AHC Media

February 8, 2016

The IMPACT Act and its Effect on Discharge Planning Standards

Speaker

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Objectives

- List the five things that must be included in discharge instructions.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

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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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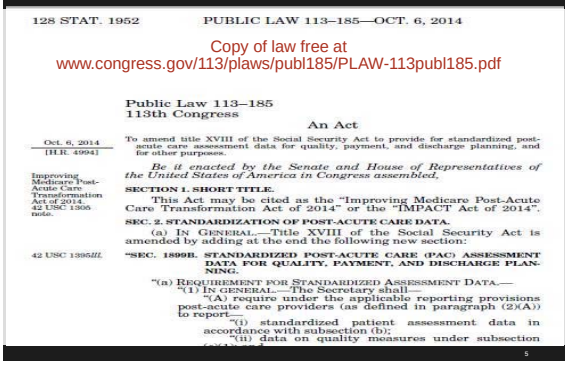
IMPACT Act



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,

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

SECTION 1. SHORT TITLE.

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

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

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

42 USC 1395lll.

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

"(a) REQUIREMENT FOR STANDARDIZED ASSESSMENT DATA.—

"(1) IN GENERAL.—The Secretary shall—

"(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

"(i) standardized patient assessment data in accordance with subsection (b);

"(ii) data on quality measures under subsection

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Free Detailed Article on the Impact Act

Compliance Mentor - December 2015

The COMPLIANCE MENTOR

AN E-NEWSLETTER FROM AHC Media

ESSENTIAL COMPLIANCE GUIDANCE FROM ROB DILL CALLOWAY, RN, MSN, JD, COMPLIANCE OF THE AWARD WINNING PUBLISHER OF:

December [illegible], 2015

REPRINTS

SHARE

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Discharge Planning: Proposed Changes Six Standards

It was only a year ago that CMS published the final discharge planning worksheet and a little more than two years ago when the hospital discharge planning standards were totally rewritten. They were 39-pages long and the number of standards decreased from 24 to 13.

Now CMS is proposing 20 pages of changes to the discharge planning standards and process. Once they're final, CMS will add interpretive guidelines and publish them on this page and in the Federal Register.

There is a 60-day comment period. CMS will review the comments and then issue the final regulations.

www.ahcmedia.com/articles/136797-compliance-mentor---december-2015

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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 **fou**r post-acute care providers (PACs)
- Wants data to be interoperable so as to allow exchange of data between the four 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)
- 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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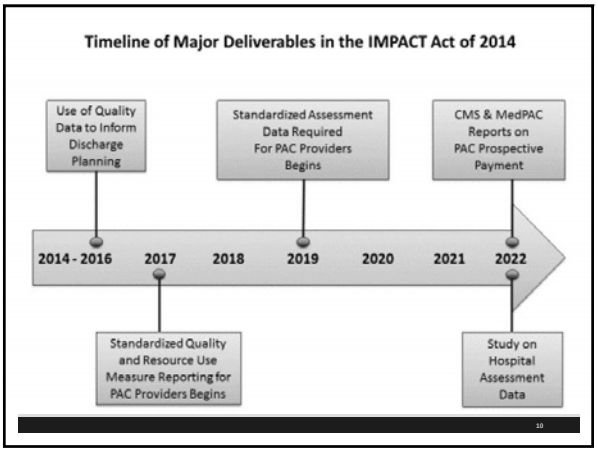

Why the IMPACT Act was Passed

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

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CMS Website on IMPACT Act

Definition of PAC Assessment Instruments

Defines PAC assessment instruments and 4 different payment systems:

1) Outcome and Assessment Information Set (OASIS) and HH 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
4) LTCH-Continuity Assessment and Record and Evaluation Data Set (LTCH-CARE) and LTC PPS

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Standardize 5 Patient Assessments

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

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Standardize Patient Assessments

- Medical conditions and co-morbidities, such as DM, CHF, and pressure ulcers
- Impairments, such as incontinence and an impaired ability to hear, see, or swallow
- Other categories deemed necessary and appropriate by the Secretary
  - Claims data will be aligned with the standardized patient assessment data
- So hospitals and PACs will need to change their admission assessment forms to collect this data
  - RN does admission assessment no later than 24 after admission

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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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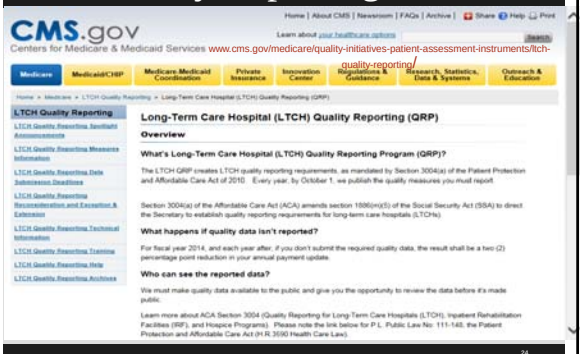
LTC Quality Reporting



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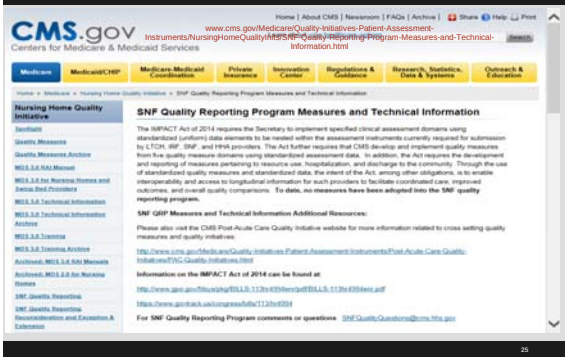
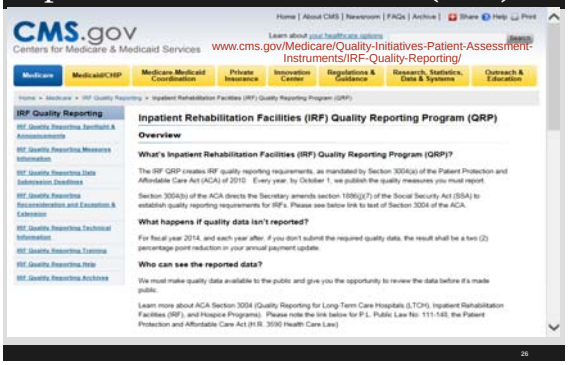
Skilled Nursing Facilities SNF



Inpatient Rehab Facilities (IRF)



Home Health Agencies HHA

Hospice

- Mandates surveys of Medicare certified hospital providers every three years
- This will be done for at least the next ten years
- Medical reviews for hospice programs with a soon to be determined percentage/number of patients receiving care for more than 180 days
- The specific patient load that would trigger this medical review will be set by CMS
- Hospice aggregate financial cap will be aligned with hospice reimbursement

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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 of bundling
- Providers will need to create a process to capture these quality measures
- This would include redoing forms to capture the assessment criteria

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What Does This New Law Mean?

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

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Proposed Changes in CMS Discharge Planning in 2016

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 revises discharge planning interpretive guidelines to reflect transition literature to reduce readmissions
- Includes advisory practices to promote better patient outcomes and Called **blue boxes**
- Reorganized all the standards and a number of tags were eliminated
  - The prior 24 standards have been consolidated into 13
- Now amending them again

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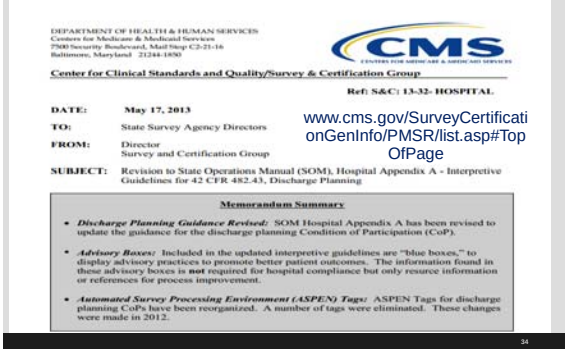
Discharge Planning Rewritten



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

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-32- HOSPITAL

DATE: May 17, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

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

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

Memorandum Summary

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

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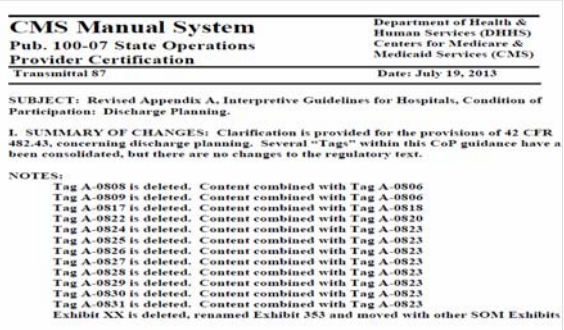
Discharge Planning Transmittal July 19, 2013



CMS Manual System
Pub. 100-07 State Operations
Provider Certification
Transmittal 87

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Date: July 19, 2013

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

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

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

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CMS Hospital Worksheets History

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

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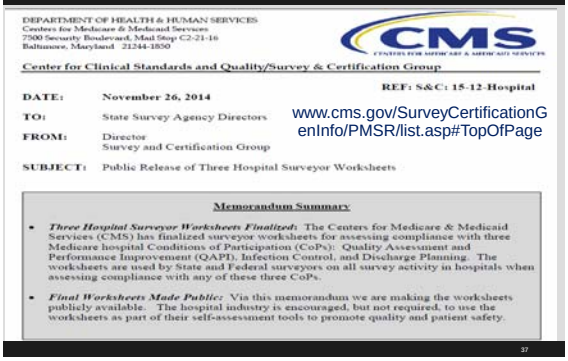
Final 3 Worksheets QAPI



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

Center for Clinical Standards and Quality/Survey & Certification Group

REF: S&C: 15-12-Hospital

DATE: November 26, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

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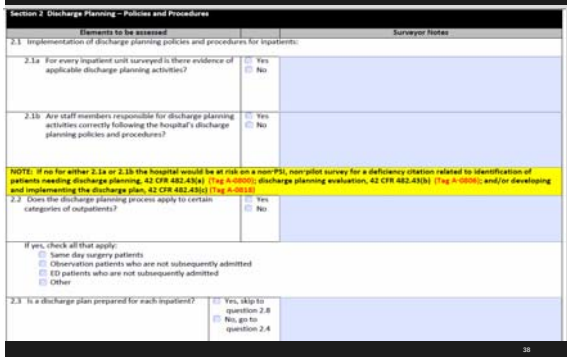
www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Discharge Planning P&P



Section 2 Discharge Planning – Policies and Procedures

Elements to be assessed		Surveyor Notes
2.1 Implementation of discharge planning policies and procedures for inpatients:		
2.1a For every inpatient unit surveyed is there evidence of applicable discharge planning activities?	☐ Yes ☐ No	
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	☐ Yes ☐ No	
NOTE: If no for either 2.1a or 2.1b the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to identification of patients needing discharge planning, 42 CFR 482.43(a) (Tag A-0800); discharge planning evaluation, 42 CFR 482.43(b) (Tag A-0806); and/or developing and implementing the discharge plan, 42 CFR 482.43(c) (Tag A-0810)		
2.2 Does the discharge planning process apply to certain categories of outpatients?	☐ Yes ☐ No	
If yes, check all that apply: ☐ Same day surgery patients ☐ Observation patients who are not subsequently admitted ☐ ED patients who are not subsequently admitted ☐ Other		
2.3 Is a discharge plan prepared for each inpatient?	☐ Yes, skip to question 2.8 ☐ No, go to question 2.4	

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Discharge Planning Proposed Changes

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

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This document is scheduled to be published in the Federal Register on 11/03/2015 and available online at http://federalregister.gov/a/2015-27840, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-P]

RIN 0938-AS59

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

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

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

ACTION: Proposed rule.

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CMS Proposed Discharge Planning

FEDERAL REGISTER

Vol. 80 Tuesday,
No. 212 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

Discharge Planning Proposed Rule Focuses on Patient Preferences

Date 2015-10-29

Title Discharge Planning Proposed Rule Focuses on Patient Preferences

Contact go.cms.gov/media

Discharge Planning Proposed Rule Focuses on Patient Preferences

Today, the Centers for Medicare & Medicaid Services (CMS) proposed to revise the discharge planning requirements that hospitals, including long-term care hospitals and inpatient rehabilitation facilities, critical access hospitals, and home health agencies, must meet in order to participate in the Medicare and Medicaid programs. The proposed changes would modernize the discharge planning requirements by: bringing them into closer alignment with current practice; helping to improve patient quality of care and outcomes; and reducing avoidable complications, adverse events, and readmissions.

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

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

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

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Improved Discharge Planning

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

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Proposed Revised Discharge Planning

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

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Proposed Discharge Planning Changes

- Would need to incorporate many new things into the discharge plan so will need to redo the form
  - Such as admitting diagnosis, relevant co-morbidities, past medical history, past surgical history, anticipated needs, readmission risk, and relevant psychosocial history and more
- Hospitals and CAHs must do discharge plan within 24 hours of admission
- A discharge plan must be done before the patient is discharged home or transferred to another facility
  - Applies to inpatients and certain outpatients
  - Does not apply to emergency transfers

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Discharge Evaluation & Plan

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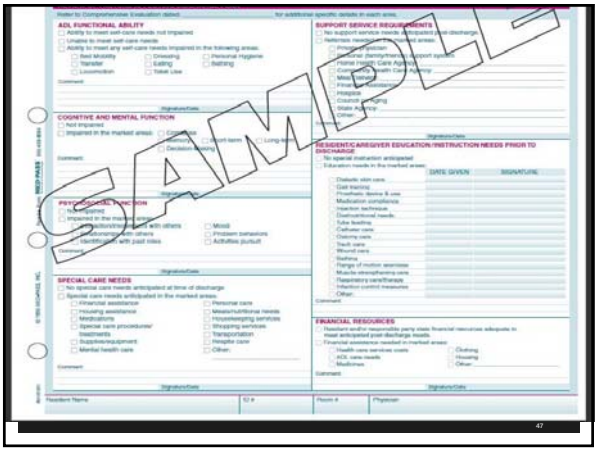

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CMS Hospital CoPs Proposed Changes

- Applies to inpatients, observation, surgery or other same day surgery patients
- 3 requirements for discharge planning P&P including it must be reviewed by the board
- 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 patients and do daily chart review to determine if any changes

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Discharge Summary

- 5 things must be in the written discharge summary including medication reconciliation and the side effects of each drug must be disclosed
  - **Must** include follow-up care, pending tests, planned additional testing, document follow-up appointments and contact information of provider
- Discharge instructions and discharge summary must be given to provider within **48 hours**
- Pending test results must be sent to the provider within 24 hour of their availability

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Sample Form Follow Up Appointments

What is my main medical problem?

Chest Pain

When are my appointments?

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

- Applies whether moderate sedation is use or anesthesia
- Applies to certain ED patients who have been identified as needing a discharge plan
- Hospitals and CAHs must provide discharge instructions for patients discharged home
- Hospitals and CAH must do medication reconciliation
  - Including for patients transferred to another facility
- Develop a discharge follow-up process

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Hospital CoPs on Discharge Planning

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

55

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

56

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 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

57

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

58

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
- If the patient's stay is less than 24 hours still needs to make sure the discharge planning is done before discharge home or transfer
  - It cannot unnecessarily delay the discharge or transfer

60

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

62

8 Things in Evaluating Patient Needs

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

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8 Things in Evaluating Patient Needs

- There are 8 things to consider in evaluating the patient's discharge needs: (continued)
- Patient access to non-healthcare services and community based providers
- Communication needs
  - Language barriers
  - Diminished eyesight and hearing
  - Self reported literacy of patient or caregiver

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RARE Reducing Avoidable Readmissions

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

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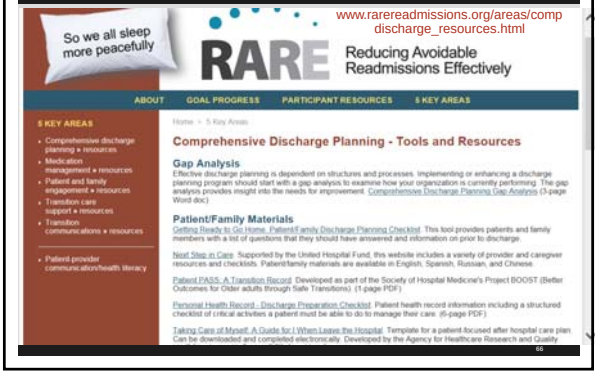
RARE Reducing Avoidable Readmissions



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RARE Reducing Avoidable Readmissions Effectively

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

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

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Content of a Discharge Plan

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

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Hospital Discharge Planning Process

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

69

Hospital Discharge Planning Process

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

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Evaluation and Discharge Plan

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

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Hospital Discharge Planning Process

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

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AHRQ Resources On Hospital Discharge

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

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

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

Abstract

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

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AHRQ Hospital Guide to Reducing Readmissions

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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: ☐ the level at which the patient and family or other caregiver understands the patient's medical condition and the reason for hospitalization ☐ the patient/caregiver's stated expectations

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Hospital Discharge Instructions

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

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Teach Back Toolkit

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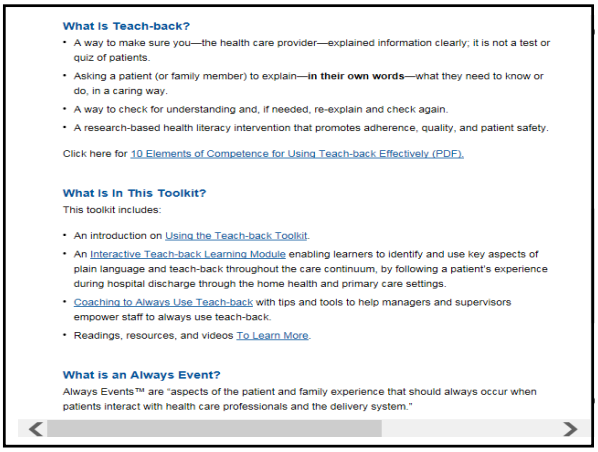

What Is Teach-back?

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

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

What Is In This Toolkit?

This toolkit includes:

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

What is an Always Event?

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

Hospital 5 Discharge Instructions

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

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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

83

Transfer Form Preamble

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

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Medication Reconciliation Preamble

- CMS suggests use generic and proprietary 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

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AHRQ Medications at Transitions

MARQUIS Medication Reconciliation

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

Requirements for PAC Services

- If patient 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 date 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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Resources

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

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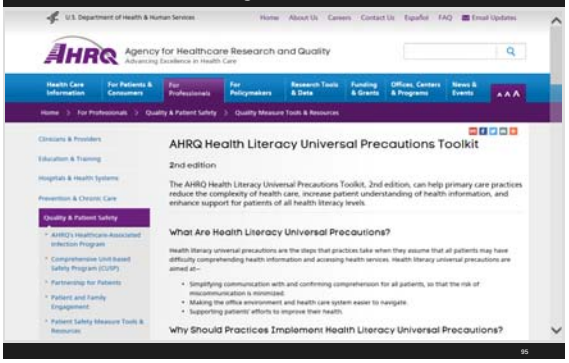
AHRQ Literacy Toolkit



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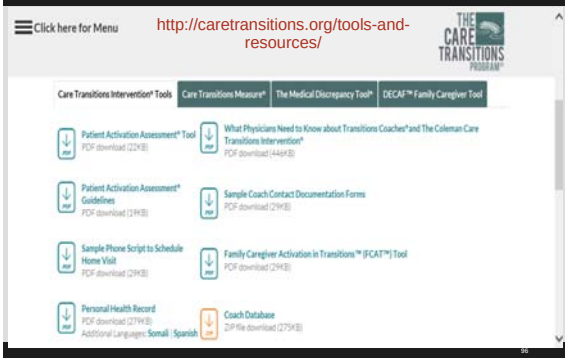
Care Transition Tools



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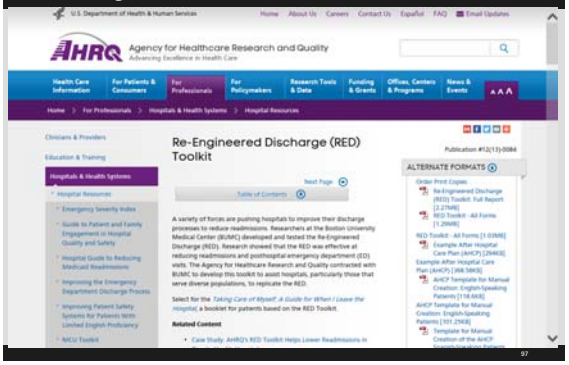
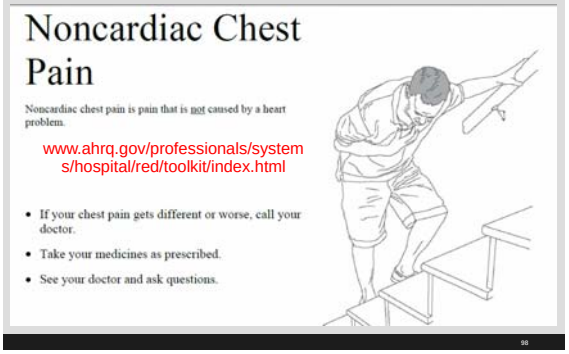
AHRQ RED Toolkit and Forms



Written Discharge Instructions



Project RED

Role of Caregivers in RED

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

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

http://www.bu.edu/fammed/projectred/Project%20RED%20Revised%20Toolkit%209-2012/REDTool7FamilyCaregiversUnitedHospitalFund.pdf

Purpose of This Tool

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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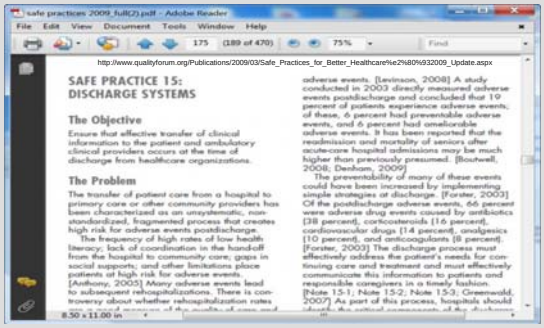
34 Safe Practices for Better Healthcare



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CMS Discharge Planning Medicare Learning

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

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CMS DP Checklist for Patients

For Information- Not Required/Not to be Cited

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

Examples of available tools include:

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

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CMS Discharge Checklist

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

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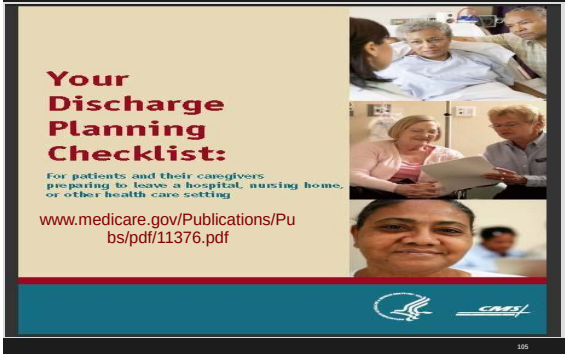
CMS Your Discharge Planning Checklist



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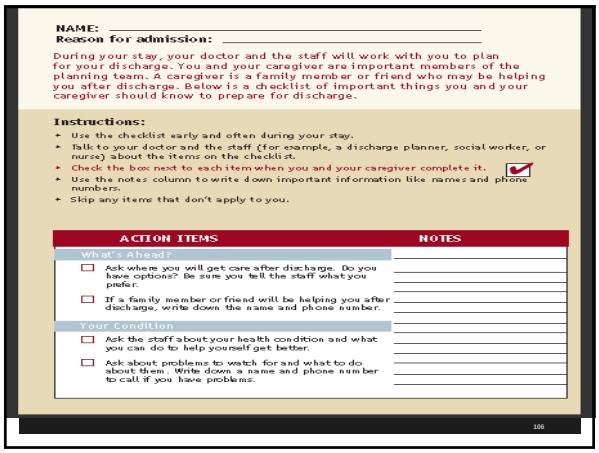

NAME: _____
Reason for admission: _____

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

Instructions:

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

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

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Critical Access Hospitals CAHs

CAH Provisions of Care

- Must have discharge planning (DP) P&P
- Must develop and implement a 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 CoP Manual

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

(Rev. 149, 10-09-15)

Transmittals for Appendix W

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

INDEX

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

Regulations and Interpretive Guidelines for CAHs

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CAH Discharge P&P

- P&P must be in writing
- Discharge planning applies to same five 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 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 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 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 Cah often overlook the special discharge planning needs of these patients
- Consider options of tele-behavioral health services
- Identify community services or establish partnerships with others; Aging and Disability Resource Centers, Area Agencies on Aging, Substance Abuse Mental Health Admin, Centers for Independent Living etc.

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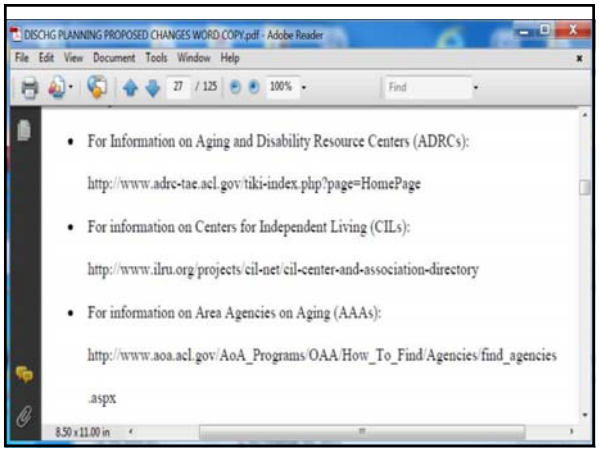

CAH Discharge Process

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

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Home Health Services

Home Health Discharge Planning

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

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HHA Discharge Planning Process

- Must re-evaluation patient to identify any changes
- If changes need to modify discharge plan
- PCP responsible for home health plan of care 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 on 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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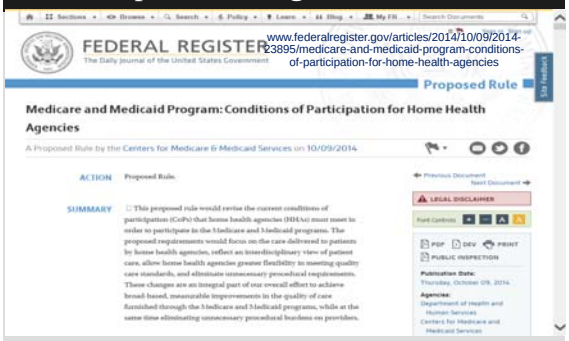
CMS Proposed Changes HHA CoPs



www.federalregister.gov/articles/2014/10/09/2014-23895/medicare-and-medicaid-program-conditions-of-participation-for-home-health-agencies

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HHA Proposed Changed Revised

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

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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

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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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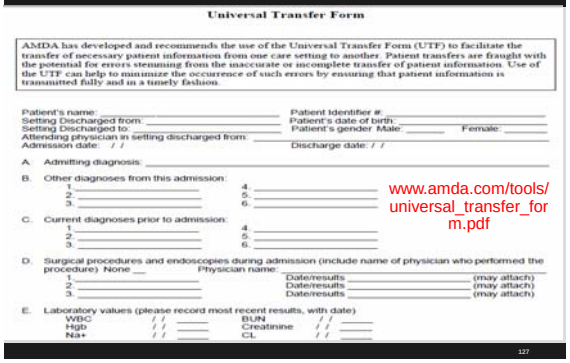
AMDA Universal Transfer Form



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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www.amda.com/tools/universal_transfer_form.pdf

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*

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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Thanks for Attending!

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