

§482.43(b) Standard: Discharge Planning Evaluation

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

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

(4) - 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.

Interpretive Guidelines §482.43(b)(1), §482.43(b)(3) & §482.43(b)(4)

For every inpatient identified under the process required at §482.43(a) as at potential risk of adverse health consequences without a discharge plan, a discharge planning evaluation must be completed by the hospital. In addition, an evaluation must also be completed if the patient, or the patient's representative, or the patient's attending physician requests one. Unless the hospital has adopted a voluntary policy of developing an evaluation for every inpatient, the hospital must also have a process for making patients, including the patient's representative, and attending physicians aware that they may request a discharge planning evaluation, and that the hospital will perform an evaluation upon request. Hospitals must perform the evaluation upon request, regardless of whether the patient meets the hospital's screening criteria for an evaluation.

In contrast to the screening process, the evaluation entails a more detailed review of the individual patient's post-discharge needs, in order to identify the specific areas that must be addressed in the discharge plan.

§482.43(b)(4) requires that the evaluation include assessment of the patient's capacity for self-care or, alternatively, to be cared for by others in the environment, i.e., the setting, from which the patient was admitted to the hospital. In general, the goal upon discharge is for a patient to be able to return to the setting in which they were living prior to admission. This may be the patient's home in the community or residence in a nursing home. In the case of transfer from another hospital, generally the preferred goal is to return the patient to the setting from which he/she presented to the transferring hospital.

The evaluation must consider what the patient's care needs will be immediately upon discharge, and whether those needs are expected to remain constant or lessen over time. If the patient was admitted from his/her private residence, the evaluation must include an assessment of whether the patient is capable of addressing his/her care needs through self-care. The evaluation must include assessment of whether the patient will require

specialized medical equipment or permanent physical modifications to the home, and the feasibility of acquiring the equipment or the modifications being made. If the patient is not able to provide some or all of the required self-care, the evaluation must also address whether the patient has family or friends available who are willing and able to provide the required care at the times it will be needed, or who could, if willing, be trained by the hospital sufficiently to provide the required care.

§482.43(b)(3) requires the evaluation to consider the patient's likelihood of needing post-hospital services and the availability of such services.

If neither the patient nor the patient's family or informal caregiver(s) are able to address all of the required care needs, then the evaluation must determine whether there are community-based services that are available to meet the patient's needs while allowing the patient to continue living at home.

Such health care services include, but are not limited to:

- Home health, attendant care, and other community-based services;
- Hospice or palliative care;
- Respiratory therapy;
- Rehabilitation services (PT, OT, Speech, etc.);
- End Stage Renal Dialysis services;
- Pharmaceuticals and related supplies;
- Nutritional consultation/supplemental diets; and/or
- Medical equipment and related supplies.

However, services may also include those that are not traditional health care services, but which may be essential to a patient's ongoing ability to live in the community, including, but not limited to:

- Home and physical environment modifications;
- Transportation services;
- Meal services; and/or
- Household services, such as housekeeping, shopping, etc.

Some of the information related to needed services will emerge from the required evaluation of the patient's ability to receive care in the home, either as self-care or provided by someone else. All patients, even those with a high capability for self-care, are likely to require some follow-up ambulatory health care services, e.g., a post-discharge appointment with their surgeon, specialist or primary care physician, or a series of appointments for physical or occupational therapy. Some patients might have more complex care needs which nevertheless may still be met in the home setting, depending on the specific clinical needs and the services available in the patient's community.

For example, some patients require wound care that exceeds the capabilities of their family or others who act as informal caregivers. But they may be able to receive sufficient care in the home setting through a home health service, if such services are available. Some patients with chronic conditions may prefer to remain in their home and would be able to do so using available community-based services, but also require financial supports, such as Medicaid-financed home and community-based waiver services. If such supports are not immediately available at the time of discharge while an application for waiver services is pending, the evaluation should consider the availability of other short term supports that would allow the patient to be discharged home.

If the result of the evaluation is that the patient cannot receive required care if he/she returns to home, then an assessment must be made of options for transfer to another inpatient or residential health care facility that can address the patient's needs, including

other types of hospitals, such as rehabilitation hospitals; skilled nursing facilities; assisted living facilities; nursing homes; or inpatient hospice facilities.

If prior to the hospital admission the patient was a resident in a facility that he or she wishes to return to, such as an assisted living or nursing facility or skilled nursing facility, the evaluation must address whether that facility has the capability to provide the post-hospital care required by the patient. The post-discharge care requirements may be different than the care that was previously provided. This requires dialogue and cooperation between hospitals and post-hospital care facilities in the area served by the hospital, as well as with the physicians who provide care to patients in either or both of these settings.

Long term care facilities often express concern that hospitals discharge patients to their facilities with care needs that exceed their care capabilities, necessitating sending the patient to the emergency department for care and possible readmission. On the other hand, hospitals often express concern that long term care facilities send patients to the emergency department with ambulatory care-sensitive conditions, i.e., conditions that either do not require an acute level of care, or which could have been prevented from escalating to an acute level had appropriate primary care been provided in a timely manner.

While hospitals cannot address these concerns in isolation, they are expected to be knowledgeable about the care capabilities of area long term care facilities and to factor this knowledge into the discharge planning evaluation.

Hospitals are expected to have knowledge of the capabilities and capacities of not only of long term care facilities, but also of the various types of service providers in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient's needs in theory, but also can be implemented. This includes knowledge of community services, as well as familiarity with available Medicaid home and community-based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients.

If the hospital is one with specialized services that attract a significant number of patients who will receive their post-hospital care in distant communities, the hospital is expected to take reasonable steps to identify the services that will be available to the patient.

Once the determination has been made that services will be necessary post-discharge, the team must then determine availability of those services or identify comparable substitutions. Included in the evaluation is coordination with insurers and other payors, including the State Medicaid agency, as necessary to ensure resources prescribed are approved and available.

For Information– Not Required/Not to be Cited

Although not required under the regulations, hospitals would be well advised to develop collaborative partnerships with post-hospital care providers to improve care transitions of care that might support better patient outcomes. This includes not only skilled nursing facilities and nursing facilities, but also providers of community-based services. For example, Centers for Independent Living (CIL) and Aging and Disability Resource Centers (ADRC) are resources for community-based services and housing available to persons with disabilities and older adults. Hospitals can find local CIL's at <http://www.ilru.org/html/publications/directory/index.html> and ADRC's and other resources at <http://www.adrc-tae.org/tiki-index.php?page=HomePage>.

The ability to pay out of pocket for services must also be discussed with the family or other support persons. Although hospitals are not expected to have definitive knowledge of the terms of any given patient's insurance coverage or eligibility for community-based services,

or for Medicaid coverage, they are expected to have a general awareness of these matters and their impact on the patient's post-discharge needs and prospects for recovery. For example, if the patient is a Medicare beneficiary, the hospital is expected to be aware of Medicare coverage requirements for home health care or admission to a rehabilitation hospital, a skilled nursing facility, or a long term care hospital, etc. and to make the beneficiary aware that they may have to pay out of pocket for services not meeting the coverage requirements.

Similarly, for Medicaid, they should know coverage options for home health, attendant care, and long term care services or have contacts at the State Medicaid agency that can assist with these issues. As noted above, hospitals are also expected to have knowledge of community resources to assist in arranging services. Some examples include Aging and Disability Resource Centers and Centers for Independent Living (see box above).

For Information– Not Required/Not to be Cited

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

Examples of available tools include:

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

The hospital CoP governing patients' rights at §482.13(b) provides that "The patient has the right to participate in the development and implementation of his or her plan of care." (CMS views discharge planning as part of the patient's plan of care). "The patient or his/her representative (as allowed under State law) has the right to make informed decisions regarding his/her care" and "The patient's rights include...being involved in care planning and treatment." Accordingly, hospitals are expected to engage the patient, or the patient's representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient's goals and preferences as much as possible into the evaluation. A patient's goals and preferences may be, in the hospital's view, unrealistic. Identifying divergent hospital and patient assessments of what is realistic enables a discussion of these differences and may result in an assessment and subsequent development of a discharge plan that has a better chance of successful implementation.

For Information – Not Required/Not to be Cited

If a patient exercises the right to refuse to participate in the discharge planning evaluation, documentation of the refusal is recommended in the medical record.

Survey Procedures §482.43(b)(1), §482.43(b)(3) & §482.43(b)(4)

- In every unit with inpatient beds surveyed, is there evidence of discharge planning evaluation activities?
- Are staff members who are responsible for discharge planning evaluation correctly following the hospital's policies and procedures?
- If the hospital does not require a discharge planning evaluation for all inpatients:
 - Does the hospital have a standard process for notifying patients, their representative, and physicians that they may request a discharge planning evaluation and that the hospital will conduct an evaluation upon request?
 - Can discharge planning and unit nursing staff describe the process for a patient or the patient's representative to request a discharge planning evaluation?
 - Interview patients and their representatives. If they say they were not aware they could request a discharge planning evaluation, can the hospital provide evidence they received notice of their right?
 - Interview attending physicians to see if they are aware they can request a discharge planning evaluation. If they are not aware, can the hospital provide evidence of how they inform the medical staff about this?
- Review a sample of cases to determine if the discharge planning evaluation documents the patient's (or the patient's representatives) goals and preferences for post-discharge placement and care.
- Review a sample of cases to determine if the discharge planning evaluation includes an assessment of:
 - The patient's post-discharge care needs being met in the environment from which he/she entered the hospital? What the patient's care needs will be immediately upon discharge, and whether those needs are expected to remain constant or lessen over time?
 - The patient's insurance coverage (if applicable) and how that coverage might or might not provide for necessary services post-hospitalization?
 - For patients admitted from home --
 - Whether the patient can perform activities of daily living (personal hygiene and grooming, dressing and undressing, feeding, voluntary control over bowel and bladder, ambulation, etc.)?
 - The patient's or family/other support person's ability to provide self-care/care?
 - Whether the patient will require specialized medical equipment or home modification?
 - If yes, did the evaluation include an assessment of whether the equipment is available or if the modifications can be made to safely discharge the patient to that setting?

- If the patient or family/support person is unable to meet care needs or there are additional care needs above their capabilities, did the evaluation include an assessment of available community-based services to meet post-hospital needs?
- For patients admitted from a nursing facility, skilled nursing facility or assisted living facility did the evaluation assess whether the prior facility has the capability to provide necessary post-hospital services to the patient (i.e. is the same, higher, or lower level of care required and can those needs be met?) If yes, is there any documentation that the patient's care needs fall within the capabilities of the facility?
- Are the results of the discharge planning evaluation documented in the medical record?