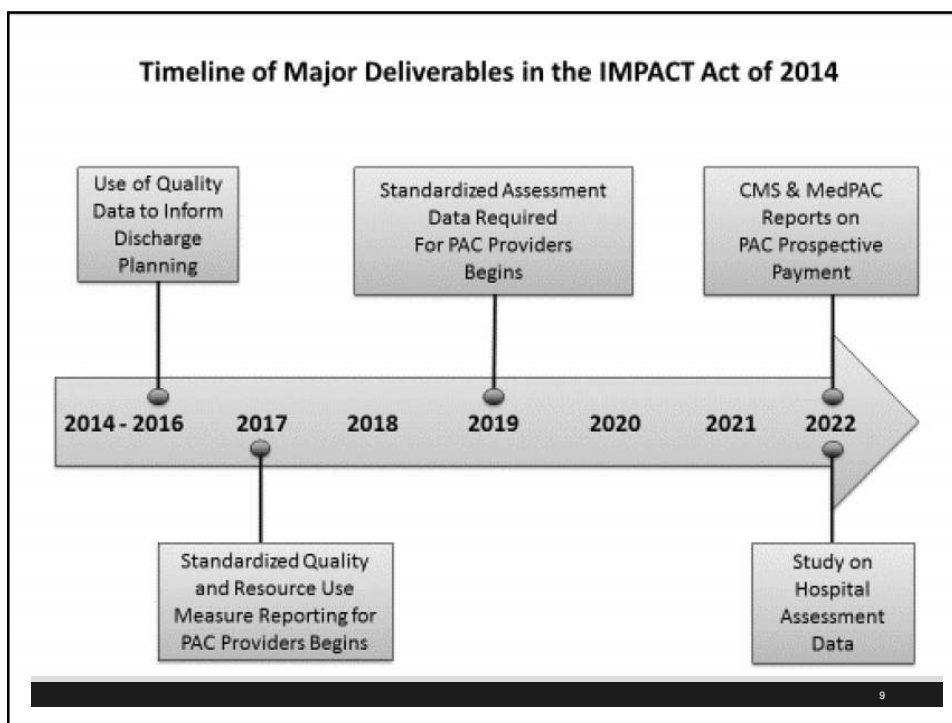
- Signed by the President on October 7, 2014
- Stands for “Improving Medicare Post-Acute Care Transformation Act of 2014”
- Wants to standardize the information collected between the **four** post-acute care providers (PACs)
 - Wants data to be interoperable so as to allow exchange of data and information 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

CMS Website on IMPACT Act

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Post-Acute Care Quality Initiatives

[CARE Item Set and B-CARE](#)

[Functional Measures](#)

[Cross-Setting Pressure Ulcer Measurement & Quality Improvement](#)

[IMPACT Act of 2014 & Cross Setting Measures](#)

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

IMPACT Act of 2014 & Cross Setting Measures

Quality Initiatives: IMPACT Act of 2014

Background:

On September 18, 2014, Congress passed the *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act). The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).

Specifically, the IMPACT Act requires, among other significant activities, the reporting of standardized patient assessment data with regard to quality measures, resource use, and other measures. It further specifies that the data [elements] "... be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes..."

In addition, the IMPACT Act intends for cross-setting quality comparison, and importantly, the Act conveys the inclusion of patient-centeredness in its references and requirements related to capturing patient preferences and goals.

The IMPACT Act provides a tremendous opportunity to address all of the priorities within the CMS Quality Strategy, which is framed using the three broad aims of the National Quality Strategy:

- **Better Care:** Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.
- **Healthy People, Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.

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IMPACT Act of 2014

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IMPACT Act Downloads and Videos

VIDEOS

[Introduction to the IMPACT Act](#)

Downloads

[Falls Public Comment Summary Report.pdf \[PDF, 800KB\]](#)

[MeasureSpecificationsForCY17-HH-QRP-FR.pdf \[PDF, 1MB\]](#)

[ItemSetSpecificationsForCY17-HH-QRP-FR.pdf \[PDF, 163KB\]](#)

[HH QRP Measure Specifications_pressure_ulcer_2017_final.pdf \[PDF, 383KB\]](#)

[Function TEP Member Listing_10_17_16.pdf \[PDF, 193KB\]](#)

[DRR Item Pilot Test Report 10-6-16.pdf \[PDF, 298KB\]](#)

[SODF Announcement IMPACT ACT- 9-15-16 \[PDF, 39KB\]](#)

[SNFQRPPressureUlcerSpecs2016 \[PDF, 155KB\]](#)

[IMPACT Act 2nd qtr - FAQ_Final \[PDF, 129KB\]](#)

[September 15 2016-CMS-SODF-IMPACT-Act 2_Final \(003\) \[PDF, 255KB\]](#)

[2016_07_20_mspb_pac_ltch_irf_snf_measure_specs \[PDF, 822KB\]](#)

[Copy1 of 2016_04_06_mspb_pac_snf_service_exclusions \[XLSX, 63KB\]](#)

[Copy of 2016_04_06_mspb_pac_ltch_service_exclusions \[XLSX, 63KB\]](#)

[Copy of 2016_04_06_mspb_pac_irf_service_exclusions \[XLSX, 66KB\]](#)

[Measure Specifications for FY17 IRF QRP Final Rule \[PDF, 5MB\]](#)

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

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IMPACT Act of 2014

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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](#).

Upcoming Events and Updates

November 29, 2016

Upcoming Special Open Door Forum

The IMPACT Act and Improving Care Coordination

Thursday, December 8, 2016

2:00-3:00 pm Eastern Time

Conference Call Only

The purpose of this Special Open Door Forum (SODF) is to provide information and solicit feedback pertaining to the Improving Medicare Post-Acute Care Transformation Act of 2014 (commonly referred to as the [IMPACT Act](#)). This SODF will focus on the goals of the IMPACT Act, update attendees on the RAND contract activities for item development, and identify opportunities for providers, consumers, stakeholders, researchers, and advocates to become involved over the next year. Visit the downloads section below for more information.

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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

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

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LTCH Quality Reporting

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[LTCH Quality Reporting Archives](#)

Long-Term Care Hospital (LTCH) Quality Reporting (QRP)

Overview

What's Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)?

The LTCH QRP creates LTCH quality reporting requirements, as mandated by Section 3004(a) of the Patient Protection and Affordable Care Act of 2010. Every year, by October 1, we publish the quality measures you must report.

Section 3004(a) of the Affordable Care Act (ACA) amends section 1886(m)(5) of the Social Security Act (SSA) to direct the Secretary to establish quality reporting requirements for long-term care hospitals (LTCHs).

What happens if quality data isn't reported?

For fiscal year 2014, and each year after, if you don't submit the required quality data, the result shall be a two (2) percentage point reduction in your annual payment update.

Who can see the reported data?

We must make quality data available to the public and give you the opportunity to review the data before it's made public.

Learn more about ACA Section 3004 (Quality Reporting for Long-Term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), and Hospice Programs). Please note the link below for P.L. Public Law No: 111-148, the Patient Protection and Affordable Care Act (H.R.3590 Health Care Law).

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LTCH Quality Public Reporting

[LTCH Quality Reporting Spotlight Announcements](#)

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[LTCH CARE Data Set & LTCH QRP Manual](#)

[LTCH Quality Reporting Technical Information](#)

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[LTCH Quality Reporting Data Submission Deadlines](#)

[LTCH Quality Reporting Reconsideration and Exception & Extension](#)

[LTCH Quality Reporting Help](#)

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Public-Reporting.html

Background:

Section 3004(a) of the Affordable Care Act established the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP). In addition, The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the reporting of standardized patient assessment data on quality, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Beginning in fall 2016, CMS will publicly report LTCH quality data on the LTCH Compare website. CMS will initially publicly report performance data on four quality measures

- Percent of residents or patients with pressure ulcers that are new or worsened (short stay)- NQF #0678
- National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) outcome measure- NQF #0138
- National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) outcome measure- NQF #0139
- All-cause unplanned readmission measure for 30 days post-discharge from long-term care hospitals- NQF #2512

March 01, 2017

LTCH QRP Provider Preview Reports Now Available

LTCHs now have the opportunity to review their performance data on each quality measure based on Quarter 3 -2015

Skilled Nursing Facilities SNF

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www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQuality/IRF-Quality-Reporting-Program-Measures-and-Technical-Information.html

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Home > Medicare > Nursing Home Quality Initiative > SNF Quality Reporting Program Measures and Technical Information

Nursing Home Quality Initiative

[Spotlight](#)
[Quality Measures](#)
[Quality Measures Archive](#)
[MDS 3.0 RAI Manual](#)
[MDS 3.0 for Nursing Homes and Swing Bed Providers](#)
[MDS 3.0 Technical Information](#)
[MDS 3.0 Technical Information Archive](#)
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SNF Quality Reporting Program Measures and Technical Information

The IMPACT Act of 2014 requires the Secretary to implement specified clinical assessment domains using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers. The Act further requires that CMS develop and implement quality measures from five quality measure domains using standardized assessment data. In addition, the Act requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community. Through the use of standardized quality measures and standardized data, the intent of the Act, among other obligations, is to enable interoperability and access to longitudinal information for such providers to facilitate coordinated care, improved outcomes, and overall quality comparisons. **To date, no measures have been adopted into the SNF quality reporting program.**

SNF QRP Measures and Technical Information Additional Resources:

Please also visit the CMS Post-Acute Care Quality Initiative website for more information related to cross setting quality measures and quality initiatives:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/PAC-Quality-Initiatives.html>

Information on the IMPACT Act of 2014 can be found at:

<http://www.gpo.gov/fdsys/pkg/BILLS-113hr4944enr/pdf/BILLS-113hr4944enr.pdf>

<https://www.govtrack.us/congress/bills/113/hr4944>

For SNF Quality Reporting Program comments or questions: SNFQualityQuestions@cms.hhs.gov

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Inpatient Rehab Facilities (IRF)

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www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting-Program-Measures-and-Technical-Information.html

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Home > Medicare > IRF Quality Reporting > Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP)

IRF Quality Reporting

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Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP)

Overview

What's Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP)?

The IRF QRP creates IRF quality reporting requirements, as mandated by Section 3004(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. Every year, by October 1, we publish the quality measures you must report.

Section 3004(b) of the ACA directs the Secretary amends section 1886(j)(7) of the Social Security Act (SSA) to establish quality reporting requirements for IRFs. Please see below link to text of Section 3004 of the ACA.

What happens if quality data isn't reported?

For fiscal year 2014, and each year after, if you don't submit the required quality data, the result shall be a two (2) percentage point reduction in your annual payment update.

Who can see the reported data?

We must make quality data available to the public and give you the opportunity to review the data before it's made public.

Learn more about ACA Section 3004 (Quality Reporting for Long-Term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), and Hospice Programs). Please note the link below for P.L. Public Law No. 111-148, the Patient Protection and Affordable Care Act (H.R. 3590 Health Care Law)

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IRF Quality Public Reporting

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Public-Reporting.html

Background:

Section 3004(b) of the Affordable Care Act established the IRF Quality Reporting Program (QRP). In addition, The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the reporting of standardized patient assessment data on quality, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

IRF Compare Website Now Live

December 14, 2016, CMS unveiled the new IRF Compare website. This new tool takes reported data and puts it into a format that can be used more readily by the public to get a snapshot of the quality of care each facility provides. For instance, this tool will help families compare some key quality metrics, such as pressure ulcers and readmissions, for over 1,100 IRFs across the nation. The following quality measures are reported on the new Compare site for IRFs:

- Percent of residents or patients with pressure ulcers that are new or worsened (short stay) - NQF #0678
- All-cause unplanned readmission measure for 30 days post-discharge from Inpatient Rehabilitation Facilities - NQF #2502

Procedures for requesting CMS review of an IRF's measure data:

CMS encourages IRFs to review their data as provided in the Preview Reports. If an IRF disagrees with performance data (numerator, denominator, or quality metric) contained within their Preview Report, they will have an opportunity to request review of that data by CMS. In order to make such a request, IRFs must adhere to the process outlined below:

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www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html

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Home Health Quality Initiative > Home Health Quality Reporting Requirements

Home Health Quality Reporting Requirements

Statutory Authority for Use of the OASIS Data Item Set and Home Health Quality Reporting

The reporting of quality data by home health agencies (HHAs) is mandated by Section 1895(b)(3)(B)(v)(II) of the Social Security Act ("the Act"). This statute requires that "each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause."

OASIS reporting is mandated in the Medicare regulations at 42 C.F.R. §484.250(a), which requires HHAs to submit OASIS assessments and Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HH CAHPS) data to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

Section 1895(b)(3)(B)(v)(II) of the Act states that "for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points."

The requirement that HHAs report quality data to CMS is contained in the Medicare regulations. Section 484.225(i) of Part 42 of the Code of Federal Regulations (C.F.R.) provides that HHAs that meet the quality data reporting requirements are eligible to receive the full home health (HH) market basket percentage increase. HHAs that do not meet the reporting requirements are subject to a two (2%) percentage point reduction to the HH market basket increase. Section 1895(b)(3)(B)(v)(III) of the Act states that "[t]he Secretary shall establish procedures for making data submitted under subclause (II) available to the public. Such procedures shall ensure that a home health agency has the opportunity to review the data that is to be made public with respect to the agency prior to such data being made public."

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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 than originally realized
- The secretary will make confidential feedback reports to providers so they are 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 Medicare Post-Acute Care Transformation 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



UCLA Borun Center
FOR GERONTOLOGICAL

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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 [JRF 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.

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AHA 14 Page Comment Letter



800 10th Street, NW
Two City Center, Suite 200
Washington, DC 20004
(202) 638-1100 Phone
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 21244-1890



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

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

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

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 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



Center for Clinical Standards and Quality/Survey & Certification Group

DATE: November 26, 2014

REF: S&C: 15-12-Hospital

TO: State Survey Agency Directors

www.cms.gov/SurveyCertification/enInfo/PMSR/list.asp#TopOfPage

FROM: Director
Survey and Certification Group

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?	<input type="radio"/> Yes <input type="radio"/> No
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No
If yes, check all that apply: <input type="checkbox"/> Same day surgery patients <input type="checkbox"/> Observation patients who are not subsequently admitted <input type="checkbox"/> ED patients who are not subsequently admitted <input type="checkbox"/> Other	
2.3 Is a discharge plan prepared for each inpatient?	<input type="radio"/> Yes, skip to question 2.8 <input type="radio"/> 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
No. 212

Tuesday,
November 3, 2015

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

[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."

[Learn more about Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies](#)

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



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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

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

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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	 6.06 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

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[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](#)

[Psychiatric Hospital Survey Module](#)

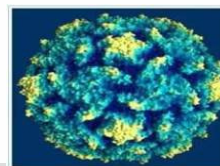
[Psychiatric Unit Survey Module](#)

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CMS Survey and Certification Website

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- [Nursing Home Quality Assurance & Performance Improvement Initiative](#)
- [Revised User Fee Program](#)
- [Accreditation](#)
- [Policy & Memos to States and Regions](#)

Policy & Memos to States and Regions

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

Select From The Following Options:

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

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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 Budget Act of 1997 (P.L. 105-33) required

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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

61

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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		The 8Ps: Assessing Your Patient's Risk For Adverse Events After Discharge	
Risk Assessment: SP 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) <input type="checkbox"/>	<input type="checkbox"/> Medication specific education using Teach Back provided to patient and caregiver <input type="checkbox"/> Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) <input type="checkbox"/> Specific strategies for managing adverse drug events reviewed with patient/caregiver <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications		
Psychological (depression screen positive or no depression diagnosis) <input type="checkbox"/>	<input type="checkbox"/> Assessment of need for psychiatric aftercare if not in place <input type="checkbox"/> Communication with aftercare providers, highlighting this issue if new <input type="checkbox"/> Involvement/awareness of support network insured		
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) <input type="checkbox"/>	<input type="checkbox"/> Review of national discharge guidelines, where available <input type="checkbox"/> Disease specific education using Teach Back with patient/caregiver <input type="checkbox"/> Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms <input type="checkbox"/> Discuss goals of care and chronic illness model discussed with patient/caregiver		
Polypharmacy (>5 more routine meds) <input type="checkbox"/>	<input type="checkbox"/> Elimination of unnecessary medications <input type="checkbox"/> Simplification of medication scheduling to improve adherence <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications		
Poor health literacy (inability to do Teach Back) <input type="checkbox"/>	<input type="checkbox"/> Committed caregiver involved in planning/administration of all general and risk specific interventions <input type="checkbox"/> Aftercare plan education using Teach Back provided to patient and caregiver <input type="checkbox"/> Link to community resources for additional patient/caregiver support <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications		
Patient support (absence of caregiver to assist with discharge and home care) <input type="checkbox"/>	<input type="checkbox"/> Follow-up phone call at 72 hours to assess condition, adherence and complications <input type="checkbox"/> Follow-up appointment with aftercare medical provider within 7 days <input type="checkbox"/> Involvement of home care providers of services with clear communications of discharge plan to those providers		
Prior hospitalization (non-elective, in last 6 months) <input type="checkbox"/>	<input type="checkbox"/> Review reasons for re-hospitalization in context of prior hospitalization <input type="checkbox"/> Follow-up phone call at 72 hours to assess condition, adherence and complications <input type="checkbox"/> 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: <input type="checkbox"/>	<input type="checkbox"/> Assess need for palliative care services <input type="checkbox"/> Identify goals of care and therapeutic options <input type="checkbox"/> Communicate prognosis with patient/family/caregiver <input type="checkbox"/> Assess and address bothersome symptoms <input type="checkbox"/> Identify services or benefits available to patients based on advanced disease status <input type="checkbox"/> Discuss with patient/family/caregiver role of palliative care services and benefits and services available		

Discharge Evaluation & Plan

		DISCHARGE EVALUATION & PLAN PLAN OF CARE, REVIEWS & SUMMARY	
ADMISSION EVALUATION Admit Date: _____ (Please fill for Admission (refer to admission, H + P and Discharge forms for additional information))			
REHABILITATION POTENTIAL: <input type="checkbox"/> Resident believes self capable of increased independence in at least some ADL's <input type="checkbox"/> Direct Care staff believes resident capable of increased independence in at least some ADL's <input type="checkbox"/> Other: _____			
DISCHARGE POTENTIAL: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Marginal <input type="checkbox"/> Guarded <input type="checkbox"/> Poor <input type="checkbox"/> None			
DISCHARGE anticipated within 90 days of admission? <input type="checkbox"/> Yes, Anticipated to: <input type="checkbox"/> No, Reason(s): _____ <input type="checkbox"/> Requires 24 hr supervision <input type="checkbox"/> Dependent on others for all ADL's <input type="checkbox"/> Condition expected to deteriorate <input type="checkbox"/> Complicated medical care/regimen <input type="checkbox"/> Alternate Care setting not possible due to physical disability <input type="checkbox"/> Dependent psychologically on placement in facility <input type="checkbox"/> Uncertain/Unknown due to: <input type="checkbox"/> Mental Health status <input type="checkbox"/> Family refuses to provide care <input type="checkbox"/> Family unable to meet needs due to other responsibilities <input type="checkbox"/> Financial limitations in meeting care needs <input type="checkbox"/> Resident refuses to leave facility <input type="checkbox"/> Other: _____			
Resident and/or Resident Representative agrees to be discharged to: _____ Additional Comments: _____			
REVIEW OF FACTORS AFFECTING DISCHARGE PLAN (Refer to Comprehensive Evaluation dates) _____ for additional specific details in each area.			
ADL FUNCTIONAL ABILITY <input type="checkbox"/> Ability to meet self-care needs not impaired <input type="checkbox"/> Unable to meet self-care needs <input type="checkbox"/> Ability to meet any self-care needs impaired in the following areas: <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Dressing <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Transfer <input type="checkbox"/> Lifting <input type="checkbox"/> Bathing <input type="checkbox"/> Locomotion <input type="checkbox"/> Toilet Use Comment: _____		SUPPORT SERVICE REQUIREMENTS <input type="checkbox"/> No support service needs anticipated post-discharge. <input type="checkbox"/> Referrals needed in the following areas: <input type="checkbox"/> Primary Physician <input type="checkbox"/> Personal (family/friend) support system <input type="checkbox"/> Home Health Care Agency <input type="checkbox"/> Community Health Care Agency <input type="checkbox"/> Meal Delivery <input type="checkbox"/> Financial Assistance <input type="checkbox"/> Hospital <input type="checkbox"/> Council on Aging <input type="checkbox"/> State Agency <input type="checkbox"/> Other: _____	
COGNITIVE AND MENTAL FUNCTION <input type="checkbox"/> Not impaired <input type="checkbox"/> Impaired in the marked areas: <input type="checkbox"/> Orientation <input type="checkbox"/> Memory <input type="checkbox"/> Short-term <input type="checkbox"/> Long-term <input type="checkbox"/> Decision Making Comment: _____		RESIDENT/CAREGIVER EDUCATION/INSTRUCTION NEEDS PRIOR TO DISCHARGE <input type="checkbox"/> No special instruction anticipated <input type="checkbox"/> Education needs in the marked areas: <input type="checkbox"/> Diabetes, skin care <input type="checkbox"/> Gait training <input type="checkbox"/> Prosthetic device & use <input type="checkbox"/> Medication compliance <input type="checkbox"/> Injection technique <input type="checkbox"/> Distraction needs <input type="checkbox"/> Tube feeding <input type="checkbox"/> Catheter care <input type="checkbox"/> Ostomy care <input type="checkbox"/> Trach care	
PSYCHOSOCIAL FUNCTION <input type="checkbox"/> Not impaired <input type="checkbox"/> Impaired in the marked areas: <input type="checkbox"/> Relationships with others <input type="checkbox"/> Interactions with past roles <input type="checkbox"/> Mood <input type="checkbox"/> Problem behaviors <input type="checkbox"/> Activities pursuit		DATE GIVEN: _____ SIGNATURE: _____	

Refer to Comprehensive Evaluation dated: _____ for additional specific details in each area.

ADL FUNCTIONAL ABILITY

☐ Ability to meet self-care needs not impaired

☐ Unable to meet self-care needs

☐ Ability to meet any self-care needs impaired in the following areas:

☐ Bed Mobility ☐ Dressing ☐ Personal Hygiene

☐ Transfer ☐ Eating ☐ Bathing

☐ Locomotion ☐ Toilet Use

Comment: _____

Signature/Date: _____

COGNITIVE AND MENTAL FUNCTION

☐ Not impaired

☐ Impaired in the marked areas:

☐ Cognitive Memory ☐ Short-term ☐ Long-term

☐ Decision-Making

Comment: _____

Signature/Date: _____

PSYCHOSOCIAL FUNCTION

☐ Not impaired

☐ Impaired in the marked areas:

☐ Interaction/Involvement with others ☐ Mood

☐ Relationship with others ☐ Problem behaviors

☐ Identification with past roles ☐ Activities pursuit

Comment: _____

Signature/Date: _____

SPECIAL CARE NEEDS

☐ No special care needs anticipated at time of discharge

☐ Special care needs anticipated in the marked areas:

☐ Financial assistance ☐ Personal care

☐ Housing assistance ☐ Meals/nutritional needs

☐ Medications ☐ Housekeeping services

☐ Special care procedures/treatments ☐ Shopping services

☐ Supplies/equipment ☐ Transportation

☐ Mental health care ☐ Respite care

☐ Other: _____

Comment: _____

Signature/Date: _____

SUPPORT SERVICE REQUIREMENTS

☐ No support service needs anticipated post-discharge

☐ Referrals needed in the marked areas:

☐ Private Physician

☐ Personal (family/friend) support system

☐ Home Health Care Agency

☐ Community Health Care Agency

☐ Meal Delivery

☐ Financial Assistance

☐ Hospice

☐ Council on Aging

☐ State Agency

☐ Other: _____

Comment: _____

Signature/Date: _____

RESIDENT/CAREGIVER EDUCATION/INSTRUCTION NEEDS PRIOR TO DISCHARGE

☐ No special instruction anticipated

☐ Education needs in the marked areas:

	DATE GIVEN	SIGNATURE
<input type="checkbox"/> Diabetic skin care		
<input type="checkbox"/> Gait training		
<input type="checkbox"/> Prosthetic device & use		
<input type="checkbox"/> Medication compliance		
<input type="checkbox"/> Injection technique		
<input type="checkbox"/> Diet/nutritional needs		
<input type="checkbox"/> Tube feeding		
<input type="checkbox"/> Catheter care		
<input type="checkbox"/> Ostomy care		
<input type="checkbox"/> Trach care		
<input type="checkbox"/> Wound care		
<input type="checkbox"/> Bathing		
<input type="checkbox"/> Range of motion exercises		
<input type="checkbox"/> Muscle strengthening care		
<input type="checkbox"/> Respiratory care/therapy		
<input type="checkbox"/> Infection control measures		
<input type="checkbox"/> Other:		

Comment: _____

Signature/Date: _____

FINANCIAL RESOURCES

☐ Resident and/or responsible party state financial resources adequate to meet anticipated post-discharge needs.

☐ Financial assistance needed in marked areas:

☐ Health care services costs ☐ Clothing

☐ ADL care needs ☐ Housing

☐ Medicines ☐ Other: _____

Comment: _____

Signature/Date: _____

Resident Name: _____ ID #: _____ Room #: _____ Physician: _____

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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

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

So we all sleep more peacefully

RARE Reducing Avoidable Readmissions Effectively

www.rareadmissions.org/areas/comp_discharge_resources.html

ABOUT GOAL PROGRESS PARTICIPANT RESOURCES **5 KEY AREAS**

Home > 5 Key Areas

5 KEY AREAS

- » Comprehensive discharge planning » resources
- » Medication management » resources
- » Patient and family engagement » resources
- » Transition care support » resources
- » Transition communications » resources
- » Patient-provider communication/health literacy

Comprehensive Discharge Planning - Tools and Resources

Gap Analysis
Effective discharge planning is dependent on structures and processes. Implementing or enhancing a discharge planning program should start with a gap analysis to examine how your organization is currently performing. The gap analysis provides insight into the needs for improvement. [Comprehensive Discharge Planning Gap Analysis](#) (3-page Word doc)

Patient/Family Materials
[Getting Ready to Go Home: Patient/Family Discharge Planning Checklist](#). This tool provides patients and family members with a list of questions that they should have answered and information on prior to discharge.

[Next Step in Care](#). Supported by the United Hospital Fund, this website includes a variety of provider and caregiver resources and checklists. Patient/family materials are available in English, Spanish, Russian, and Chinese.

[Patient PASS: A Transition Record](#). Developed as part of the Society of Hospital Medicine's Project BOOST (Better Outcomes for Older adults through Safe Transitions). (1-page PDF)

[Personal Health Record - Discharge Preparation Checklist](#). Patient health record information including a structured checklist of critical activities a patient must be able to do to manage their care. (6-page PDF)

[Taking Care of Myself: A Guide for I When Leave the Hospital](#). Template for a patient-focused after hospital care plan. Can be downloaded and completed electronically. Developed by the Agency for Healthcare Research and Quality

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

Component	Best practice/Strategy	Present	Gap/Opportunity
Discharge Planning - Process	<p>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)</p> <p>Develop a comprehensive shared care plan using a shared decision making approach – consider patient values and preferences, social and medical needs</p> <p>Discharge summary and medication plan are complete and up to date</p> <p>Work with patient/family to prepare for the post discharge visit planning (goals, questions, concerns)</p>		

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Content of a Discharge Plan

Discharge Planning – Content	<p><u>advance directives as appropriate</u></p> <p>Written discharge plan includes the following:</p> <ul style="list-style-type: none"> • 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 be 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 patient's 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

AHRQ Agency for Healthcare Research and Quality
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Clinicians & Providers
Education & Training
Hospitals & Health Systems
 + Hospital Resources
 + Emergency Severity Index
 + Guide to Patient and Family Engagement in Hospital Quality and Safety
 + **Hospital Guide to Reducing Medicaid Readmissions**
 + Improving the Emergency Department Discharge Process
 + Improving Patient Safety Systems for Patients With Limited English Proficiency
 + NICU Toolkit
 + Preventing Falls in Hospitals
 + Preventing Pressure Ulcers in Hospitals

Hospital Guide to Reducing Medicaid Readmissions

Publication #14-0050-EF

ALTERNATE FORMATS
 Order Print Copies
 Hospital Guide [1.85MB]
 Toolbox [1.39MB]

Reducing readmissions is a national priority for payers, providers, and policymakers seeking to improve health care and lower costs. Readmissions are a significant issue among patients with Medicaid. The Agency for Healthcare Research and Quality (AHRQ) commissioned this guide to identify ways evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population.

Prepared by:
Collaborative Healthcare Strategies, Inc.
Amy Boutwell, M.D., M.P.P.

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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 -Originated 06/10/05 -Reviewed w/ changes 04/11/03 -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: <ul style="list-style-type: none"> <input type="checkbox"/> the level at which the patient and family or other caregiver understands the patient's medical condition and the reason for hospitalization <input type="checkbox"/> 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



Always Use
Teach-back!

www.teachbacktraining.org/

[Home](#)

[Using the Teach-back Toolkit](#)

[Interactive Learning Module](#)

[Coaching to Always Use Teach-back](#)

[To Learn More](#)

[Acknowledgements](#)

Welcome to the **Always Use Teach-back!** training toolkit



The purpose of this toolkit is to help all health care providers learn to use teach-back—every time it is indicated—to support patients and families throughout the care continuum, especially during transitions between health care settings.

Tools and Videos

10 Elements of Competence for Using Teach-

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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 Primary Care Provider (Doctor)	Dr. Anita Jones Rheumatologist	Dr. Lin Wu Cardiologist
100 Main St, 2 nd Floor Anytown, ST	100 Pleasant Rd, Suite 105 Anytown, ST	100 Park Rd, Suite 504 Anytown, ST
For a Followup appointment	For your arthritis	To check your heart
Office Phone #: (555) 555-5555	Office Phone #: (555) 555-6666	Office Phone #: (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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Sections

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FEDERAL REGISTER
 The Daily Journal of the United States Government

www.federalregister.gov/articles/2015/10/16/2015-25597/2015-edition-health-information-technology-health-it-certification-criteria-2015-edition-base

Rule

Site Feedback

2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications

A Rule by the Health and Human Services Department on 10/16/2015

ACTION

Final Rule.

SUMMARY

This final rule finalizes a new edition of certification criteria (the 2015 Edition health IT certification criteria or "2015 Edition") and a new 2015 Edition Base Electronic Health Record (EHR) definition, while also modifying the ONC Health IT Certification Program to make it open and accessible to more types of health IT and health IT that supports various care and practice settings. The 2015 Edition establishes the capabilities and specifies the related standards and implementation specifications that Certified Electronic Health Record Technology (CEHRT) would need to include to, at a minimum, support the achievement of meaningful use by eligible professionals (EPs).

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PUBLIC INSPECTION

Publication Date:

Friday, October 16, 2015

Agencies:

Office of the Secretary

Department of Health and

<https://www.federalregister.gov/policy/legal-status>

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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

Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation

www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/match/match.pdf



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MARQUIS Medication Reconciliation

www.hospitalmedicine.org/Web/Quality___Innovation/Implementation_Toolkit/MARQUIS/Overview_Medication_Reconciliation.aspx

shm
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Quality and Safety

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Overview | Medication Reconciliation Implementation toolkit

MARQUIS Unintentional medication discrepancies during transitions in care (such as hospitalization and subsequent discharge) very common and represent a major threat to patient safety. One solution to this problem is medication reconciliation. response to Joint Commission requirements, most hospitals have developed medication reconciliation processes, but have been more successful than others, and there are reports of proforma compliance without substantial improvement in patient safety. There is now collective experience about effective approaches to medication reconciliation, but these have yet to be consolidated, evaluated rigorously, and disseminated effectively.

In 2010, the Agency for Healthcare Research and Quality (AHRQ) awarded the Society of Hospital Medicine (SHM) a \$1.5 million grant for a three-year I Center Medication Reconciliation Quality Improvement Study (MARQUIS). The goal of MARQUIS is to develop better ways for medications to be prescribed, documented, and reconciled accurately and safely at times of care transitions when patients enter and leave the hospital.

Role of the Hospitalist:

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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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AHRQ Health Literacy Universal Precautions Toolkit

2nd edition

The AHRQ Health Literacy Universal Precautions Toolkit, 2nd edition, can help primary care practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all health literacy levels.

What Are Health Literacy Universal Precautions?

Health literacy universal precautions are the steps that practices take when they assume that all patients may have difficulty comprehending health information and accessing health services. Health literacy universal precautions are aimed at—

- Simplifying communication with and confirming comprehension for all patients, so that the risk of miscommunication is minimized.
- Making the office environment and health care system easier to navigate.
- Supporting patients' efforts to improve their health.

Why Should Practices Implement Health Literacy Universal Precautions?

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Care Transition Tools

Click here for Menu

<http://caretransitions.org/tools-and-resources/>



Care Transitions Intervention® Tools

Care Transitions Measure®

The Medical Discrepancy Tool®

DECAF™ Family Caregiver Tool



Patient Activation Assessment® Tool
PDF download (22KB)



What Physicians Need to Know about Transitions Coaches® and The Coleman Care Transitions Intervention®
PDF download (446KB)



Patient Activation Assessment® Guidelines
PDF download (19KB)



Sample Coach Contact Documentation Forms
PDF download (29KB)



Sample Phone Script to Schedule Home Visit
PDF download (29KB)



Family Caregiver Activation in Transitions™ (FCAT™) Tool
PDF download (29KB)



Personal Health Record
PDF download (279KB)
Additional Languages: [Somali](#) | [Spanish](#)



Coach Database
ZIP file download (275KB)

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AHRQ RED Toolkit and Forms



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Emergency Severity Index

Guide to Patient and Family Engagement in Hospital Quality and Safety

Hospital Guide to Reducing Medicaid Readmissions

Improving the Emergency Department Discharge Process

Improving Patient Safety Systems for Patients With Limited English Proficiency

NICU Toolkit

Re-Engineered Discharge (RED) Toolkit

Publication #12(13)-0084

ALTERNATE FORMATS

Order Print Copies

Re-Engineered Discharge (RED) Toolkit: Full Report [2.27MB]

RED Toolkit - All Forms [1.29MB]

RED Toolkit - All Forms [1.03MB]

Example After Hospital Care Plan (AHCP) [294KB]

Example After Hospital Care Plan (AHCP) [368.58KB]

AHCP Template for Manual Creation: English-Speaking Patients [118.6KB]

AHCP Template for Manual Creation: English-Speaking Patients [101.25KB]

Template for Manual Creation of the AHCP: Spanish-Speaking Patients

A variety of forces are pushing hospitals to improve their discharge processes to reduce readmissions. Researchers at the Boston University Medical Center (BUMC) developed and tested the Re-Engineered Discharge (RED). Research showed that the RED was effective at reducing readmissions and posthospital emergency department (ED) visits. The Agency for Healthcare Research and Quality contracted with BUMC to develop this toolkit to assist hospitals, particularly those that serve diverse populations, to replicate the RED.

Select for the *Taking Care of Myself: A Guide for When I Leave the Hospital*, a booklet for patients based on the RED Toolkit.

Related Content

Case Study: AHRQ's RED Toolkit Helps Lower Readmissions in

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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>

Funded by the Agency for Healthcare Research and Quality, National Heart, Lung and Blood Institute, the Blue Cross Blue Shield Foundation, and the Patient-Centered Outcomes Research Institute

[Home](#)
[Development of the RED](#)
[Components of the RED](#)
[Meet Louise...](#)
[The Project RED Toolkit](#)
[Our Team](#)
[Recognitions](#)
[Newsroom](#)
[Presentations](#)
[Publications & Abstracts](#)
[Funding](#)
[Links](#)
[Hospitals Using RED](#)

Project RED (Re-Engineered Discharge)

Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-

Latest Project RED News

The most recent Project RED tool — **Tool 7: Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge** — was highlighted in the *Care Alliance Ireland Exchange – Summer 2014 Newsletter* (page 16).

[Click here to download the Newsletter](#)

Now available, the new resource titled **Hospital Guide to Reducing Medicaid Readmissions**. Medicaid readmission reduction efforts. It helps identify readmission risks, transitional care needs, and adapt best practices from proven strategies like AHRQ's Re-Engineered Discharge, the Institute for Healthcare Improvement's SI Action on Avoidable Readmissions, and the Society of Hospital Medicine's Better Outcome for Older Adults Safe Transitions to serve the transitional care requirements of Medicaid.

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Role of Caregivers in RED

Tool 7: Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge¹

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%93932009_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



Discharge Planning

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.

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/trans toolkit/>).

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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

Your Discharge Planning Checklist:

For patients and their caregivers preparing to leave a hospital, nursing home, or other health care setting

www.medicare.gov/Publications/Publications/pdf/11376.pdf




CMS

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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?	
<input type="checkbox"/> Ask where you will get care after discharge. Do you have options? Be sure you tell the staff what you prefer.	
<input type="checkbox"/> If a family member or friend will be helping you after discharge, write down the name and phone number.	
Your Condition	
<input type="checkbox"/> Ask the staff about your health condition and what you can do to help yourself get better.	
<input type="checkbox"/> 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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Taking Care of Myself: A Guide for When I Leave the Hospital



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

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

www.patientsafety.org/page/transtoolkit/

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](#)

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Survey Protocol

Introduction

Regulatory and Policy Reference

Tasks in the Survey Protocol

Survey Team

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

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

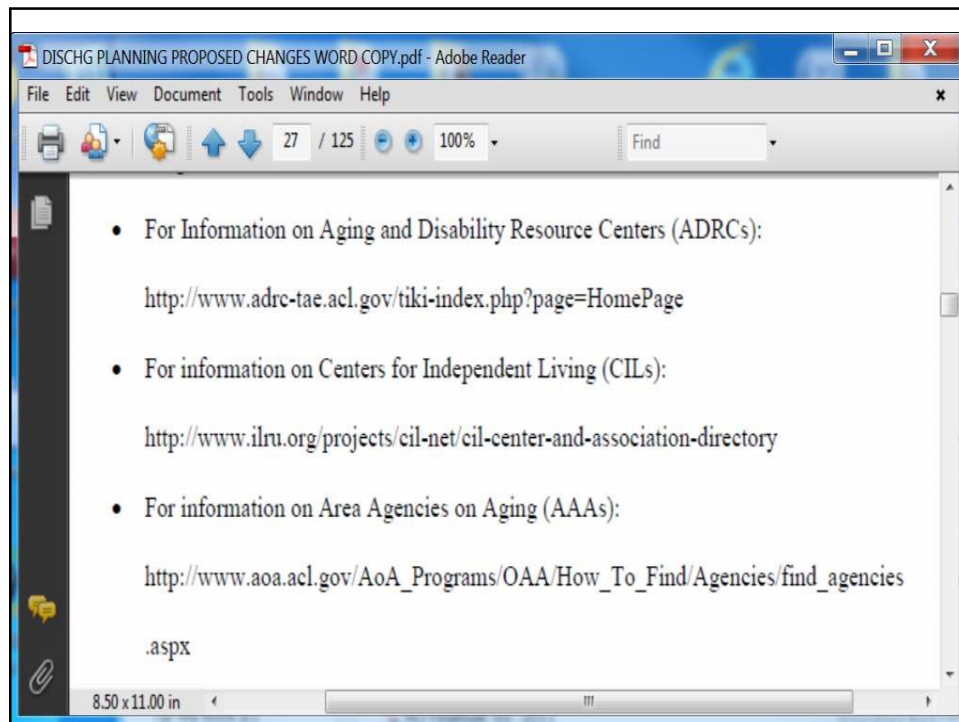
- Must assess patient ability to do self care
- Must assess if caregiver can do care
- Must assess if follow up from a community based provider, LTC or residential facility to include same things as discussed previously
 - Admitting diagnosis, co-morbidities, readmission risk, communication needs, psychosocial 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

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

The screenshot displays the Federal Register website for a proposed rule. The header includes the Federal Register logo and navigation links. The main title is "Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies". Below the title, it states "A Proposed Rule by the Centers for Medicare & Medicaid Services on 10/09/2014". The "ACTION" section is labeled "Proposed Rule". The "SUMMARY" section contains the following text: "This proposed rule would revise the current conditions of participation (CoPs) that home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. The proposed requirements would focus on the care delivered to patients by home health agencies, reflect an interdisciplinary view of patient care, allow home health agencies 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 furnished through the Medicare and Medicaid programs, while at the same time eliminating unnecessary procedural burdens on providers." The right sidebar includes a "LEGAL DISCLAIMER" section, "Font Controls", and a "PUBLIC INSPECTION" section with a "Publication Date" of Thursday, October 09, 2014, and "Agencies" listed as the Department of Health and Human Services and the Centers for Medicare and Medicaid Services. The page number 137 is visible at the bottom right.

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

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

PUBLISHED DOCUMENT

Start Printed Page 4504

ENHANCED CONTENT - SUBMIT PUBLIC COMMENT

This feature is not available for this document.

0

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

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Rule

Document Citation:

82 FR 4504

ACTION:

www.federalregister.gov/documents/2017/01/13/2017-00283/medicare-and-medicicaid-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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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 furnished through the Medicare and

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, and other CoPs as the Secretary finds

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 the OASIS data collection instrument

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. _____

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??



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- 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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The screenshot displays the Federal Register website interface. At the top, there is a navigation bar with links for Sections, Browse, Search, Policy, Learn, Blog, and My FR. A search bar is also present. Below the navigation bar is the Federal Register logo and the text "The Daily Journal of the United States Government". The main heading for the document is "Proposed Rule" in blue. The title of the rule is "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities". Below the title, it states "A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/16/2015". There are social media icons for Facebook, Twitter, and YouTube. The "ACTION" section is labeled "Proposed Rule." The "SUMMARY" section contains the text: "This proposed rule would revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. These proposed changes are necessary to reflect the substantial advances that have been made over the past several years". On the right side, there are links for "Previous Document" and "Next Document", a "LEGAL DISCLAIMER" button, and a "Font Controls" section with plus, minus, and A icons. At the bottom right, there are buttons for "PDF", "DEV", and "PRINT". A "Site Feedback" link is visible on the right edge of the page.

<https://www.federalregister.gov/articles/2015/07/16/2015-17207/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

Proposed Rule

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/16/2015

ACTION Proposed Rule.

SUMMARY This proposed rule would revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. These proposed changes are necessary to reflect the substantial advances that have been made over the past several years

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