

Breathing Life Into Discharge Planning

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I. Introduction

This article focuses on discharge planning across several care settings, each with its own legal framework. It gives particular attention to the acute care hospital setting, noting the importance of the acute care hospital as a care setting from which discharge planning and transitions from one care setting to another most often spring.

In addition, the article examines the discharge planning requirements of the Medicare statute in some detail. It identifies two principle Medicare-related short-comings: (1) the failure of the Medicare statute and its implementing regulations to give specific guidance about the responsibilities and duties for discharge plan implementation as patients move from care setting to care setting and (2) the lack of vigorous oversight and monitoring of discharge planning as a condition of participation in the Medicare program.

Strategies for improvement are also offered, embracing a variety of approaches. They include strengthening the Medicare statutory framework so that it is more specific about care transitions and responsibilities, including payment; working with the Medicare agency in expanding program oversight and guidance; looking to state laws as a basis for expanding beneficiary rights to discharge planning and transitions services; and building upon the dynamic research about the importance of care transitions, both as to clinical standards and better patient outcomes, and expanding patient and family education opportunities.

II. Background

Medicare beneficiaries are left on their own to sort out and apply the bits and pieces of Medicare law, regulation, and policy relevant to discharge planning and transitions. In many instances, the need to assert these rights arises when Medicare beneficiaries and their advocates are confronted with a discharge or reduction in services in hospital, skilled nursing, and home health care settings, or when services called for in a discharge plan are not in fact instituted or put in place in the home.

As a consequence, the beneficiary must be on notice to: (1) read carefully all documents that purport to explain Medicare rights or have family members, friends, or other representatives read such document(s) if the beneficiary is unable to do so; (2) question treating physicians, nurses, social workers, home health care providers, and other care providers about necessary services as the beneficiary's condition improves, remains the same, or requires more services, and to voice opinions and concerns about his or her care, and participate fully in all care decisions; (3) become

familiar with Medicare guidelines about eligibility for hospital and home and community based care, including nursing facility services and home health services available under the Medicare and Medicaid programs, as well as services that are available under other state sources of coverage for home and community-based services; and (4) identify and become familiar with the health care services that are available, such as visiting nursing services, home health agencies, nursing homes, respite care, friendly visiting services, and religious and civic groups that provide services.

Discharge planning provides important opportunities for advocates to assist patients in arranging post-hospital services in settings of choice. These opportunities involve developing both administrative and court initiatives to assure the Centers for Medicare & Medicaid Services (CMS) appropriately implements federal discharge-planning requirements and policies through its interpretive and enforcement mechanisms. The work of advocates also involves collaboration with ombudsmen, other community advocates, discharge-planning staff of Medicare-participating hospitals, and researchers in transitions.

While acknowledging that the process of discharge planning, including the patient evaluation and the development of the plan, should be continuous, advocates have suggested that the Secretary must be more specific about when the discharge-planning process should begin. Absent specific timeliness requirements, discharge planning is often a “last-minute” exercise and options for post-hospital care are not fully explored. The Secretary has acknowledged that sufficient opportunity for the involvement of family and friends in the consideration of post-hospital needs and options is important.

A. Discharge Planning Across Care Settings

1. The Acute Care Hospital Setting

(a). Notice and Quality Improvement Organization (QIO) Review

When concerned that a discharge from a Medicare participating hospital is too soon or without the necessary post-hospital services having been arranged, one should contact the local Quality Improvement Organization (QIO) and file a complaint. The hospital discharge notice should provide the name, address, and phone number of the QIO serving the hospital, along with instructions on how to file a complaint.¹

¹ See, 42 C.F.R. §§412.42-412.48. When the QIO or hospital makes a determination whether an inpatient hospital stay is medically necessary, it must make an individualized assessment of the patient’s need for skilled nursing facility care. If the patient requires skilled nursing facility care, the QIO or hospital must determine whether there is a bed available to the

For persons in a hospital that is part of a managed care plan, also known as a Medicare+Choice Organization (MCO), or “Medicare Advantage”(as re-designated in the Medicare Modernization Act 2003)², the MCO, or the hospital that has been delegated the authority to make the discharge decision, must provide the beneficiary with written notice of non-coverage when the beneficiary disagrees with the discharge decision; or the MCO, or the hospital that has been delegated the authority to make the discharge decision, is not discharging the individual but no longer intends to continue coverage of the inpatient stay.³

(b). Notice of Non-coverage and Important Time Frames

CMS takes the position that the “Important Message from Medicare,” is the only written notice that an inpatient will receive about his or her rights unless, upon being told that he or she is about to be discharged, and the inpatient disagrees. If the patient disagrees, he or she will be given a notice of non-coverage with specific information about the basis of the hospital’s discharge decision and appeal rights. An enrollee is entitled to coverage until at least noon of the day after the above notice is provided.⁴

If the beneficiary requests immediate QIO review of non-coverage of inpatient hospital care, coverage is extended as authorized by that section provided that the enrollee submits a request for immediate review to the QIO that has an agreement with the hospital. The request must be in writing or by telephone and must be submitted by noon of the first working day after the beneficiary receives written notice that the Medicare+Choice Organization (MCO) or hospital has determined that the hospital stay is no longer necessary; the QIO must make a determination and notify the enrollee, the hospital, and the MCO by close of business of the first working day after it receives all necessary information from the hospital, or the organization, or both.⁵

Before providing a notice of non-coverage, the entity making the non-coverage/discharge determination must obtain the concurrence of the physician who is responsible for the

patient in a participating skilled nursing facility in the community or local geographic area. *See, 42 C.F.R. §§424.13(b)(1), 412.42(c)(1).*

² See, Pub. L. No. 108-173, §201(a) of the Medicare Modernization Act of 2003 (MMA).

³ See, 42 C.F.R. § 422.620(a)(2).

⁴ See, 42 C.F.R. §422.622.

⁵ See, 42 C.F.R. §422.620(b).

beneficiary's inpatient care.⁶ Written notice of non-coverage must be issued no later than the day before hospital coverage ends. The written notice must include:(1) the reason why inpatient hospital care is no longer needed; (2) the effective date and time of the enrollee's liability for continued inpatient care; (3) the enrollee's appeal rights; and (4) additional information specified by CMS.⁷

(c). Hospital Notice

Persons in the traditional Medicare fee-for-service program are also entitled to notice when their Medicare-participating hospital determines that the hospital stay is no longer medically necessary and the hospital intends to charge them for any continued stay under the following conditions: (1) the hospital determines that the beneficiary no longer requires inpatient care (including a patient awaiting placement in a skilled nursing facility (SNF) level bed when acute care is no longer necessary); (2) the attending physician agrees with the hospital's determination in writing; or; (3) if the physician disagrees with the hospital's decision, the hospital may request an immediate QIO review of the case and concurrence by the QIO in the hospital's determination will serve in lieu of the physician's agreement; and (4) the hospital notifies the beneficiary in writing that: (a) in the hospital's opinion, and with the attending physician's concurrence, or that of the QIO, the beneficiary no longer requires inpatient hospital care; (b)customary charges will be made for continued hospital care beyond the second day following the date of the notice;(c) the QIO will make a formal determination of the validity of the hospital's finding if the beneficiary remains in the hospital after he or she is liable for charges; (d) the determination of the QIO made after the beneficiary received purportedly non-covered services will be appealable by the hospital, the attending physician, or the beneficiary under QIO Medicare Part A appeals procedures affecting Medicare Part A payment.⁸

(d). Hospital QIO Appeal

An inpatient of a Medicare participating hospital has a right to an appeal to the QIO of a hospital's notice of non-coverage as follows: if a beneficiary files a timely request for reconsideration of an initial denial determination, the QIO must complete its reconsideration determination and send a written notice to the beneficiary within the following time limits - within three (3) working days after the QIO receives the request for reconsideration if (i) the beneficiary is still an inpatient in a hospital for the stay in question when the QIO receives the request for reconsideration; (ii) the initial determination relates to institutional services for which admission to the institution is sought, the initial determination was made before the a patient was admitted to the institution, and a request was submitted timely for an expedited reconsideration; within ten

⁶ See, 42 C.F.R. §422.620 (c).

⁷ Ibid.

⁸ See, 42 C.F.R. § 412.42(c)(1)-(4).

(10) working days after the QIO receives the request for reconsideration if the beneficiary is still an inpatient in a SNF for the stay in question when the QIO receives the request for reconsideration; or within thirty (30) working days after the QIO receives the request for reconsideration if - (i) the initial determination concerns ambulatory or noninstitutional services; (ii) the beneficiary is no longer an inpatient in a hospital or SNF for the stay in question; or (iii) the beneficiary does not submit a request for expedited reconsideration timely.⁹

(e). Discussion of Post-hospital Needs

Before leaving the hospital, it is important to make sure that the hospital has discussed with the beneficiary and his or her family member(s) all post-hospital care needs and that a post-hospital plan of care and services has been developed before discharge. Particular vigilance is necessary to ascertain whether the patient's discharge plan identifies the services that are needed and how those services will be provided. Beneficiaries should also request assistance in assuring that necessary services are put in place prior to discharge.

2. *The Nursing Facility Setting*

(a). Resident Assessment

Skilled nursing facilities (SNFs) and nursing facilities (Nfs) are required to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment.¹⁰ Facilities also assess the resident's discharge potential, an assessment of the facility's expectation of discharging the resident from the facility within the next 3 months.¹¹

(b). Discharge Planning

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.¹² Resident records should contain a final resident

⁹ See, 42 C. F.R. § 478.32.

¹⁰ See, 42 C.F.R. §483.20(b).

¹¹ See, 42 C.F.R. §483.20(b)((xvi).

¹² See, 42 C.F.R. §483.12(a)(7).

discharge summary that addresses the resident's post-discharge needs.¹³

Facilities are required to develop a post-discharge plan of care that is developed with the participation of the resident and his or her family, to assist the resident in adjusting to his or her new living environment. This requirement applies to discharges to a private residence, to another nursing facility, or to another type of residential facility such as board and care¹⁴

Post-discharge plan of care means the discharge planning process which includes assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community.¹⁵

Questions to explore in assessing whether a facility has provided appropriate post-discharge planning include : (1) does the discharge summary have information pertinent to continuing care for the resident; (2) is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (*e.g.*, the next 7-14 days); (3) do discharge plans address necessary post-discharge care; (4) did the facility aid the resident and his/her family in locating and coordinating post-discharge services; and, (5) what types of pre-discharge preparation and education has the facility provided the resident and his/her family.¹⁶

(c). Avoiding the Medical Improvement Trap

Skilled nursing services include observation and assessment of a patient's medical condition. A frail or chronically ill person need not show deterioration or medical setback in order to justify skilled nursing observation and assessment, including the observation and assessment of acute psychological problems in addition to physical problems.¹⁷ The Medicare program recognizes maintenance therapy as a legitimate aspect of skilled care services provided in a SNF. Coverage cannot be denied merely because a beneficiary has no restoration potential or has achieved insufficient progress toward medical improvement.¹⁸

¹³ See, 42 C.F.R. §483.20(1).

¹⁴ See, 42 C.F.R. §483.20(1).

¹⁵ See, 42 C.F.R. §483.20(1).

¹⁶ See Long-Term Care and Resident Assessment Surveys. State Operations Manual Transmittal No. 8, May 1, 1999, Medicare and Medicaid: SNF Surveys, F284.

¹⁷ See, 42 C.F.R. §§409.31(b)(1)-(5); 409.32; 409.33.

¹⁸ See, 42 C.F.R. §409.32(c).

(d). Notice of Admission

The Nursing Home Reform Law does not require that a facility provide a beneficiary a notice of denial of admission. The Nursing Home Reform Law prohibits certain discriminatory admissions practices (*e.g.*, waiving rights to Medicare, requiring written or oral assurance that the individual is not eligible for and will not apply for Medicare or Medicaid, requiring third-party guarantee of payment) and requires that facilities display prominently in the facility information about how to apply for and use Medicare benefits.¹⁹

(e). Prospective Payment and Access

As a practical matter, with respect to admissions, some skilled nursing facilities – in response to Medicare’s Prospective Payment System (PPS) for Nursing Facilities, (Resource Utilization Groups (RUG-III) criteria) – are evaluating potential patients before formal hospital discharge and making admission decisions based on the beneficiary’s likely RUG-III categorization. Patients in these circumstances do not get a notice of a denial of admission and in fact may not even know that they have been evaluated for purposes of a skilled nursing facility admission. Note: The PPS RUG-III system does not change Medicare SNF criteria for admission or services. In addition, the failure to be placed in a high RUGs category does not automatically mean that the beneficiary would be denied SNF coverage under Medicare.²⁰

(f). Transfer of Patient to Non-skilled Bed

If a skilled nursing facility determines that a resident no longer qualifies for Medicare-covered skilled nursing services and wishes to transfer the patient to a non-Medicare certified bed, it must give the beneficiary a transfer notice, explaining appeal rights and the steps to take to exercise the right of appeal.²¹

(g). Refusal of Transfer

A Medicare beneficiary has the right to refuse a transfer from a portion of the facility that is a

¹⁹ See, 42 U.S.C. §1395i-3(c)(5)(A); 42 C.F.R. §§483.12(d)(1), (2).

²⁰ See, Pub. L. No. 105-33 (Aug. 5, 1997) §4432(a), amending §1888 of the Social Security Act, by adding subsection (e), 42 U.S.C. §1395yy, effective on or after July 1, 1998. See also, 42 C.F.R. §413.330 *et seq.*

²¹ See, 42 C.F.R. §483.12(a).

skilled nursing facility to a portion that is not a skilled nursing facility.²²

(h). Bed-hold Policies and Readmission

The Medicare law does not provide for holding beds as does Medicaid. However, under Medicaid, when a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the facility's bed-hold policies. The policies must be consistent with the provisions of the state Medicaid plan regarding bed-hold.²³

The Medicare law does not guarantee readmission rights for a Medicare beneficiary who is hospitalized. There is, however, a right of readmission under Medicaid law for Medicaid beneficiaries whose hospitalization or therapeutic leave exceeds the period paid by the state for bed-hold if the Medicaid beneficiary requires the facility's services. The right of readmission is an immediate right to the first available bed in a semi-private room.²⁴

(i). Demand Bills

If a SNF decides that Medicare will no longer cover an item, service, or procedure and the facility wishes to bill the beneficiary, it must give the beneficiary written notice of non-coverage, including information about the right to request an appeal of the facility's non-coverage decision and the steps to take to exercise that right.²⁵

If the beneficiary does not agree with the facility's non-coverage decision, he or she may request that the SNF submit the bill to Medicare *even when* the facility believes that services will not be covered by Medicare. This submission is called a "demand bill" or "no-payment bill." Demand bills are required to be submitted at the request of the beneficiary. The facility cannot bill the beneficiary for the disputed charges until the Medicare fiscal intermediary issues a formal claims

²² See, 42 U.S.C. §1395i-3(c)(1)(A)(x); 42 C.F.R. §483.10(o).

²³ See, 42 U.S.C. §1396r(c)(2)(D); (42 C.F.R. §483.12(b).

²⁴ See, 42 U.S.C. §1396r(c)(2)(D).

²⁵ See, 42 U.S.C. §1395pp (waiver of liability provisions); 42 C.F.R. §411.100 *et seq.*; Sarrassat v. Sullivan, Medicare and Medicaid Guide (CCH), ¶38,504 (N.D. Cal. 1989), HCFA Ruling 95-1 (Dec. 22, 1995); Medicare's Claims Processing manual, CMS Pub, 100-4, 30-§30.1 (establishing when the beneficiary is on notice of non-coverage); §30-§30.40.2 (presumption that beneficiary did not know services were not covered unless there is evidence of written notice to the beneficiary).

determination.²⁶

(j). HMO Issues

Medicare+Choice organizations (“Medicare Advantage” organizations under the Medicare Modernization Act 2003²⁷) are obligated to provide the same coverage for SNF services and Part B services as are provided under traditional Medicare.²⁸ Medicare+Choice Organizations must also provide written notice if SNF coverage will terminate and must allow opportunity for an appeal.²⁹ Beneficiaries and their advocates should consider requesting expedited review of termination decisions.³⁰ Medicare+Choice organizations and their skilled nursing facilities may want to discharge beneficiaries when Medicare coverage ends.

3. *The Home Health Care Setting*

Discharge planning rights in the home health care arena are not developed as they are in the hospital and nursing facility context. In many instances, the absence of services in the home results in nursing home placement or other forms of institutional placement. For others, it means continuing on at home under adverse circumstances with little or no support where there is an absence of family or friends willing and/or able to provide assistance.

In home health care, the appropriate focus of advocacy is keeping services in place. Central to doing so is obtaining notice from the home health provider agency about contemplated denials, reductions, or terminations of services. This notice should provide an opportunity for discussion and negotiation with the home health agency, necessary appeals, and collaboration with the beneficiary’s physician.

In addition to assuring that their Medicare rights are protected, beneficiaries should explore other sources of coverage where Medicare home health coverage is in question. Private health care coverage, services under the Older Americans Act, Medicaid, and other home and community

²⁶ See, Sarrassat v. Sullivan, Medicare and Medicaid Guide (CCH), ¶38,504 (N.D. Cal. 1989).

²⁷ Pub. L. No. 108-173, §201(a) of the Medicare Modernization Act of 2003 (MMA).

²⁸ See, 42 C.F.R. §422.101.

²⁹ See, 42 C.F.R. §422.560 et seq.

³⁰ See, 42 C.F.R. §422.584.

based health care may be useful options. (Advocates and beneficiaries should contact the **Eldercare Locator** identified at the beginning of this writing for an exploration of local options.³¹)

(a). Prospective Payment and Access to Services

Effective October 1, 2000, the Medicare program moved to a Prospective Payment System (PPS) for home health care. Under this system, home health providers are paid on the basis of 60-day episode of care in accordance with standard payment amounts.³²

Prospective payment does not change Medicare eligibility criteria for the home health care benefit. Nonetheless, PPS for home health relies on a patient assessment instrument, the Outcome and Assessment Information Set (OASIS), as part of the process of establishing a case-mix index to determine the PPS amount the Home Health Agency will be paid for each patient.³³ The use of the assessment process to set payment raises significant issues about the relationship of payment criteria, access to services, and eligibility. When a Home Health Agency (HHA) accepts a patient, it must perform an OASIS assessment of the patient.³⁴

The case mix index organizes the OASIS data elements into three dimensions – clinical severity, functional severity, and services utilization – and assigns score values for each dimension. CMS has developed a computer program that sums up the patient’s scores within each of the three dimensions and assigns them a severity level. The four clinical severity levels, five functional severity levels, and four service utilization severity levels result in 80 possible combinations, each of which defines a group for the case-mix system. Each patient is assigned to a home health resource group (HHRG) based on the combination of his or her severity levels.³⁵

(b). Notice Generally

The Medicare program requires each participating home health agency to provide its Medicare home health patients with: (1) information in advance about the care and treatment to be provided

³¹ In addition, advocates may wish to review the National Senior Citizens Law Center’s *Planning Care At Home: A Guide for Advocates and Families.*, see, <http://www.nsclc.org>.

³² See, 42 U.S.C. §1395fff, 42 C.F.R. §484.200 *et seq.*

³³ See, 42 C.F.R. §§484.210, 484.215, 484.220.

³⁴ See, 42 C.F.R. §484.250.

³⁵ See, Home Health PPS final regulations, 65 Fed. Reg. 41128, at 41192-41203 (July 3, 2000).

by the agency; information about any changes in the care or treatment to be provided by the agency that may affect the individual's well-being; and (except with respect to an individual adjudged incompetent), information about participation in planning care and treatment or changes in care or treatment; and (2) the right to be fully informed orally and in writing (in advance of coming under the care of the agency) of any changes in the charges for items of services to be provided, as well as the beneficiary's rights and entitlements under Medicare.³⁶ The Secretary is obligated to enforce notice and appeal rights of home health beneficiaries through several means, including intermediate sanctions and terminating the home health agency as a Medicare-certified agency.³⁷

(c). **Healey v. Shalala** (Notice and appeal rights in home health care)

The United States Court of Appeals for the Second Circuit has held that home health agencies (HHAs) must provide written notice before reducing or terminating services, regardless of the reasons for the action.³⁸ The district court had recognized the right to notice only when the HHA was making a coverage determination, and had denied the request for a pre-deprivation review process.³⁹

³⁶ See, 42 U.S.C. §1395bbb(a)(1)(A); 42 C.F.R. §484.10((c)(1) and (2); HCFA Pub. 11, §265.1 (the Home Health Manual).

³⁷ See, 42 U.S.C. §1395bbb(e)(2).

³⁸ See, Lutwin v. Thompson, No. 01-6269 (2d Cir., Feb. 26, 2004). Previously known as Healey v. Thompson .

³⁹ Healey v. Thompson, 186 F.Supp.2d 105 (D.Conn. 2001). As part of the government's response in Healey and in its effort to implement PPS in home health care, HCFA published a set of advanced beneficiary notices (65 Fed. Reg. 57821 (September 29, 2000)). The notices require home health agencies to provide certain information to beneficiaries explaining when services will be terminated, the reason for the termination, and explaining the beneficiary's right to appeal. This set of notices did not contain instructions on a process for review.

On September 29, 2000 CMS sent to its Regional Home Health Intermediaries (RHHIs) an instruction Bulletin saying that home health agencies must provide notice, including information about the demand bill process and how to use it. (Bulletin available from the Center for Medicare Advocacy, Inc.) The Bulletin also refers to CMS' program instructions PMs A-99-52 and A-99-54 as remaining in effect which describe the demand bill process. (Advocates should check the CMS website at www.hcfa.gov/regs/prdact95htm for information about the CMS Home Health Advance Beneficiary Notices (HHABNs). (See also 65 Fed. Reg. 59858 (Oct. 6, 2000), for HCFA's further statement that its requirements outlined in PMs A-99-52 and A-99-54 remain in effect with respect to the demand bill process.)

On appeal, the plaintiffs, who consisted of numerous individual home health beneficiaries from around the country and a nationwide class whom they represented, argued that both the Medicare statute at 42 U.S.C. § 1395bbb(a)(1)(E) and the due process clause required written notice before any discharge or termination. The majority of the three-judge panel agreed, concluding that the statute unambiguously required written notice in all terminations or cutbacks, not just in those involving alleged coverage determinations. One judge dissented, contending that the statute was ambiguous and that therefore the court should defer to the Secretary's interpretation. All three members of the panel, however, upheld the district court's refusal to view the due process clause as requiring pre-deprivation review. The burden to the government, the court said, outweighed the risk of erroneous deprivation.

(d). Notice under the Perspective Payment System (PPS)

Beneficiaries and their advocates should remain vigilant in this emerging PPS system. Changes in health status or other patient circumstances occurring within a 60-day episode of care should trigger notice to the beneficiary. CMS responded in its pleadings in *Healey v. Shalala* that notice and appeals rights are not affected by PPS and that the same notice and appeals processes currently in place apply, including the demand bill process.

(e). Physician Orders

It is important to work with physicians and advocacy groups to assure that detailed orders for home health care services are prepared; that physicians fully understand that physician-ordered services are not to be terminated by home health agencies without the consent of the treating physician. Advocates and others should demand that home health agencies provide the HHABNs and report agencies to the RHHIs when they do not. To the extent possible, it is important to provide physicians and home health agencies with information that supports Medicare coverage when coverage issues may be questioned and before a notice of non-coverage is submitted. Similarly, patients should be encouraged to use the demand bill process where feasible, keeping in mind that the issue of paying for services pending an appeal will be difficult for many beneficiaries. Patients should appeal home health care coverage denials and enlist physician support in the form of detailed statements about the need for coverage.

III. Discharge Planning As a Condition of Participation Under the Medicare Program

On December 13, 1994, the Secretary of Health and Human Services (HHS) published as Conditions of Participation final Medicare discharge-planning rules that hospitals must meet in order to

participate in the Medicare program.⁴⁰ It is important to talk about the contents of the rules in some detail. The rules provide a framework for understanding the scope of discharge planning under the Medicare statute. The rules provide a useful frame for developing and evaluating strategies to make discharge planning a more finely honed tool toward good transitions.⁴¹ The requirements are set out below.

A. Discharge planning: General Requirement

The hospital must have in effect a discharge planning process that applies to all patients. The policies and procedures for discharge planning must be specified in writing.

The statute requires Medicare-participating hospitals to have a discharge-planning process for Medicare patients. Using the broad authority conferred on her by the Social Security Act,⁴² the

⁴⁰ 59 Fed. Reg. 64141 et seq. (Dec. 13, 1994)(codified at 42 C.F.R §482.43). The regulations became effective on January 12, 1995. Discharge-planning requirements are included in the Social Security Act, §§1861(e),(ee), codified at 42 U.S.C. §1395x(ee). The discharge planning regulations were added to the statute by the Omnibus Budget Reconciliation Act of 1986. (OBRA'86), Pub. L No . 99-509, §9305(c), 100 Stat. 1989 (Oct. 21, 1986). The proposed regulations are located at 53 Fed. Reg. 22506 et seq. (June 16 1988). The State Operations Manual includes interpretive guidelines and survey procedures for the Conditions of Participation (COPs) for hospitals. See, State Operations Manual, Appendix A, HCFA. Pub. 7, Transmittal No. 283, revised August 1, 1997, effective September 12, 1997. See also, Medicare/Medicaid Hospital Survey Report form, CMS-1537(1-97), pp. 4-6. This form is used by surveyors in the review of Conditions of Participation.

Interpretive guidelines, while not having the force and effect of law or rules promulgated pursuant to the Administrative Procedures Act (APA), 5 U.S.C. §553(b)(3)(A), are given weight and consideration by courts in disputes about an agency's interpretation of the statutes it administers. Friedrick v. Secretary of HHS, 894 F.2d 829 (6th Cir. 1990); Linoz v. Heckler, 800 F.2d 829, 871 (9th Cir. 1986).

⁴¹ The material in this section expands and updates an article on the Medicare discharge planning regulations as an advocacy tool prepared by Alfred J. Chiplin, Jr., in 1995 for the Clearinghouse Review for Legal Services (now the Journal of Poverty Law and Policy). See, 29 Clearinghouse Review 152-161 (June 1995).

⁴² The Secretary's statement of authority, 59 Fed. Reg. 64143 (Dec. 13, 1994), is not apparent from the language of §§1861(c) and 1861(ee) of the Social Security Act. It is her view that §1861(ee) gives her the authority to include standards and guidelines beyond those explicitly

Secretary of Health and Human Services, Donna Shalala, extended this provision to all hospital patients, encompassing the sweep of discharge planning practices of most hospitals,⁴³ and their accrediting bodies.

Later the Secretary issued interpretive guidelines, Tag Number A330, Subpart C, §483.43, that provide that the discharge plan must be revealed in a thorough, clear, comprehensive process that is understood by the hospital staff. The applicable survey procedures and probes require surveyors⁴⁴ to review a hospital's written policies and procedures to determine the existence of a discharge planning process. Surveyors interview a sample of hospital staff who are involved in direct patient care, and ask how discharge planning is conducted at a given hospital and how staff is kept apprised of the hospital's policies and procedures for discharge planning.⁴⁵

B. Identification of Patients in Need of Discharge Planning

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

Many advocates express concern about how and when patients in need of discharge-planning services are identified. Some advocates suggest that the Secretary adopt specific criteria such as age, functional ability, psychological factors, etc., for determining who needs a discharge-planning evaluation. Instead, the Secretary has asserted that hospitals should have flexibility in this regard. For the Secretary, the "early stage" of hospitalization, for discharge planning purposes, presupposes

enumerated in the statute. 59 Fed. Reg. 64143 (Dec. 13, 1994). The Secretary's view is that the reference in §1861(e)(9) to the "health and safety of individuals who are furnished services in the institution" supports her extension of the provision to all patients of a Medicare-participating hospital. 59 Fed. Reg. 64144 (Dec. 13, 1994).

⁴³ The Secretary finds that the discharge-planning standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association (AOA) apply to all patients. 59 Fed. Reg. 64143 (Dec. 1994). Note, however, it is the view of the JCAHO that it does not have "deemed status" with respect to compliance with its discharge planning standards being "deemed" compliance with Medicare's discharge planning requirements. See, 42 U.S.C. §1395bb(a)(2)(B), (a)(3); §1395x(e)(6)(B). These provisions carve out discharge planning as an exception to JCAHO deemed status.

⁴⁴ Surveys are performed by the surveyors who evaluate other Conditions of Participation for Medicare-participating hospitals, skilled nursing facilities, and home health agencies. To date, surveyors give little attention to the discharge planning process.

⁴⁵ See, footnote 40, *supra*, and State Operations Manual, Appendix A, HCFA. Pub. 7, Transmittal No. 283, revised August 1, 1997, effective September 12, 1997, §482.43.

a hospital admission. Thus, in the Secretary's view, the discharge-planning requirements do not apply to a person who is treated in an emergency room without an admission.⁴⁶

The discharge-planning evaluation process may be initiated by persons other than hospital staff; patients and/or their representatives may request a discharge-planning evaluation.⁴⁷ As discussed below, the actual discharge plan is developed on the basis of the findings of the discharge-planning evaluation. Physician involvement is presupposed.⁴⁸

Medicare's standard for identification of patients in need of discharge planning is limited to those persons identified at an early stage of hospitalization who are likely to suffer adverse consequences upon discharge if there is no adequate discharge planning. In interpretive guidelines, Medicare hospitals are afforded great flexibility in setting the criteria for identifying these patients. In doing so, the guidelines note that presently there is no nationally accepted tool or criteria for identifying these individuals. Patients at high-risk of requiring post-hospital services must be identified through a screening process. For those patients, the following factors have been identified as important: functional status, cognitive abilities, and family support.

Medicare participating hospitals are required to reevaluate the needs of the patients on an ongoing basis and prior to discharge. This is in recognition that needs may change based on the individuals' status; that there is no set time frame for identification of patients requiring a discharge planning evaluation; and that the identification of patients must be done as early as possible, with the timing of the evaluation left up to the hospital, its staff, and the patient's attending physician.

As part of their evaluation process, hospitals must have a high-risk screening procedure. Surveyors ask how the high-risk screening process works; what staff are involved; who is ultimately

⁴⁶ 59 Fed. Reg. 64145 (Dec. 13, 1994).

⁴⁷ 42 C.F.R. §482.43(b)(10).

⁴⁸ 59 Fed. Reg. 64147 (Dec. 13, 1994)(preamble); 42 C.F.R. §482.43(c)(2)(a discharge plan must be developed if the discharge evaluation indicates the need for it, or upon the request of the physician).

accountable; and how the procedure is evaluated to make sure patients are appropriately evaluated.⁴⁹

C. Discharge-Planning Evaluation

1. The Evaluation Requirement

The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of 42 C.F.R. §482.43 and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or at the request of a physician.

The discharge-planning evaluation is different from the discharge plan. The evaluation is an assessment that looks at the patient's physical and mental condition, the likely post-hospital living situation, and the patient's ability to engage in such daily living activities as eating, dressing, bathing, and ambulating. The plan, including the type of setting to which the patient is to be discharged, focuses on the medical and social support needs of the patient in that setting.

The Secretary has not established a specific format for the evaluation, although the work of the Secretary's Advisory Panel on Needs Assessment, which submitted its report to Congress on June 30, 1992,⁵⁰ is identified as a source to be viewed as possible guidance. The report makes no formal recommendations but states that more work needs to be done on needs-assessment instruments, including field testing to assure administrative feasibility and clinical effectiveness.⁵¹

There is lack of clarity over who can actually cause a discharge plan (distinct from a discharge evaluation) to be written. The regulations establish that the physician has the "last say" as to whether the actual discharge plan is to be written, even if the hospital finds a discharge plan unnecessary. From the Secretary's comment,⁵² it would seem that, if a hospital patient or family member requests a discharge plan but the physician does not agree to the request, there is no way to compel the development of a plan. Patients could, however, consider asking the QIO to review the denial of the

⁴⁹ See footnote 40, *supra*; Interpretive Guidelines, §482.43(a).

⁵⁰ The Advisory Panel on Needs Assessment was created by OBRA '86, Pub. L. No. 99-509, §9305(h), 100 Stat. 1874.

⁵¹ See, Health Care Financing Administration Report of the Secretary's Advisory Panel (Dec. 1992)(Publication No. 10957).

⁵² See, 59 Fed. Reg. 64145 (Dec. 13, 1994).

plan.⁵³ The discharge evaluation would form the basis of any such review. This heightens the need to assure that the discharge-planning evaluation is thorough.

CMS' Interpretive Guidelines provide that the needs assessment can be formal or informal. The hospital may develop an evaluation tool or protocol. Generally, the assessment should include an evaluation of factors that affect an individual's needs for care after discharge from the acute care setting, such as an assessment of biopsychosocial needs, the patient's and care-giver's understanding of discharge needs, and identification of post-hospital care resources. At the present time, nonetheless, there is no nationally accepted standard for this evaluation. The purpose of a discharge planning evaluation is to determine continuing care needs after the patient leaves the hospital setting. It is not intended to be a care planning document.

In evaluating the needs assessment process surveyors: interview a sample of hospital staff and ask how patients are made aware of their rights to request a discharge plan; talk to a sample of patients and family members who are expecting a discharge soon and ask whether the hospital staff assisted them in planning for post-hospital care; ask whether the patient/family express that they feel prepared for discharge; determine whether the patient/family was given the pamphlet, "Important Message from Medicare;" ask whether they are aware that they may request assistance with discharge planning.⁵⁴ Note, however, the current "Important Message from Medicare" does not contain a specific reference to discharge planning. At one time there was such a reference, although it was merely a reference in a list of services available to patients without specific explanation or elaboration.

2. Who Performs the Evaluation

A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

The Secretary has established no specific criteria for nurses, social workers, or other appropriately qualified person who perform discharge-planning and discharge-planning -evaluation services. The lack of such standards, in some instances, raises quality of service concerns. It is the Secretary's position that the agency should, where possible, avoid prescriptive administrative requirements and use of specific details.⁵⁵

⁵³ Some state laws that give beneficiaries additional rights, *e.g.*, New York, Massachusetts, and Connecticut. See, infra.

⁵⁴ See footnote 40, supra; Interpretive Guidelines, §482.43(b)(1).

⁵⁵ 59 Fed. Reg. 64246 (Dec. 13, 1994).

The Secretary's Interpretive Guidelines point out that the responsibility for discharge planning is often multi-disciplinary. There is no restriction to a particular discipline and hospitals have flexibility in designing the responsibilities of the registered nurse, social worker, or other appropriately qualified personnel for discharge planning. The responsible personnel, nonetheless, should have experience in discharge planning, knowledge of social and physical factors that affect functional status at discharge, and knowledge of community resources to meet post-discharge clinical and social needs and assessment skills.

The Interpretive Guidelines also note that ideally, discharge planning will be an interdisciplinary process, involving disciplines with specific expertise, as dictated by the needs of the patient. For example, for a patient with emphysema, the discharge planner could coordinate respiratory therapy and nursing care and financial coverage for home care services, oxygen equipment, and patient/caregiver education utilizing cost effective, available community services in an expedient manner.

Surveyor probes include: a review of the written policy and procedure that designates discharge planning responsibilities; a review of the job description of the designated personnel for discharge planning expectations; asking the designated personnel to describe their qualifications for and experience with discharge planning and evaluating whether they are congruent with the community standard of practice. If licensing is required, current credentials must be on file.⁵⁶

3. Elements of the Discharge-Planning Evaluation

The discharge planning evaluation must include an evaluation of the likelihood of a patient's needing post-hospital services and of the availability of the services.

Issues concerning whether and to what extent a patient will require post-hospital services upon discharge are ongoing. The question is often both a medical- and a social services-needs inquiry. Patients who disagree with a discharge-planning evaluation will need an avenue for review and redress. The discharge-planning Conditions of Participation do not address this concern.⁵⁷

⁵⁶ See footnote 40, supra; Interpretive Guidelines, §482.43(b)(2).

⁵⁷ Note, disagreeing with a discharge plan should not be viewed as refusing discharge-planning services. Documentation of a patient's choice to refuse discharge-planning services should have its own protocol.

In the past, review of discharge planning by QIOs focused not on its substantive content, but on whether the discharge plan was included in the medical record. Absent greater clarification, QIO review will not be useful. Tracking compliance with this provision focuses on an evaluation of documentation of the discharge-planning evaluation and whether the hospital has arranged for initial implementation.⁵⁸

Interpretive Guidelines provide that it is the hospital's responsibility to develop a the discharge plan for patients who need a plan and to arrange its initial implementation. The hospital's ability to meet discharge planning requirements is based on the following: (1) implementation of a needs assessment process with high risk criteria identified; (2) complete, timely, and accurate assessment; (3) maintenance of a complete and accurate file on community-based services and facilities including long term care, subacute care, home care or other appropriate levels of care to which patients can be referred; and (4) coordination of the plan among various disciplines responsible for patient care. The Interpretive Guidelines give the hospital latitude to demonstrate this function in the most efficient way possible.⁵⁹

In evaluating the arranging and initial implementation of discharge planning, surveyors ascertain what process the hospital uses to identify patients who need a discharge plan; whether the hospital uses quality assurance and/or utilization review screens that determine whether the discharge planning process effectively identifies patients in need of plans; and whether the plans are adequate and appropriately executed. The surveyors review clinical records of several patients identified for discharge planning for appropriateness, adequacy, and execution, including asking staff responsible for the patients' care to describe the steps taken to implement the plan initially for the selected patients. The surveyors also ascertain whether various disciplines are involved with discharge planning, including physical, speech, occupational, and respiratory therapists and dietitians, in addition to physicians, nurses, and social workers.⁶⁰

The discharge-planning statutes in New York⁶¹ and Massachusetts⁶² provide useful models to assist beneficiaries in addressing concerns when discharge plans are developed and implemented. Under New York law, patients may not be discharged until the services called for in the discharge plan have been arranged or until they have been reasonably determined to be available in the community. Under

⁵⁸ See footnote 40, *supra*; Interpretive Guidelines, §482.43(b)(3).

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ N.Y. Comp. Codes R. & Regs. Title 10, §§405.22(j) *et seq.*

⁶² Mass. Gen. L. Ch. 111 (amending 51D by inserting §13, ch. 574, of the Acts of 1985).

Massachusetts law, the discharge plan must specify the services to be provided, the names and addresses of the providers, medications and prescriptions, and the follow-up schedule for the patient.⁶³ A review mechanism for disputes about the discharge plan is also provided.⁶⁴

4. Evaluating the Likelihood of Self-Care

The discharge planning evaluation must include an evaluation of the likelihood of a patient's need for self-care or the possibility of patients being cared for in the environment from which they entered the hospital.

It is important to assure that a patient's wishes are given a great deal of weight in the evaluation process even where using a strict medical or clinical model might suggest that the patient's post-hospitalization wishes are not feasible. This is a particular concern where home health care might be more difficult to manage and/or arrange because of the level and frequency of services required.

The Secretary states that the patient's wishes are an integral aspect of the capacity for self-care. Secretary Shalala identified the ability of the patient, the availability and willingness of caregivers, the availability of resources in the community, and the patient's preferences as important considerations;⁶⁵ but that patient preferences are not always realistic due to the physical or mental condition of patients, the availability of community resources, or any combination of these.⁶⁶

The Secretary's Interpretive Guidelines provide that the capacity for self-care includes the ability and willingness for such care; that the choice of a continuing care provider depends on the self-care component, as well as availability, willingness, and ability of family/caregivers and the availability of resources. The hospital must inform the patient of his or her freedom to choose among providers of post-hospital care, where possible. Patient preferences should also be considered; although preferences are not necessarily congruent with the capacity for self-care. Patients should be evaluated for return to the pre-hospital environment, but also should be offered a range of realistic options for consideration for post-hospital care. This includes patients admitted to a hospital from a SNF, who should be evaluated to determine an appropriate discharge site. Similarly, hospitals staff should incorporate information provided by the patient and/or caregivers to implement the process and should

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ 42 C.F.R. §482.43(c)(2).

⁶⁶ Ibid.

determine whether appropriate interdisciplinary input is documented. Also, the surveyors should ascertain whether the patient/or caregiver participated in the needs assessment and decisions for post-hospital care. Further, the surveyors should ascertain whether a patient admitted from a SNF was given a full-range of realistic options for post-hospital continuation of care.⁶⁷

5. Timely Discharge Planning Required

The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge and to avoid unnecessary delays in discharge.

While acknowledging that the process of discharge planning, including the patient evaluation and the development of the plan, should be continuous, advocates have suggested that the Secretary be more specific about when the discharge-planning process should begin. Absent specific timeliness requirements, discharge planning is often a “last-minute” exercise and options for post-hospital care are not fully explored. The Secretary has acknowledged that sufficient opportunity for the involvement of family and friends in the consideration of post-hospital needs and options is important.

Under the Secretary’s Interpretive Guidelines, a patient’s hospital length of stay varies widely. The timing of the discharge evaluation should be related to the patient’s clinical condition and anticipated length of stay. Assessment should start as soon after admission as possible and should be updated periodically during the episode of care. Information about the patient’s age and sex could be collected on admission while functional ability data are best collected closer to discharge, indicating more accurately a patient’s continuing care requirements. Surveyors review several patients’ discharge plans for appropriate coordination of health and social care resources based on the individual patient and caregiver post-hospital needs. They also consider whether there is a pattern of prolonged length of stay for certain patient populations because implementation of post-hospital care was delayed, and if delayed, whether the delay was due to no fault of the hospital, or to poor hospital planning for timely post-hospital arrangements.⁶⁸

6. Documentation of Discharge Planning and Patient Discussion

The hospital must include the discharge planning evaluation in the patient’s medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

⁶⁷ See footnote 40, supra; Interpretive Guidelines, §482.43(b)(4).

⁶⁸ See footnote 40, supra; Interpretive Guidelines, §482.43(b)(5).

Including the discharge-planning evaluation in the medical record also serves as an initial monitoring and enforcement screen for the survey and certification process and demonstrates that at least some assessment of the patient's post-hospital care needs has been made. Discussion of the discharge-planning evaluation with the patient's family members should also be documented. Although this is not an explicit requirement, it should be reviewed in the survey and certification process. The requirement of written policies and procedures for the entire discharge-planning process includes documentation of conversations with family members about the patient's post-hospital needs.⁶⁹

The Secretary's Interpretive Guidelines provide that the hospital must demonstrate its development of discharge plans for patients in need and the initial implementation of the plan. Documentation of these activities is expected, but the hospital has the latitude to demonstrate its compliance in the most efficient way possible. The discharge plan generally can be found in the clinical notes if there is no dedicated form. The hospital will be expected to document its decision about the need for a plan, document the existence of plans when needed, and indicate what steps were taken to implement the plans initially. Evidence of an ongoing evaluation of the discharge planning needs is the important factor.

Documented evidence of discussion of the evaluation with the patient (if possible), interested persons, and the next caregiver should exist in the medical record. Although not mandated, it is preferable that the hospital staff seek information from the patient and family to make the discharge plan as realistic and viable as possible. Surveyor procedures and probes include a review of several clinical records for evidence of a discharge planning evaluation and a thorough review of the clinical record notes and questioning of the patient and/or caregiver and staff, and a verification discussion of the evaluation with the persons involved.⁷⁰

CMS's Transmittal No. A-02-106, October 25, 2002, provides that hospitals should counsel beneficiaries being discharged to home health services, that the primary home health agency will develop the patient's care plan and provide all services. The transmittal goes on to state that hospitals should provide a list of home health agencies for beneficiaries to choose from, and that when referring the beneficiary to his or her chosen home health agency, the hospital should notify the beneficiary that all services will be provided by them at the "primary" home health agency; that hospitals play a key role in making patients and/or their caregivers, aware of Medicare home health coverage policies to help ensure that those services are provided within the appropriate venue.

⁶⁹ 42 C.F.R. §482.43(e).

⁷⁰ See footnote 40, supra; Interpretive Guidelines, §482.43(b)(6).

D. The Discharge Plan

1. Qualified Personnel for Discharge Plan Development

A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

The Secretary has established in Interpretive Guidelines a set of minimum discharge-planning criteria. The Guidelines state that it is a management function of the hospital to ensure proper supervision of its employees; that existing training and licensing requirements of a registered nurse and social worker in discharge planning are sufficient; and that other appropriately qualified personnel may include a physician. The hospital should determine who has the requisite knowledge and skills to do the job regardless of how these skills were acquired. However, because post-hospital services and ultimately, the patient's recovery and quality of life can be affected by the discharge plan, the plan should be supervised by qualified personnel to ensure professional accountability. Surveyor procedures and probes include an examination of the patients' clinical records for references to a registered nurse, social worker, or other designated qualified personnel or their signature on a written discharge plan notation.⁷¹

2. Physician Request for Discharge Plan

In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

The rule requires that the physician command the actual development of the discharge plan. Without the physician's consent, no plan (distinct from the discharge evaluation) has to be developed. This places the physician and the patient (or patient representative) in potentially adversarial positions and highlights the importance of the needs-assessment process in determining who might be at risk absent discharge-planning services.

The Secretary's Interpretive Guidelines provide that the physician can make the final decision whether

⁷¹ See footnote 40, supra; Interpretive Guidelines, §482.43(c)(1).

a discharge plan is necessary. The hospital will develop a plan if a physician requests one even if the interdisciplinary team had determined one to be unnecessary. Surveyor procedures and probes include the review of the hospital policy and procedure to determine who may request a discharge plan; whether there is a reference to or the existence of a discharge plan in the clinical record when requested by a physician; and that the surveyors are to ask a physician involved with discharge planning about experiences with requesting development of discharge plans when the interdisciplinary team does not recommend a plan.⁷²

3. Hospital to arrange services

The hospital must arrange for the initial implementation of the patient's discharge plan.

The initial implementation of the discharge plan may include any necessary reassessment, based on changed circumstances, of the patient's discharge-planning evaluation. Initial implementation questions focus on whether necessary post-hospital services are in fact in place and on the responsibility of the hospital to ascertain whether those services are in fact available and being provided. The Secretary's comments on initial implementation focus on arranging services and transferring and referring patients.⁷³ These functions do not necessarily presuppose assuring that services are actually in place. Hospitals should keep accurate information on community long-term care services and facilities so that they can advise patients and their representatives of their options.⁷⁴

The Secretary's Interpretive Guidelines require the hospital to arrange for the initial implementation of the discharge plan. This includes arranging for necessary post-hospital services and care, and educating patients, families, caregivers, and community providers about post-hospital care plans. The surveyor procedures and probes require documented evidence of implementation of the discharge plan, including contact and transmission of information to the patient (when possible) and the next caregiver.⁷⁵

4. Reassessing the Discharge Plan

⁷² See footnote 40, *supra*; Interpretive Guidelines, §482.43(c)(2).

⁷³ See, 42 C.F.R. §482.43(c)(3); 42 C.F.R. 482.43(d.)

⁷⁴ Ibid.

⁷⁵ See footnote 40, *supra*; Interpretive guidelines, §482.43(c)(3).

The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

The Secretary requires reassessment, as needed, on the basis of the continuing care needs of the patient and the appropriateness of the discharge plan. The rules do not specify when reassessment is to occur. Some advocates suggest that the regulations specify that patients' discharge plans must be reassessed before discharge.

The Secretary's Interpretive Guidelines provide that the discharge planning evaluation is initiated as soon as possible after admission and updated as changes in the patient's condition and needs occur, and, as close as possible to the patient's actual discharge. Survey procedures and probes provide that several clinical records are reviewed for evidence of reassessment of the patient and related changes with regard to the care plan/critical pathway(s) in the discharge plan when warranted. Surveyors ask staff involved with discharge planning to discuss the reassessment process and/or present a clinical record that documents reassessment.⁷⁶

5. Pre-discharge Counseling

As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

Counseling as envisioned by this provision occurs on an as-needed basis. The rule requires hospital discharge-planning staff and the physician to determine whether and under what circumstances counseling services are necessary before discharge. Advocates should watch this process carefully to ensure that patients and their representatives receive counseling before discharge.

The Secretary's Interpretive Guidelines provides that evidence should exist that the patient and/or family and/or caregiver is/are provided information and instructions in preparation for post-hospital care and is/are kept informed of the process; that hospital personnel are in the best position to judge the appropriate time for such guidance; that use of family caregivers in providing post-hospital care should occur when the family is both willing and able to do so; that if appropriate community resources with or without family support should be used whenever necessary. Survey procedures and probes provide that where possible, surveyors interview patients and their family members to determine whether they have been instructed in post-hospital care, e.g., medication administration, dressing change, and cast care (for example, broken bones). If the patient is being transferred to an alternative care delivery setting, surveyors inquire whether this information has

⁷⁶ See footnote 40, supra; Interpretive Guidelines, §482.43(c)(4).

been shared with the patient and whether there is documentation that care instruction has been communicated to the post-hospital care setting.⁷⁷

E. Transfer and Referral

The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

As described above, the Secretary's response to comments on the proposed regulations acknowledges the lack of explicit authority to require hospitals to follow through and actually discharge or transfer the patient to facilities or outpatient services. However, finding that this authority is implicit in the purpose of the legislation – to assure proper post-hospital care – the rules require that hospitals keep accurate records of post-hospital services available in the community for use in counseling patients about their post-hospital care options and in evaluating the ongoing discharge-planning and reassessment process.⁷⁸

The Secretary's Interpretive Guidelines provide that a hospital must ensure that patients receive proper post-hospital care within the constraints of a hospital's authority under State law and within the limits of a patient's right to review discharge planning services. If a patient exercises the right to refuse discharge planning or to comply with a discharge plan, documentation of the refusal is recommended.⁷⁹ The survey procedures and probes include asking staff involved with discharge planning to describe the process of transfer of patient information from the hospital to a post-discharge facility; determining whether the process assures continuity of care; determining whether the patient's rights, such as for confidentiality, refusal, and preference are considered; if required, determining whether there is evidence of written authorization by the patient before release of information.⁸⁰

As pointed out by Robert A. Berenson and Jane Horvath, many Medicare beneficiaries leaving the

⁷⁷ See footnote 40, supra; Interpretive Guidelines, §482.43(c)(5).

⁷⁸ Ibid.

⁷⁹ "Medical information" may be released only to authorized individuals according to §482.24(b)(3). Examples of necessary information include functional capacity of the patient, requirements for health care services/procedures, discharge summary, and referral forms. "Appropriate facilities" refers to facilities that can meet the patient's assessed needs on a post-discharge basis and that comply with Federal and State health and safety standards.

⁸⁰ See footnote 40, supra; Interpretive Guidelines, §482.43(d).

acute hospital setting need chronic care management services in a post-hospital setting.⁸¹ As currently constituted, the Medicare program does not provide a reimbursement incentive for providers of care to more fully embrace care management as an aspect of transitions through the provision of services in a comprehensive and systematic fashion. Rather, the services that are provided are fragmented and incomplete, leading to repeated re-hospitalizations, worsening health conditions, and more costly down-stream interventions. Moreover, those services provided, such as patient education, are often provided by non-physician personnel, unless provided in accordance with Medicare's narrow definition of services 'incident to' physician services (i.e., generally furnished in physicians' offices and commonly rendered without charge or included in the physicians' bill). In addition, Berenson and Horvath note that changes in Medicare's Traditional Fee-for-Service (FFS) law to address these concerns are complicated, replete with unintended consequences, and should be approached cautiously. They suggest a modification of the home health care benefit under Medicare as a way to address this critical beneficiaries' need for post-acute care management services.⁸²

F. Reassessment

The Secretary notes that the overall regulation of discharge planning requires written policies and procedures for the entire discharge-planning process and that hospitals must develop written procedures for their reassessment process.⁸³

The Secretary's Interpretive Guidelines provide that the hospital must have a mechanism in place for ongoing reassessment of its discharge planning process. Although specific parameters or measures that would be included in a reassessment are not required, the hospital should assure the following factors in the reassessment process: (1) timely effectiveness of the criteria to identify patients needing discharge plans; (2) the quality and timeliness for discharge planning evaluations and discharge plans; (3) the hospital discharge personnel; maintaining complete and accurate information to advise patients and their representatives of appropriate options; and (4) the hospital's coordinating the discharge planning process with other functional departments, including the quality assurance and utilization review activities of the institution, and involving various disciplines. Survey procedures and probes include: reviewing hospital policies and procedures to determine how often the discharge planning process is reassessed; asking hospital staff how often

⁸¹ Berenson, RA, Horvath, J, "Confronting the Barriers to Chronic Care Management In Medicare," Health Affairs, 22 January 2003; http://www.healthaffairs.org/WevExclusives/Berenson_Web_Excl_0.

⁸² Ibid.

⁸³ 42 C.F.R. §483.43.

the discharge planning process is reassessed, including what data are examined to determine how well the process works in providing for continued care of the patient.⁸⁴

IV. Strategies for Improvement

A. Legal Considerations

(1) Litigation and Administrative Review

Litigation and administrative review activity in the nursing home and home health care arenas provide some insights into the value and difficulties associated with oversight and enforcement. In the nursing home context, litigation and administrative activity has focused generally on CMS' failure to enforce regulations designed to assure provider compliance with federal statutes, regulations, and survey protocols, and their interplay with state enforcement procedures. While this arena has been labor-intensive and time-consuming,⁸⁵ beneficiaries have enjoyed incremental successes, namely in the area of providing input in the design of survey and certification protocols.

The Secretary's failure to address a specific mechanism for patients to obtain review of the sufficiency of discharge planning raises basic due process issues. Advocates may wish to pursue the failure to develop a patient-review mechanism in the context of a due process challenge (or Conditions of Participation challenge). Such challenges may force the agency to take seriously the need to expand QIO review to include a substantive review of the quality of discharge-planning evaluations and discharge planning.⁸⁶

⁸⁴ See footnote 40, *supra*; Interpretive guidelines, §482.43(e).

⁸⁵ See, *Valdivia v. California Dept of Health Services.*, No. S-90-1226EJG EM, (E.D. Cal. Feb. 25, 1991), 1991 WL 80896; Stipulation of settlement requiring the State of California to comply with the Nursing Home Reform Law, April 13, 1993.) The enforcement provisions of the Nursing Home Reform Law were at issue. See, Pub. L. No. 100-203, §§4213(enforcement), 4212 (survey and certification process).

⁸⁶ It should be noted that advocates have not been satisfied with the QIO review process. Anecdotal experience indicates that QIOs tend to give less weight to beneficiary/patient concerns while giving more weight to the interests and points of view of hospitals and physicians; that QIOs only recently began to have beneficiary representatives as part of their make-up (by law now??) And that QIOs tend to make it difficult for beneficiaries to obtain access to data in support of their claims.

(2) *Further Work on Interpretive Guidelines*

Since the development of its Interpretive Guidelines, CMS has taken a rather “hands-off” approach to discharge planning and its interplay with transitions and other post-hospital services. This is a particular problem in the absence of any specific Medicare-enforceable directive to hospitals to make sure that anticipated post-hospital services, protocols, and procedures are in fact in place and implemented. The statute, regulations, and Interpretive Guidelines stop short of this. Moreover, the state survey process, a primary vehicle for monitoring Medicare Conditions of Participation, is seriously over-committed and underfunded. This leaves the discharge planning process largely unregulated and with little specific programmatic oversight.

The Medicare program has dedicated few resources to the area of enforcing the discharge planning requirements. It is largely up to individuals to be the agents of enforcement, at least to the extent of making sure that a discharge planning evaluation is developed and that a discharge plan, as necessary, flows from the evaluation. Moreover, discharge planning as a condition of participation in the Medicare program, is enforceable.⁸⁷ Nonetheless, the lack of service integration and connection can render the discharge planning process ineffective.

It would be useful to have more linkage with the QIO and state survey agencies to assure that discharge planning is appropriately reviewed and that discharge planners are held accountable to create meaningful discharge plans, including informing beneficiaries and their families of what to expect in terms of services and procedure that are to flow from the discharge plan.

In addition, it is important that CMS clarify its understanding of its relationship to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)⁸⁸ with respect to discharge planning. Currently, JCAHO believes that it does not have a “deemed status” agreement with CMS with respect to discharge planning, although it enjoys deemed status in many other areas of hospital operation. Thus, in the view of JCAHO, the discharge planning standards it provides are limited in their impact on the Medicare program and the Medicare discharge planning process itself. Language in the Medicare statute supports the JCAHO interpretation that it does not have deemed status for purposes of discharge planning.⁸⁹

⁸⁷ See, Lutwin v. Thompson, No. 01-6269 (2d Cir., Feb. 26, 2004)(previously known as Healey v. Thompson); see also, 42 U.S.C. §1395bbb(a)(1)(A).

⁸⁸ See, JCAHO continuum of care standards which include the discharge and transfer of patients to another organization or level of care:
http://www.wramc.army.mil/JCAHO/Division.cfm?D_Id=3 .

⁸⁹ See, 42 U.S.C. §1395bb(a)(2)(B), (a)(3); §1395x(e)(6)(B).

The Association of Osteopathic Hospitals (AOH) also has an accreditation program of relevance. Its standards are viewed broadly and deemed compliant with CMS standards.⁹⁰ Generally, AOH takes the approach of developing standards after CMS promulgates its standards.

A major advocacy activity remains working with CMS in broadening its reach with respect to post-acute hospital implementation of discharge plans. This may well involve further legislative clarification. In the meantime, CMS might be encouraged to expand its Interpretive Guidelines to make more explicit its understanding and policy with respect to discharge plan implementation. At a minimum, more resources and support, particularly to the survey process and to hospital staff training, are necessary. This will enhance significantly the discharge plan development and plan implementation process, giving it greater visibility and support, while giving hospital officials more clarity as to the scope of services and staff necessary to make more useful discharge planning as a service and benefit under the Medicare program.

(3). *Adding a Coordinated Benefit to Medicare*

As part of our deliberations at the Center for Medicare Advocacy's Coordinated Care Conference,⁹¹ we considered the development of a coordinated care benefit to be included in the fee-for-service program of the Medicare statute.⁹² As described below, the proposed coordinated

⁹⁰ See, <http://www.aoa-net.org/Accreditation/HFAP/HFAP.htm>; and see, <http://www.aoa-net.org/Accreditation/accreditation.htm>; deemed status recognized by CMS: <http://www.aoa-net.org/MediaCenter/PressReleases/2001/hfap01.htm>.

⁹¹ See, http://medicareadvocacy.org/Reform_CoordinatedCare.htm.

⁹² See, §1812 of the Social Security Act, 42 U.S.C. § 1395d, and the article and discussion, "Medicare Legislation to Create a Coordinated Care Benefit: Legal and Policy Issues," Sally Hart, J.D., M.B.T, of the Center for Medicare Advocacy, Inc. This article, found at http://www.medicareadvocacy.org/chronic_HartPaper.htm#ACUTE HOSPITAL, models a benefit based on the current Medicare hospice benefit, offered under Part A of the Medicare program and financed by the Medicare Trust Fund, which includes matching employer and employee taxes. We have made further modifications to the coordinated care model initially proposed to address discharge planning issues more specifically.

Note too, in 1998, Medicare Part C, also known as Medicare+Choice, and now "Medicare Advantage," under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), was added to the Medicare program. It comprises a variety of financing and service delivery options, most notably managed care plans. Beneficiaries who choose a Medicare+Choice plan (Medicare Advantage) should receive at least the same level of services and coverage as in the traditional program. Plans are paid a capitated rate for Medicare covered services provided to their beneficiary members.

care benefit consists of a comprehensive package of services prescribed by the attending physician and supervised by a care manager working with the physician.

What would be particularly useful across the spectrum of discharge planning, including transitions, would be the ability to have the services of a care coordinator extended to include such tasks as working with the staff of the discharging facility to assure that the elements of the discharge plan are in place, that the patient and his or her family are fully aware of post-acute care options, and that the patient and family fully understand what is expected in the home, including medicine regimens and the implementation of physician-ordered services including various outpatient therapies.

(a). Condition of Medicare Participation

As proposed, the provision of coordinated care services would be one of Medicare’s “Conditions of Participation,” giving rise to legal rights to beneficiaries to have these services put in place and available to them, and recognized under the Medicare statute. To this end, we propose amending §1891 of the Social Security Act, 42 U.S.C. § 1395bbb, conditions of participation for home health agencies, to add a new subsection (h), as follows:

(h) A coordinated care agency that provides home health services directly rather than under arrangements with a participating home health agency shall be subject to the conditions of participation set out in this subsection.

(b). Individual in Need of Coordinated Care Services

As proposed, an individual would be determined to be in need of chronic care based on a finding of both a medical condition, as certified by the individual's attending physician and renewed at least once every 60 days, or by a significant reduction in the individual's ability to perform activities of daily living, measured by an instrument and process developed by the Secretary in consultation with experts in the fields of geriatric medicine, public health, and geriatric social services.

We propose a set of tasks, responsibilities, and services to be provided under the auspices of a care coordinator. The task and responsibilities we propose are similar to those provided under the institutional, hospice, and home health benefit and covered under Part A of Medicare. Unlike the types of individual medical services covered under Part B of Medicare, the coordinated care benefit will usually include a bundle of services. Moreover, unlike the managed care option established in Part C of Medicare, the coordinated care benefit is not primarily a financing system. Thus, the most suitable place for the new coordinated care benefit appears to be the Part A section of the Medicare statute.

(c). Modeling the Coordinated Care Benefit

The proposed coordinated care benefit most closely resembles the current Medicare hospice benefit. Although there are significant differences in terms of the purposes of the two benefits, the expected durations of their services, and perhaps the payment methodologies (hospice being an all encompassing capitated benefit, and coordinated care possibly a combination of structures), other characteristics such as the inclusion of social services and the focus on maintenance rather than improvement are the same for both hospice and coordinated care benefits.

We would amend §1812 of the Social Security Act, 42 U.S.C. § 1395d, scope of benefits, to add to subsection (a) a new subsection (5), as follows:

"(5) coordinated care services provided to an individual in need of such care. "

Add a new subsection (g), as follows:

"(g) (1) An individual shall be determined to be in need of coordinated care based on,

(A) a physician certification of need based on the likelihood that without such services the individual's condition will deteriorate, renewed at least once every 60 days, and

(B) a finding of a significant reduction in the individual's ability to retain maximum level of function in a community-based environment; and

(2) An individual who has been determined to be in need of coordinated care can elect a coordinated care agency from which to receive such services. The election of a particular agency can be made and revoked by such individual on a monthly basis."

(d). Criteria for Eligibility

Criteria for eligibility will necessarily be broad and would not require a specific diagnosis, but would accommodate a variety of patient needs, including the recognition of particular medical conditions as indicators of the need for coordinated care. Particular attention would be given to such diseases as asthma, diabetes, congestive heart failure and related cardiac conditions, hypertension, coronary artery disease, cardiovascular and cerebrovascular conditions, multiple sclerosis, and chronic lung disease. As with the hospice benefit, the patient's individual physician, in conjunction with others, including the patient and family members and designated friends, would play a major role in determining the patient's medical needs.

(e). Payment and Deductibles

We would amend §1813 of the Social Security Act, 42 U.S.C. § 1395e, deductibles and coinsurance, to add to subsection (a) a new subsection (5), as follows:

"(5) (A) [include here any coinsurance or deductibles to be imposed with respect to the coordinated care benefits.]

(B) During the period when an individual is receiving coordinated care services by the election described in §1812(a)(5), no coinsurance payments or deductibles other than those under subparagraph (A) shall apply with respect to such coordinated care services."

Under the hospice model, recipients must pay coinsurance for outpatient drugs and biologicals that approximates 5% of the average cost for drugs to the particular coordinated care agency, not to exceed \$5 per prescription. They also pay coinsurance for respite care that, again, is calculated as 5% of the average cost of such services to the particular coordinated care agency.

Using Medicare hospice coinsurance amounts as a model, these coinsurance requirements would be 5% of the average cost of the particular service to the provider. Alternatively, coinsurance for coordinated care services could be imposed at a uniform flat rate, such as \$5 per service. Other options that should be considered include imposition of a deductible at the beginning of a period when coordinated care services are used, with or without coinsurance requirements for subsequent services.

As to conditions and limitations on payment for services, §1814 of the Social Security Act, 42 U.S.C. § 1395f provides a model. We propose adding to subsection (a) a new subsection (9), as follows:

"(9) In the case of coordinated care provided to an individual—

(A) (i) The individual's attending physician certifies that such services are required to prevent deterioration in the individual's medical condition;

(ii) There is a finding of a significant reduction in the individual's ability to perform activities of daily living measured by a functional screening test developed by the Secretary; and

(iii) The individual's attending physician and care manager re-certify at the beginning of each subsequent 60 day period that the individual continues to meet the conditions specified in (i) and (ii).

(B) A written plan for providing coordinated care services with respect to such individual has been developed for the individual by the individual's personal care manager and attending physician prior to the beginning of services, and the written plan is reviewed and updated by the care manager and attending physician to respond to the individual's current needs once every 60 days thereafter.

(C) The delivery to the individual of the coordinated care services specified in the written care plan shall be supervised by the care manager to assure that the services are actually provided on a dependable basis and that they meet standards of quality care."

Section 1814 of the Social Security Act., 42 U.S.C. § 1395f, provides a statutory place where we might locate the reimbursement provisions for the coordinated care benefit. Methods of payments must be carefully evaluated in order to create incentives for coordinated care providers to deliver services that are adequate in quantity, high in quality, and yet reasonable in cost to the Medicare trust fund. Options include: traditional fee-for-service payments; prospective payments based on level-of-care-need groupings of beneficiaries; and flat capitation payments per beneficiary, as well as payment arrangements that recognize the services of other providers.

We would define the term "coordinated care services" in §1861 of the Social Security Act, 42 U.S.C. § 1395x, by adding a new subsection (uu), as follows:

"(uu) (1) The term "coordinated care services" means items and services furnished by, or by others under arrangements made by, a coordinated care agency to an individual who meets the eligibility criteria set out in section 1812(g)(1), which are prescribed in a personal care plan developed by the individual's care manager and attending physician.

(f). Physician Involvement

We propose an ongoing level of involvement in the coordinated care services benefit by the individual beneficiary's attending physician. Other models assume that the attending physician will be less involved in designing and monitoring coordinated care services, and place sole or primary responsibility on the coordinated care agency and the care manager to initiate, supervise and modify the care plan and services. The rationale for the latter model is that constant physician involvement in non-acute care for chronically ill, but stable, patients is unnecessary and unrealistic in light of other demands on physician time and interests.⁹³ On the other hand, the rationale for identifying the physician as the key to commencing and continuing care is that patients' attending physicians are best situated to know their medical conditions and related needs. In addition, Medicare has historically based authorization for services in the hands of physicians, and physicians should be actively involved in their patients' care.

(g). Services Available

⁹³ See, e.g., "The Physician's Role in Medicare Home Health, 2001," OIG Report, OEI-02-00-00620, December, 2001.

A broad array of service providers could provide coordinated care services. Coordinated care services would not be limited to services that are considered "skilled", "acute" or "restorative", but would also include unskilled health-related services provided to eligible individuals who have "chronic" or "maintenance" care needs.

Generally, we would define coordinated care services as including: care manager services; home health services, including: (i) nursing care; (ii) home health aide; (iii) medical supplies (including drugs and biologicals), equipment, and appliances; (iv) physical therapy; (v) occupational therapy; (vi) respiratory therapy; (vii) speech and audiology services; and (viii) counseling and other behavioral health services; (ix) medical supplies (including drugs and biologicals) and (x) durable medical equipment; necessary transportation services; adult day health services, including: (i) planned care supervision and activities; (ii) personal care; (iii) personal living skills training; (iv) meals and health monitoring; (v) preventive, therapeutic, and restorative health-related services; and, (vi) counseling and behavioral health services; personal care services; homemaker services; home delivered meals; and discharge planning services.

The coordinated care benefit package is so broad that agencies may not have the capacity to provide all of the diverse types of benefits directly. It is anticipated that the care manager would arrange for services to be provided by other agencies so long as the care manager coordinates and remains ultimately responsible for all services provided to the client by an interdisciplinary group of personnel which includes at least a physician, a registered nurse, and a social worker, employed by or, in the case of the physician, under contract with the agency or organization providing services that provides (or supervises the provision of) the care and services and establishes the policies governing the provision of such care and services; maintains central clinical records on all patients; in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed according to such law; and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

In keeping with the notion of providing for an appeal of adverse determinations, §1869(a)(1) of the Social Security Act, 42 U.S.C. § 1395ff(a)(1), determinations, appeals would be modified to add to subsection (a)(1) a new subsection (D), as follows:

(D) Cases in which a provider of services plans to reduce or terminate services, or to discharge the individual. In such situations, written notice must be given to the individual by the provider, including a specific, personalized explanation of the reasons for reduction or discharge and a description of the individual's right to an initial or expedited determination.

(4). *Establish a Discharge Ombudsman/Patient Information Program*

There is an ongoing need for ombudsmen or other patient advocates to work to assure that discharge-planning services and information about the discharge-planning process are provided to patients and their families or representatives. The work of an ombudsman in assuring that patients are informed about discharge planning as a process and as a patient benefit during hospitalization is substantially different from post-hospital review or accountability measures conducted pursuant to CMS' survey and certification process. Advocates may find associations of discharge planners and care managers interested in working on creating mechanisms to assure that patients are provided this type of ombudsman resource.

In addition, a number of hospitals have brochures that describe their discharge-planning services. Advocates may wish to work with hospital discharge planners to develop additional informational pieces on discharge planning and to provide community outreach on discharge planning as a post-hospital care planning tool, including long-term care planning.

(5). *Explore Comprehensive Discharge Planning and Needs-Assessment Instruments*

As the Secretary notes in the preamble to the final regulations, HHS has submitted its report to Congress on the use of needs-assessment instrument(s).⁹⁴ That report essentially calls for further study of needs-assessment instruments and expresses the concern that needs-assessment instruments are appropriately developed to address individual needs and circumstances. Advocates may want to participate in federal and state initiatives that explore the use of needs-assessment instruments.

(6). *Discharge Planning and State Laws*

Appendices A (Chart: Hospital Discharge Planning Criteria selected states) and B (Chart: Long Term Care Facilities Discharge Planning Criteria by selected states) offer a look at what several states have in their laws and regulations that give point and meaning to discharge planning and transitions at the state and local levels. Additional state laws possibilities are identified and set out in *infra*, note 94.

⁹⁴ See, Health Care Fin. Admin. Rpt. Of the Secretary's Advisory Panel (December 1992), Publication No. 10957, and submitted to Congress on June 30, 1992. The report was mandated by Congress in Public Law No. 99-509, 100 Stat. 1874, §9305(h). (The report made no formal recommendations but stated that more work needs to be done on needs-assessment instruments, including field-testing to assure administrative feasibility and clinical effectiveness.)

Several states, including New York⁹² and Massachusetts,⁹³ have discharge planning requirements. New York requires hospitals to ensure that each patient has a discharge plan that meets the needs of the patient. Moreover, patients can not be discharged until the services called for in the discharge plan have been arranged, or until it can be reasonably determined by the hospital that the services are available to the patient. The hospital must also have on staff a discharge coordinator. Rural hospitals may employ the services of a discharge coordinator by contract. In addition, the coordinator is to be part of the hospital's utilization review committee.

New York hospitals are also to adopt and implement written discharge policies and procedures that will ensure that there are criteria for a discharge planning screening system, allowing for patient screening in accordance with written criteria, and that each patient has an opportunity to participate in the development of the discharge plan. Moreover, discharge planning in New York is to be provided in both residential care facilities and in home and community-based services such as home care, long-term health care, day care, and respite. Nonetheless, the New York requirements are not explicit on the issue of patient recourse if a patient objects to a discharge plan.

Massachusetts has adopted an approach in which the plan specifies the services to be arranged and the names, addresses, and telephone numbers of the providers; and the patients' medications, prescriptions and follow-up schedule. Medicare patients in Massachusetts are entitled to a notice that explains their discharge rights, including the right to request a review of the discharge plan through the Advocacy Office of the Department of Public Health.

Other states have provisions under their general health and welfare codes that allow them the flexibility to promulgate discharge planning or similar requirements.⁹⁴ It is important that advocates compare their state offerings with federal law and regulations and seek appropriate extensions and refinements where necessary.

⁹² 10 N.Y. Comp. Codes R. & Regs. §§ 405.22(j) et seq. (Apr. 1987)(Discharge planning requirements are applicable to all patients.)

⁹³ Mass. Gen. L. ch. 111, amending §51D by inserting Section 13 of chapter 574 of the Acts of 1985. (Discharge planning requirements are limited to Medicare patients.)

⁹⁴ Az ADC, R9-10-211; CA Health and S §1262.5; CT St §19a-504c; 19a-535; IL St. Ch.210, §85/6.09; MA St. 111, §50; NV St, 449.700;449.705; WA St,70.41.320. See also, Minn. Stat. §§144A.51 et seq.; 144.651, subd 29 (Transfer and Discharge); 144.654(Monitoring of Subacute or Transitional Care Services); 144.562, subd.3 (License Approval); Miss. Code Ann. §§41-1-5 et seq (Hospital and health Care Committee); Mich. State. Ann. §24.602(5)(b)(meeting certification standards of the Medicare program). See also, Cal. Welf. & Inst. Code, §9390.5(pre-admission screening); §14064 (inpatient rehabilitation hospital services).

B. Linking with Clinicians Toward Transitions

As shown below, the findings of researchers and clinicians demonstrate the clinical consequences of absence of effective discharge planning and transitions measures. This information forms a useful link for advocates as they make the case for stronger, more focused discharge planning requirements and their enforcement.

(1). Moving Toward Transitional Care

The importance of reducing care fragmentation during care transitions, as patients move from care setting to care setting, has historically been under-developed, particularly as an area of inquiry for the legal advocacy community. The scope of care transitions is broader than simply the discharge process; it involves the comprehensive preparation of the patient in a manner that optimizes continuity and coordination of practitioners and services across settings. Upon discharge to home, patients and family members are abruptly expected to assume a considerable self-management role in the recovery of their condition. It is at this critical juncture that the Medicare discharge planning process becomes problematic.

Generally, transitional care is defined as a set of actions designed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care within the same location. Transitional care, which encompasses both the sending and receiving aspects of the transfer, includes logistical arrangements, education of the patient and family, and coordination among health professionals involved in the transition.

Persons whose conditions necessitate complex, continuous management frequently require care from different health professionals in multiple settings. Although patients with complex acute and chronic care needs experience heightened vulnerability during these transitions, systems of care often fail to ensure that: (i.) the essential elements of the patient's care plan that were developed in one setting are communicated to the next team of clinicians; (ii.) the necessary steps prior to and after a patient's transfer are properly and fully executed, and (iii.) the requisite information about the care delivered by the sending care team is communicated to the receiving care team. Problems also include inappropriate and/or conflicting care recommendations for health care providers.

(2). A Care Transitions Measure

A Care Transitions Measure (CTM) has been developed and tested by a team of researchers at the Division of Health Care Policy and Research, the University of Colorado Health Science Center,

Denver, CO and the Multicampus Division of Geriatric Medicine and Gerontology, University of California, Los Angeles.⁹⁵ The impetus for this measure was the concern that during the course of an illness, patients often see a variety of practitioners in multiple settings, resulting in care fragmentation and poor patient outcomes.

The team designed and tested a patient-centered measure to capture what is essential to successful care transitions, including a sampling strategy to identify patients who have recently experienced one or more care transitions, including returning home from an acute hospital setting. The strategy employed resulted in a cross-section of patients, representing minorities, women, and persons of lower socio-economic status. Patients selected for the study were contacted by telephone and invited to attend a focus group at one of six primary care clinic sites. The focus groups sessions, moderated by two researchers, and lasting 90 minutes each, provided the researchers an opportunity to obtain patient and care-giver perspectives on their recent experience of care transitions.

The focus group questions were as follows:

Think back to when you were in the hospital ...

- What was most helpful in getting you back home to your normal routine?
- What aspects of your discharge did you feel were handled particularly well?
What aspects were not handled well?
- What did you need to meet your care needs after discharge from the hospital?
- Did you feel confident in knowing the questions you needed to ask about the care you were to receive after leaving the hospital and who to ask them to?
- Did you feel that the reasons that brought you into the hospital in the first place were addressed?
- After leaving the hospital, did you feel fearful or anxious? What would have reduced your fears?
- Did you or your family feel that you were prepared to come home?

⁹⁵ See, Coleman, E, Smith J, Frank J, Eilertsen T, Thiare J, Kramer A. *Developing and Testing of a Measure designed to Assess the Quality of Care Transitions*, International Journal of Integrated Care 2002: Vol 2.

- Did you receive care in a nursing facility? Did the nurse understand what had brought you into the hospital and what they did for you?
- Did you receive home care from a nurse? Did the nurse understand what had brought you into the hospital and what they did for you?
- When you returned to your primary care physician, did he or she know about your hospitalization, nursing facility or your home care experience?

The six focus groups were audio taped, the tapes were converted to written monographs by a single professional transcriptionist, and data were analyzed using standard qualitative analytical techniques. The tapes were reviewed by four members of the research team, each with different professional backgrounds, systematically identifying recurrent themes, leading to the team's agreement on key domains to be emphasized in seeking information from patients, including a methodology for identifying those patients whose cognitive abilities were such that they needed a proxy for providing the necessary information. The four domains are: Information Transfer; Patient and Caregiver Preparation; Self-Management Support; and Empowerment to Assert Preferences.

The next step in developing the CTM was to subject the draft to a series of pilot tests among patients to refine its content, wording, and organization. The draft CTM was also shared with local and national experts in geriatric health care delivery for additional review and refinement. This process led to the development of three separate versions of the measure: hospital to home; hospital to home with home skilled nursing care; and hospital to skilled nursing facility to home, with or without home skilled nursing care.

Psychometric testing of the measure focused on content validity, construct validity, floor and ceiling effects, and intra-item variation. Although there was no "gold standard" against which to assess the quality of care transitions, it was compared to a measure developed by Hendriks, et al., from the University of Amsterdam.⁹⁶

The developers of the CTM also point out that there are areas of overlap between TM items and the Consumer Assessment of Health Plans Study (CAHPS) Survey, particularly CAHPS questions which ask about patient involvement in their health care decisions, and the Picker Institute Survey, with its focus on hospital discharge experience as opposed to care received thereafter.

The researchers note as a downside that the CTM study was conducted within a single health plan, although a large one; that elders who choose a health plan may not be representative of the elderly

⁹⁶ Hendricks AAJ, Vrieling MR, Smets EMA, van Es SQ, DeHaes JCJM. Improving the assessment of (in) patients' satisfaction with hospital care. *Medical Care* 2001; 39:270-283.

population as a whole; and that the researchers deliberately over-sampled persons of diverse racial backgrounds. The researchers also note the high prevalence of delirium among older adults recently discharged from a hospital to a post-acute care facility, and that input from this population may not reflect their actual experience. Further, the researchers note that a scoring system for the CTM is being developed.

(3). *What the Data Show*

Qualitative studies (including those conducted by the UCHSC study team) have shown that patients and their caregivers are unprepared for their role in the next care setting, do not understand essential steps in the management of their condition, feel abandoned because they are unable to contact appropriate health care practitioners for guidance, and believe that their input into their care plan has been disregarded.⁹⁷ Many patients and caregivers are frustrated with the significant amount of redundancy in assessments and dissatisfied with having to perform tasks that their health care practitioners have left undone. Post-hospital satisfaction surveys have repeatedly identified discharge planning as particularly problematic.

An expanding evidence base documents significant problems in the quality of transitional care. Lack of incentives and accountability make these “hand-offs” of care extremely vulnerable to medical errors, service duplication, and unnecessary utilization. Indeed, quantitative evidence increasingly indicates that patient safety is jeopardized during transitional care. Many of these adverse events could have been prevented or ameliorated. An analysis conducted by the UCHSC study team with support from the Beeson Program examined 30-day post-hospital care patterns in a nationally representative sample of Medicare beneficiaries. Approximately 25 % of all care patterns were categorized as complicated, requiring return to a higher intensity care setting.

Medication errors pose a significant threat to patients undergoing transitions. Receiving care in multiple settings often means that patients obtain medications from different prescribers. Rarely do clinicians have complete information to monitor the entire regimen adequately, much less intervene to reduce discrepancies, duplications, or errors. Although much of the recent national attention on medication errors has been setting specific, the lack of coordination between prescribers across settings may pose an even greater challenge because there is no focus of responsibility to

⁹⁷ Note, a recent study, funded by the National Institute of Nursing Research, appearing in the May 2004 issue of the *Journal of American Geriatrics Society*, has demonstrated that elderly heart-failure patients who received specialized nursing services, during their hospital stay and during their convalescence at home, had a better quality of life and fewer hospital readmissions. Data of this sort are cumulative and speak to the value of care transitions among a variety of patient cohorts. See, <http://www.nih.gov/news/pr/may2004/ninr-12.htm>.

ameliorate the problem. The UCHSC study team has found that following hospital discharge, approximately 20% of chronically ill older adults experience at least one medication error.

The UCHSC study team has developed and tested The Care Transitions Measure (CTM), a 15-item uni-dimensional measure of the quality of preparation for care transitions that is assessed from the patient's perspective. The CTM has been found to have high internal consistency and reliability, and to reflect focus group-derived content domains (i.e., it is a truly patient-centered measure). CTM scores have been shown to discriminate among patients discharged from the hospital that did and did not have a subsequent emergency department visit or re-hospitalization for their index condition. CTM scores have also been shown to be significantly different between health care facilities known to vary in quality of care coordination. CTM addresses care processes that are within the scope of the hospital and are actionable.

(4). Lessons from the HMO Workgroup on Care Management

The Workgroup on Care Management released a February 2004 report⁹⁸ which addresses how Managed Care Organizations might improve the quality of the transitions services provided to persons with complex needs as they move between care settings, including hospitals, skilled nursing facilities, the home setting, specialty care settings, and assisted living and other long-term care facilities. The focus of this report is on adults with complex and acute conditions or chronic conditions requiring care in a variety of settings. The report offers specific strategy recommendations for improving the transitions process: (a) ensuring accountability for patients in transitions; (b) facilitating the effective transfer of information; (c) enhancing practitioners' skills and support systems; (d) enabling patients and caregivers to play a more active role in their transitions; (e) aligning financial and structural incentives to improve patient flow across care venues; and (f) initiating a quality improvement strategy for care transition.

The report calls for a shift in perspectives for both the sending and receiving care teams to reflect certain core functions. The shift entails viewing the patient discharge as a process of continuous management. The sending health team is to make sure the patient is fully prepared for the transition; that family members and the patient understand what is expected of them, of care providers, and of others in the transfer process. The receiving health team is expected to have reviewed the patient's needs before the transfer takes place and to be prepared to receive the

⁹⁸ See, HMO Workgroup on Care Management, "One Patient, Many Places: Managing Health Care Transitions" (AAHP-HIAA Foundation, Washington, DC, February 2004). The primary writer for this report is Eric A. Coleman, MD, MPH, University of Colorado Health Sciences Center and Kaiser Permanente Colorado Region. Financial support for the report was provided by The Robert Wood Johnson Foundation.

patient to be sure that the patient's goals and needs are properly reflected in the plan of cares; and to assure that discrepancies or disagreements concerning the plan of care are resolved.

In the context of the core functions described above, the report stresses the use of transitions measuring tools designed to assess specific aspects of transitional care. The report points to three principal tools: the Assessing Care of Vulnerable Elders (ACOVE), designed by researchers at RAND and UCLA, the Care Transitions Measure (CTM), developed by researchers at University of Colorado Health Sciences Center, and the Patients' Evaluation of Performance in California (PEP-C) Survey, designed by the California Health Care Foundation for their pay-for-performance initiative. With established performance measures, the focus can shift to continuous quality improvement (CQI) and other initiatives within a network of facilities.

The report also calls for Medicare+Choice Organizations to develop a Standard Operating Plan (SOP) for information flow. The SOP should clearly delineate the type of data to be conveyed from care setting to care setting, baseline patient information on health status, a current care plan, including patient goals and preferences, along with a summary of what was done for the patient at the sending institution.

Of particular interest is the call for more practitioner education in effectuating good transitions. This is a very useful adjunct. Its focus on the need for practitioners to have an understanding of what actually occurs in other care settings is refreshingly novel. Such information could lead to more nuanced and focused care planning and sharing of information about patients as they move from care setting to care setting.

(5). *The Joint Commission and its Tracer Methodology*⁹⁹

In January 2004, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) adopted a new approach to its survey process as part of its "Shared Visions - New Pathways." This new methodology will comprise 50-60% of the on-site survey time, a major component of the survey process. The new approach to the survey process includes the following elements: (a) following the course of care and services provided to a particular patient; (b) assessing relationships among disciplines and important functions; (c) evaluating the performance of relevant processes related to patient care; and (d) identifying potential vulnerabilities in care processes. It is now part of the typical 3-day onsite hospital survey process, and in most instances, a typical team of three surveyors is expected to complete approximately 11 tracers.

⁹⁹ See, http://www.jcaho.org/accredited+organizations/svnp/pfp_transcript.htm.

This methodology allows for the observation of direct care activities, includes family interviews, staff interaction, as well as the review of policies and procedures. The notion is that the survey team will have a more interactive understanding of how care is delivered. Tracer activity is determined through an analysis of pre-survey data, with a focus on clinical service groups, and is intended to allow the surveyors to customize the accreditation process.

The tracer methodology has important implications for discharge planning and transitions, particularly in that it can follow a particular patient, assessing how the patient fares along a continuum of care. It can follow how the hospital staff has ascertained the post-acute needs of a particular patient, the planning for discharge that has occurred, and, through patient interviews, what the patient understands about the post-acute care aspects of his or her care.

Currently, the tracer methodology is most effective in following patients from care setting to care setting where the patient is part of an integrated health care system. Outside such a context, the system is less effective, both as to the ability to monitor patients as well as the ability to assess the quality of services available in a given post-acute care setting.

(6). *Community Educational Strategies*

Advocates may wish to consider developing a series of community education presentations on discharge planning and planning for post-hospital needs. These events could be grouped with a series of health-information activities important to older people, for example, planning for incapacity, health care decision making, or making the choice between home health care and nursing facility care. It is important to include the perspectives of hospital discharge planners, ombudsman advocates, care managers, and lawyers (or paralegal advocates) in the training design. Together, these perspectives should highlight discharge planning as an advocacy tool for promoting beneficiary choice and access to services.

These strategies can be complemented by the development of training and education materials such as brochures and pamphlets that explain the discharge-planning statute and regulations and provide advocacy tips for patients and their families and representatives. Again, hospital discharge-planning departments may have materials that will be useful in this regard.

V *Conclusion*

Discharge planning and its interplay with the larger activity of transitions, both in the context of the federal Medicare requirement and as standards developed through independent research and

clinical practice, are important to beneficiaries. They point the way to better post-acute care outcomes for patients, their families and friends. More is needed in the area of assuring good transitions, including defining responsibilities for the development and implementation of post-acute care services and the standards against which they are to be measured and evaluated.

Advocates must continue to watch the evolution of the development of standards and services for patients who need post-acute care services. In particular, they must be attentive to what the Medicare agency does or does not do as federal action. This action must of necessity include standards development and the implementation of services. Advocates also must include program monitoring and evaluation with respect to statutory and regulatory compliance and to best practice development. Similarly, states must continue to play an important role and should be encouraged to do more, particularly with respect to creating more explicit, patient-focused laws and regulations.

VI APPENDICES

A: Chart: Hospital Discharge Planning Criteria by State

B: Chart: Long Term Care Facilities Discharge Planning Criteria by State

C: Bibliography

Appendix A: Hospital Discharge Planning Criteria by State

| The following chart displays discharge planning criteria established by Medicare and states that have specific discharge planning statutes. The parentheticals emphasize specific requirements relative to the cited standards/guidelines. | | | | | | | | | | |
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| | <u>MEDIC ARE</u> | <u>MEDIC ARE</u> | <u>AZ</u> | <u>CA</u> | <u>CT</u> | <u>IL</u> | <u>MA</u> | <u>NV</u> | <u>NY</u> | <u>WA</u> |
| | 42 USC § 1395x(e) | 42 CFR § 482.43 | AZ ADC R9-10- | CA HLTH & S § 1262.5 | CT ST § 19a- 504c; | IL ST Ch 210 § | MA ST 111 | NV ST 449. | NY PUB HEALTH § 2803-i | WA ST 70.41.320 |

| | e) | 211 | 19a-535 | 85/6.09 | § 51D | 700; 449.705 | | | |
|--|----|-----|---------|---------|-------|--------------|--|-------------------|---|
| Basic Standards/Guidelines | | | | | | | | | |
| The hospital must have in effect a written discharge planning process that applies to all patients. | | x | | x | | | | | x |
| The hospital must identify, at an early stage of hospitalization, all patients likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning. | x | x | x | x | | | | | x |
| The patient must be provided advance notice of the proposed discharge. | | | | | x | | | x (in writing) | |
| A patient transferred to another hospital is exempt from the following requirements. An administrator shall require that a transfer of a patient to another hospital complies with the requirements of the separate transfer protocols. | | | x | | | | | | |
| A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, may not contain a provision that prohibits or restricts any health care facility's compliance with the following requirements. | | | | x | | | | | |
| Whenever an aged or disabled patient who qualifies for the federal Medicare program is hospitalized, the patient shall be notified of discharge at least 24 hours prior to discharge from the hospital. The discharge notice may be waived in cases in which a discharge notice is not feasible due to a short length of stay in the hospital by the patient, or for any case in which the patient voluntarily desires to leave the hospital before the expiration of the 24 hour period. At least 24 hours prior to discharge from the hospital, the patient shall receive written information on the patient's right to appeal the discharge pursuant to the federal Medicare program, including the steps to follow to appeal the discharge and the appropriate telephone | | | | | | x | | | |

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| number to call in case the patient intends to appeal the discharge. | | | | | | | | | | | |
| The patient or the patient's agent may request a review of the determinations for discharge. | | | | | | | | | | X | |
| The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. | | X | | | | | | | | | |
| Discharge Planning Evaluation Standards/Guidelines | | | | | | | | | | | |
| There must be a discharge planning evaluation upon request of patient or patient's agent. | X | X | | | | | | | | | |
| A registered nurse, social worker, or other qualified personnel must develop or supervise the development of the evaluation. | X | X | | | | | | | | | |
| The discharge planning evaluation must include an evaluation of the likelihood of patient needing post-hospital services including hospice services and of the availability of the services. | X | X | | | | | | | | | |
| The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. | | X | | | | | | | | | |
| The evaluation must be completed in a timely fashion so that the appropriate arrangements for post-hospital care can be made before discharge, and to avoid unnecessary delays in discharge. | X | X | | | | | | | | | |
| The discharge planning evaluation must be included in the patient's medical record and must be discussed with the patient or the patient's agent. | X | X | | | | | | | | | |
| Discharge Plan Standards/Guidelines | | | | | | | | | | | |
| A registered nurse, social worker, or other qualified personnel must develop or supervise the development of the discharge plan if the evaluation indicates the need for a plan. | X | X | | | | | | | | | |
| In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request that a discharge plan be developed by the | | X | | | | | | | | | |

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| hospital. | | | | | | | | | | |
| The hospital must arrange for the initial implementation of the patient's discharge plan. | x | x | | | | | | | | |
| The discharge plan must be completed in a timely fashion so that the appropriate arrangements for post-hospital care can be made before discharge, and to avoid unnecessary delays in discharge. | | | x | | | | | | | |
| The plan should be prepared in consultation with the patient or the patient's agent. | | | | | x (specifically a written plan) | | | | | |
| The discharge plan should include at least the following information: (1) identification of the post-hospital services needed by the patient, including home health and homemaker services, and of the post-hospital social needs of the patient; (2) the services that have been arranged for the patient; (3) the names, addresses, and telephone numbers of service providers; (4) the service schedule as requested by the hospital; (5) medications prescribed and instructions for their use or verification that such information was provided separately; (6) scheduled follow-up medical appointments or verification that such information was provided separately; and (7) such other relevant information. | | | | x (written policy ensuring that patient receives information about medications) | | | x | | | x (provide written & verbal consultation to patient or agent) |
| Each hospital shall have a clear, concise front page on the discharge plan, written in large print and understandable language and contains at least the following: (1) the name and telephone number of the hospital discharge planning coordinator (2) a notice that, in the event the patient or the patient's agent does not agree with the discharge plan, the discharge planning coordinator and the patient's physician shall meet with the patient or agent in an effort to develop a plan that is acceptable to the patient; (3) a notice, including the advocacy office telephone number, that, | | | | | | | x | | | |

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| if an acceptable resolution is not reached as a result of the meeting provided for in clause (2), the patient or agent may file a request for review of the discharge plan with the advocacy office, (4) a notice that signing the discharge plan does not preclude the right to request a meeting or a review pursuant to clauses (2) and (3); and (5) a signature line for the patient or the patient's agent acknowledging participation in the dev | | | | | | | | | | |
| As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. | | X | X | X | | | | | | X |
| The patient's medical record shall document the plan and document that said plan was communicated orally to the patient or to the patient's representative. | | | X | | | | X | | | |
| The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. | | X | | | | | | | | |
| If the hospital develops a discharge plan for a patient but the attending physician does not agree with the hospital's determinations, the hospital may request by telephone a review of the validity of the hospital's determinations by an independent reviewing agency. | | | | | | | | | X | |
| Discharge Summary Standards/Guidelines | | | | | | | | | | |
| There must be a discharge summary that includes a description of the patient's medical condition and the medical services provided to the patient; and the signature of the patient's attending physician or the attending physician's designee. | | | X | X (a transfer summary; to SNF, ICF, DPSNF, etc.) | | | | | | |
| There must be a documented discharge order by an attending physician or the attending physician's designee before discharge unless the patient leaves the hospital against a medical staff member's advice. | | | X | | | | | | | |
| A copy of the discharge or transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled | | | | X | | | | | | |

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| nursing or intermediate care facility or other location. | | | | | | | | | | |
| Transfer or Referral Standards/Guidelines | | | | | | | | | | |
| A patient may be transferred to another facility or home only if the patient has received an explanation of the need to transfer him and the alternatives available, unless his condition necessitates an immediate transfer to a facility for a higher level of care and he is unable to understand the explanation. | | | | | | | | X | | |
| The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. | | X | X (must have documented discharge instructions) | X (can be provided orally or in writing to patient or agent) | | | | | | |
| The facility shall forward a copy of the medical records of the patient, on or before the date the patient is transferred, to the other medical facility or facility for the dependent, the division facility or the physician. If a person receiving services in a home for individual residential care is transferred to another home, the home shall forward a copy of his medical records to the other home. | | | | | | | | X | | |
| Outpatient Standards/Guidelines | | | | | | | | | | |
| For a discharge of an outpatient receiving emergency services, an administrator shall require a discharge order is documented by an attending physician or the attending physician's designee before the patient is discharged unless the patient leaves against a medical staff member's advice; and discharge instructions are documented and provided to the patient or the patient's agent before the patient is discharged unless the patient leaves against a medical staff member's advice. | | | X | | | | | | | |

Appendix B: Long Term Care Facilities Discharge Planning Criteria by State

| The following chart displays discharge planning criteria established by Medicare and states that have specific discharge planning statutes. The parentheticals emphasize specific requirements relative to the cited standards/guidelines. Long-term care facilities include nursing facilities, skilled nursing facilities, non-certified Medicare/Medicaid facilities, nursing homes, rest homes, or chronic disease hospitals. | | | | | | | | | | |
|---|--|--------------|-------------------------------------|--------------|----------------|-------------------------------------|----------------|------------|---------------|-----------|
| | | AR | CT | DC | FL | MD | MN | NC | OH | WA |
| | | AR ST | CT ST | DC ST | FL ST | MD | MN ST | NC ST | OH ST | WA ST |
| | | § 20-10-1204 | § 19a-504c; 19a-535: 19a-535b | § 44-1003.01 | § 400.025 5 | HEALTH GEN § 19-345; 19-345.1 | § 144A.1 35 | § 131E-117 | § 3721.1 3 | 70.41.320 |
| Basic Standards/Guidelines | | | | | | | | | | |
| Unless a resident or his agent consent otherwise, a facility may discharge or transfer the resident 1) if essential to meet documented | | x | x | x | | x | | x | | |

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| health care needs or to be in accordance with the prescribed level of care; 2) if essential to safeguard the resident or other residents from physical or emotional injury; 3) on account of nonpayment for maintenance, except as prohibited by 42 USC § 1395 et seq. and 42 USC § 1396 et seq.; 4) if essential to meet the facility's reasonable administrative needs and no practicable alternative is available or 5) if the facility is closing or officially reducing its licensed capacity. | (Transfer or discharge as a result of medical reasons or for the welfare of other residents) | (chronic disease hospital) | | | | | | | |
| The resident cannot be transferred or discharged from the home unless one of the following occurs: (a) The welfare and needs of the resident cannot be met in the home. (b) The resident's health has improved sufficiently and the resident no longer needs the home's services. (c) The safety or health of individuals in the home is endangered. (d) The resident has failed to pay or to have the medicare or medicaid program pay for the home's services. A resident shall not be considered to have failed to pay if the resident has applied for medicaid, unless both of the following are the case: (i) The resident's application, or a similar previous application, has been denied by the county department of job and family services. (ii) If the resident appealed the denial and the director of job and family services has upheld the denial. (f) The home's license has been revoked, the home is being closed or otherwise ceases to operate. (g) The resident is a recipient of medicaid or medicare, and the home's medicaid or med | | | | | | | | X | |
| The basis for transfer or discharge must be documented in the patient's record by a physician. | | X | | | | | | X | |
| No facility that is a certified Medicaid provider may discharge, transfer, or relocate a resident on account of his or her conversion from private-pay or Medicare or Medicaid status, or on account of a temporary hospitalization if payment or reimbursement for his or her bed continues to be made available. | | | X | | | | | | X |
| A Medicaid certified facility may not: (i) Include in the admission contract of a resident any requirement that, to stay at the facility, the resident will be required to pay for any period of time or amount of money as a private pay resident for any period when the resident is eligible for Medicaid benefits; or (ii) Transfer or discharge a resident involuntarily because the resident is a Medicaid benefits recipient. | | | | | X | | | | X |
| When a discharge or transfer is initiated by the nursing home, the | | | | X | | | | | |

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| nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant. | | | | | | | | | |
| The discharge plan shall contain a written evaluation of the effects of the transfer or discharge on the patient and a statement of the action taken to minimize such effects. | | x | | | | | | | |
| Notice Standards/Guidelines | | | | | | | | | |
| The resident must be provided advance notice of at least 30 days prior to discharge or transfer except in cases of emergency. | x | x (in writing at least 30 days but no more than 60 days prior to discharge or transfer) | | | | | x (only 5 days notice) | | |
| Included in the discharge notice must be the reasons therefor, the effective date, the location to which the patient is transferred or discharged, the right to appeal the proposed transfer or discharge, the procedures for initiating the appeal, the date by which the appeal must be initiated in order to stay the proposed transfer or discharge, that the patient may represent himself or be represented by legal counsel, a relative, a friend or other spokesperson, information as to bed hold and hospital readmission policy when appropriate, and the contact information for the State Long-Term Care Ombudsman. | | x (after receiving the notice, the resident has 10 days to initiate | | | x | | | | |

| | | appeal) | | | | | | | |
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| Review & Appeal Standards/Guidelines | | | | | | | | | |
| A resident may request that the local ombudsman council review any notice of discharge or transfer given to the resident. When requested by a resident to review a notice of discharge or transfer, the local ombudsman council shall do so within 7 days after receipt of the request. The nursing home administrator, or the administrator's designee, must forward the request for review contained in the notice to the local ombudsman council within 24 hours after such request is submitted. Failure to forward the request within 24 hours after the request is submitted shall toll the running of the 30-day advance notice period until the request has been forwarded. | | | | X | | | | | |
| A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer. If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing. If the resident fails to request a hearing within 10 days after receipt of the facility notice of the proposed discharge or transfer, the facility may transfer or discharge the resident after 30 days from the date the resident received the notice. | | | | X | | | | | |
| The hearing officer shall conduct a hearing in the home not later than ten days after the date the department receives a hearing request unless the resident and the home or, if the resident is not competent to make a decision, the resident's sponsor and the home, agree otherwise. Unless the parties otherwise agree, the hearing officer shall issue a decision within five days of the date the hearing concludes but not later than thirty days after the department receives the hearing request. | | | | | | | | X | |
| Except in the case of an emergency, an involuntary transfer or discharge shall be stayed pending a decision by the commissioner or designee, and if the commissioner or designee determines the transfer or discharge is appropriate, the facility may not transfer or discharge | | X | | | | | | | |

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| <p>the patient prior to 15 days from the receipt of the decision by the patient or agent.</p> | | | | | | | | | |
| <p>A copy of the decision of the commissioner or designee shall be sent to the facility. The decision shall be deemed to have been received within 5 days of the date it was mailed, unless the patient or agent proves otherwise by a preponderance of the evidence.</p> | | <p>x</p> | | | | | | | |

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