A-0820
(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(c)(3) - The hospital must arrange for the initial implementation of the patient's discharge plan….

§482.43(c)(5) - As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

Interpretive Guidelines §482.43(c)(3) & §482.43(c)(5)

The hospital is required to arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. It also includes arranging:

- Transfers to rehabilitation hospitals, long term care hospitals, or long term care facilities;

- Referrals to home health or hospice agencies;

- Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;

- Referral to medical equipment suppliers; and

- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation, or other post-discharge needs.

(See §482.43(d) for more discussion about the hospital's transfer or referral obligations and the initial implementation of the plan relating to transfer/referral.)

The discharge planning process is a collaborative one that must include the participation of the patient and the patient's informal caregiver or representative, when applicable. In addition, other family or support persons who will be providing care to the patient after discharge need to be engaged in the process. Keeping the patient, and, when applicable, the patient's representative and other support persons informed throughout the development of the plan is essential for its success. Providing them with information on post-discharge options, what to expect after discharge and, as applicable, instruction and training in how to provide care is essential. The patient needs clear instructions regarding what to do when concerns, issues, or problems arise, including who to call and when they should seek emergency assistance. Although it may be an important component of the discharge instructions, it is not acceptable to only advise a patient to "return to the ED" whenever problems arise.

There are a variety of tools and techniques that have focused on improving the support provided to patients who are discharged back to their homes. A comprehensive approach employing combinations of these techniques has been found to improve patient outcomes and reduce hospital readmission rates, including, but not limited to:

- Improved education) to patients and support persons regarding disease processes, medications, treatments, diet and nutrition, expected symptoms, and when and how to seek additional help. Teaching methods must be based on recognized methodologies. CMS does not prescribe any specific methodologies, but examples include the teach-back, repeat-back approach and simulation laboratories;

- Written discharge instructions, in the form of checklists when possible, that are legible, in plain language, culturally sensitive and age appropriate;

- Providing supplies, such as materials for changing dressings on wounds, needed immediately post-discharge; and

- A list of all medications the patient should be taking after discharge, with clear indication of changes from the patient's pre-admission medications;

The education and training provided to the patient or the patient's caregiver(s) by the hospital must be tailored to the patient's identified needs related to medications, treatment modalities, physical and occupational therapies, psychosocial needs, appointments, and other follow-up activities, etc. Repeated review of instructions with return demonstrations and/or repeat-backs by the patient, and their support persons will improve their ability to deliver care properly. This includes providing instructions in writing as well as verbally reinforcing the education and training.

It is also necessary to provide information to patients and their support persons when the patient is being transferred to a rehabilitation or a long term care hospital, or to a long term care setting, such as a skilled nursing facility or nursing facility. The information should address questions such as: the goal of treatment in the next setting and prospects for the

patient's eventual discharge home.

The hospital must document in the patient's medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient's informal caregiver or representative, as applicable.

For Information – Not Required/Not to be Cited

Additional actions hospitals might consider taking to improve the patient's post-discharge care transition:

- Scheduling follow-up appointments with the patient's primary care physician/practitioner and in-home providers of service as applicable;
- Filling prescriptions prior to discharge;
- If applicable, arranging remote monitoring technologies, e.g., pulse oximetry and daily weights for congestive heart failure (CHF) patients; pulse and blood pressure monitoring for cardiac patients; and blood glucose levels for diabetic patients; and
- Follow-up phone calls within 24 -72 hours by the hospital to the patient after discharge.

The communication with the patient to ensure implementation of the discharge plan does not stop at discharge. An initiative showing significant success in reducing preventable readmissions involves the hospital contacting the patient by phone in the first 24 to 72 hours after discharge. The phone contact provides an opportunity for the patient to pose questions and for the hospital to address any confusion related to medications, diet, activity, etc., and to reinforce the education/instruction that took place in the hospital prior to discharge. This also helps to reduce patient and family member anxieties as they manage post-hospital care needs.

Hospital staff placing the calls should be familiar with the patient's discharge plan and qualified to address typical questions that might be expected. They should also be knowledgeable about when to instruct the patient to seek a more immediate evaluation, including where to go for such evaluation. Although this follow-up phone call can serve as a customer service initiative for the hospital, the primary intent would be to provide an opportunity for questions and to reduce or eliminate any confusion or concerns regarding post-hospital care.

Survey Procedures §482.43(c)(3) & §482.43(c)(5)

- Review cases of discharged patients to determine if the hospital arranges initial implementation of the discharge plan by providing:
  - For patients discharged to home:
  - In-hospital training to patient and family/support persons, using recognized methods;
  - Written discharge instructions that are legible and use non-technical language;
  - A legible, complete, reconciled medication list that highlights changes from the post

hospital regimen;

- Referrals as applicable to specialized ambulatory services, e.g. physical therapy, occupational therapy, home health, hospice, mental health, etc.;

- Referrals as applicable to community-based resources other than health services, e.g. Departments of Aging, elder services, transportation services, Centers for Independent Living, Aging and Disability Resource Centers, etc.;

- Arranging essential durable medical equipment, e.g. oxygen, wheel chair, hospital bed, commode, etc.;

- Sending necessary medical information to providers that the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first; and

- For patients transferred to another inpatient facility, was necessary medical information ready at time of transfer and sent to the receiving facility with the patient?

- Were there portions of the plan the hospital failed to begin implementing, resulting in delays in discharge?