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§482.61(e) [The record of each patient who has been discharged must have a discharge summary that includes] . . . recommendations from appropriate services concerning follow-up or aftercare as well as …

Interpretive Guidelines §482.61(e)

The patient's discharge summary should describe the services and supports that are appropriate to the patient's needs and that will be effective on the day of discharge.

Examples include:

• A complete description of arrangements with treatment and other community resources for the provision of follow-up services. Reference should be made to prior verbal and written communication and exchange of information;

• A plan outlining psychiatric, medical/physical treatment and the medication regimen as applicable;

• Specific appointment date(s) and names and addresses of the service provider(s);

• Description of community housing/living arrangement;

• Economic/financial status or plan, i.e., supplemental security income benefits;

• Recreational and leisure resources; and A complete description of the involvement of family and significant others with the patient after discharge.

Survey Procedures §482.61(e)

How does the discharge planning process verify appointment source(s), dates and addresses?

How was the patient involved in the discharge and aftercare planning process?

Were discharge related documents made available to the patient, family, community treatment source and/or any other appropriate sources?

Is there indication that the discharge planning process included the participation of multidisciplinary staff and the patient? Have the results been communicated to the post-hospital treatment entity?

Is there evidence that contact with the post-hospital treatment entity included communication of treatment recommendations (including information regarding the patient's medications)?

Is a contact person named, and does the patient have a specific appointment date and time for the initial follow-up visit?