G562

(Rev. 219; Issued: 04-12-24; Effective: 04-12-24; Implementation: 04-12-24)

§484.58(a) Standard: Discharge planning.

A home health agency must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

Interpretive Guidelines §484.58(a)

The goal of discharge planning is to prepare patients and caregivers to be active partners in post-discharge care, to effectively transition the patient from HHA to post-HHA care, and to reduce the factors that often lead to preventable readmissions.

Data on quality and resource use measures are available on the CMS.gov web site to assist consumers in making informed decisions about the performance of HHA and other providers including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and hospices.