

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Discharge Planning





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This publication provides information about Medicare discharge planning for the following provider types:

- ❖ Home Health Agencies;
- ❖ Hospices;
- ❖ Hospitals;
- ❖ Inpatient Psychiatric Facilities;
- ❖ Long-Term Care Facilities; and
- ❖ Swing Beds.

Discharge planning is conducted to plan for when a patient or resident leaves a care setting. Health care professional(s) and the patient or resident participate in discharge planning activities.

HOME HEALTH AGENCIES (HHA)

HHAs provide Home Health care to the patient with certain care needs and who meets program requirements.

Discharge Summary

The HHA discharge summary must include the patient's medical and health status at discharge. It may be incorporated into routine summary reports furnished to the physician.

The discharge summary should be documented in the patient's medical record.

A physician's order is not required to discharge the patient unless the HHA has such a policy or it is required by State law. The patient's medical record should document that the physician was notified of the discharge. The HHA must inform the attending physician that the discharge summary is available and send it to him or her upon request.



HOSPICES

If certain conditions are met, the Medicare Hospice benefit provides Hospice services for the palliation and management of a patient's terminal illness and related conditions.

Discharge Summary

The Hospice discharge summary must include:

- ❖ A summary of the patient's stay, including treatments, symptoms, and pain management;
- ❖ The patient's current plan of care;
- ❖ The patient's latest physician orders; and
- ❖ Any other documentation that will assist in post-discharge continuity of care or is requested by the attending physician or receiving facility.

The discharge summary should be documented in the patient's medical record.

If the care of a patient is transferred to another Medicare- or Medicaid-certified facility, the Hospice must forward a copy of the following to the receiving facility:

- ❖ The Hospice discharge summary; and
- ❖ The patient's medical record, if requested.

If a patient revokes the election of Hospice care or is discharged from Hospice, the Hospice must forward a copy of the following to the patient's attending physician:

- ❖ The Hospice discharge summary; and
- ❖ The patient's medical record, if requested.

HOSPITALS

Hospitals provide acute hospital inpatient care to the patient.

Discharge Planning Process

Medicare participating hospitals must identify patients who need or have requested a discharge plan at an early stage of their hospitalization. This process must be thorough, clear, comprehensive, and understood by hospital staff. The discharge planning process must also be integrated into hospitals' Quality Assessment and Performance Improvement (QAPI) Programs. If appropriate discharge planning is not completed, the patient may suffer adverse health consequences and/or unnecessary rehospitalization.

The hospital discharge plan should be initiated as soon as possible after admission. Some patient information should be collected on admission (e.g., age and sex) while other information (e.g., functional ability) should be collected closer to discharge to accurately determine continuing care needs. To address changes that occur in the patient's condition and needs, the discharge plan must be reassessed and updated.

A hospital patient's plan of care includes information about discharge planning activities and a discharge planning evaluation.

The discharge planning process includes the following:

- ❖ Implementing a complete, timely, and accurate discharge planning evaluation process, including identification of high risk criteria;





HOSPITALS (continued)

Discharge Planning Process

- ❖ Maintaining a complete and accurate file of appropriate community-based services and facilities to which patients can be transferred or referred (e.g., Nursing Home or Skilled Nursing Facility [SNF] care, long-term acute care, rehabilitation services, Home Health care, Hospice, or other appropriate levels of care); and
- ❖ Coordinating the discharge planning evaluation among various disciplines responsible for patient care.

The physician may make the final decision as to whether a discharge plan is necessary. If a physician requests a discharge plan, the hospital must develop such plan, even if the interdisciplinary team determined that a plan was not necessary.

Depending on the patient's needs, hospital discharge planning may be completed by personnel in multiple disciplines who have specific expertise. The hospital may designate discharge planning responsibilities to appropriate qualified personnel (e.g., registered nurses, social workers, or other qualified personnel). These individuals should have:

- ❖ Discharge planning experience;
- ❖ Knowledge of social and physical factors that affect functional status at discharge; and
- ❖ Knowledge of appropriate community services and facilities that can meet the patient's post-discharge clinical and social needs.

HOSPITALS (continued)

Discharge Planning Process

Appropriate facilities are those that can meet the patient's assessed needs on a post-discharge basis and comply with Federal and State health and safety standards.

Discharge planning is not required for outpatients, including those who present to a hospital emergency department and are not admitted as hospital inpatients. However, hospitals may find it beneficial to provide some discharge planning services to selected categories of outpatients (e.g., emergency department or same-day surgery patients).

Discharge Planning Evaluation

The hospital discharge planning evaluation must be developed for patients identified as needing discharge planning. It determines the patient's continuing care needs after he or she leaves the hospital setting. Depending on the patient's clinical condition and anticipated length of stay, the discharge planning evaluation should be completed as soon as possible after admission and updated periodically during the patient's stay.

The discharge planning evaluation must be included in the patient's medical record. It identifies appropriate post-hospital care services and facilities and includes an assessment of:

- ❖ The patient's biopsychosocial needs;
- ❖ The patient's return to the pre-hospital environment;



HOSPITALS (continued)



Discharge Planning Evaluation

- ❖ Information obtained from the patient and family/caregivers; and
- ❖ The patient's and family/caregiver's understanding of the patient's discharge needs, including his or her capacity for self care.

Discharge Planning

The hospital must discuss results of the discharge planning evaluation with the patient or the individual acting on the patient's behalf. The patient should be offered a range of realistic options to consider for post-hospital care. The choice of a post-hospital care provider depends on:

- ❖ The patient's capacity for self care;
- ❖ The availability of appropriate services and facilities;
- ❖ The patient's preferences, as applicable;
- ❖ The availability, willingness, and ability of family/caregivers to provide care.

Under Section 1861(ee) of the Social Security Act (the Act), Medicare participating hospitals must share with each patient, as appropriate, a list of Medicare-certified Home Health Agencies (HHA) that serve the geographic area in which he or she resides and that request inclusion on the list. The Act prohibits hospitals from limiting or steering patients to any particular HHA. A hospital must identify those HHAs in which it has a disclosable financial interest or HHAs that have such an interest in the hospital.



HOSPITALS (continued)

Discharge Planning

Under Section 1861(ee) of the Act, the discharge plan must include an assessment of the patient's likely need for Hospice care and post-hospital extended care services. Hospitals must provide patients a list of the available Medicare-certified SNFs that serve the geographic area he or she requests. The discharge plan cannot specify or limit qualified SNFs. A hospital must identify those SNFs in which it has a disclosable financial interest or SNFs that have such an interest in the hospital.

The hospital may develop and maintain a list of HHAs and SNFs to share with patients. It may also share the list of HHAs in the geographic area in which the patient resides from Home Health Compare located at <http://www.medicare.gov/homehealthcompare> or the list of SNFs in the geographic area that the patient requests from Nursing Home Compare located at <http://www.medicare.gov/nursinghomecompare> on the Centers for Medicare & Medicaid Services (CMS) website.

The hospital must arrange initial implementation of the discharge plan, which includes:

- ❖ Arranging necessary post-hospital services and care; and
- ❖ Educating the patient, family/caregivers, and community providers about the patient's post-hospital care plans.



HOSPITALS (continued)

Discharge Planning

The hospital should provide the patient and family/ caregivers information and instructions in preparation for the patient's post-hospital care. Individuals who will be providing care should know and be able to demonstrate or verbalize the patient's care needs.

The hospital must ensure that the patient receives 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 refuse discharge planning services.

The hospital must document the following in the patient's medical record:

- ❖ Discharge planning evaluation activities;
- ❖ That discharge planning evaluation results were discussed with the patient and family/caregivers;
- ❖ That the patient refused to participate in discharge planning or comply with a discharge plan, as applicable; and
- ❖ That a list of HHAs or SNFs was provided to the patient or an individual acting on the patient's behalf, as appropriate if such services are needed.



HOSPITALS (continued)

Discharge Planning Reassessment

The hospital's QAPI Program must include a mechanism for ongoing reassessment of its discharge planning process. The following should be reassessed:

- ❖ Identifying patients who need discharge planning in a timely manner;
- ❖ Developing quality discharge evaluations and discharge plans;
- ❖ Completing discharge planning evaluations and discharge plans in a timely manner;
- ❖ Maintaining complete and accurate information to advise patients and family/caregivers about appropriate discharge options; and
- ❖ Integrating with other functional departments and various disciplines, including quality assurance and utilization review activities of the institution.

INPATIENT PSYCHIATRIC FACILITIES (IPF)

IPFs, which are classified as psychiatric hospitals or psychiatric units, provide the patient with acute psychiatric treatment that can reasonably be expected to improve his or her condition.

Discharge Planning

An IPF's discharge planning process includes consideration of:

- ❖ The discharge alternatives addressed in the psychosocial and behavioral health assessment; and
- ❖ The extent to which the goals in the treatment plan have been met.

The patient and all relevant professionals in each service caring for the patient should participate in this process.

The discharge planning process should address anticipated problems after discharge and suggested means for intervention, including:

- ❖ Accessibility and availability of community resources and support systems, including transportation; and
- ❖ Special needs related to the patient's functional ability to participate in aftercare planning.



INPATIENT PSYCHIATRIC FACILITIES (IPF) (continued)

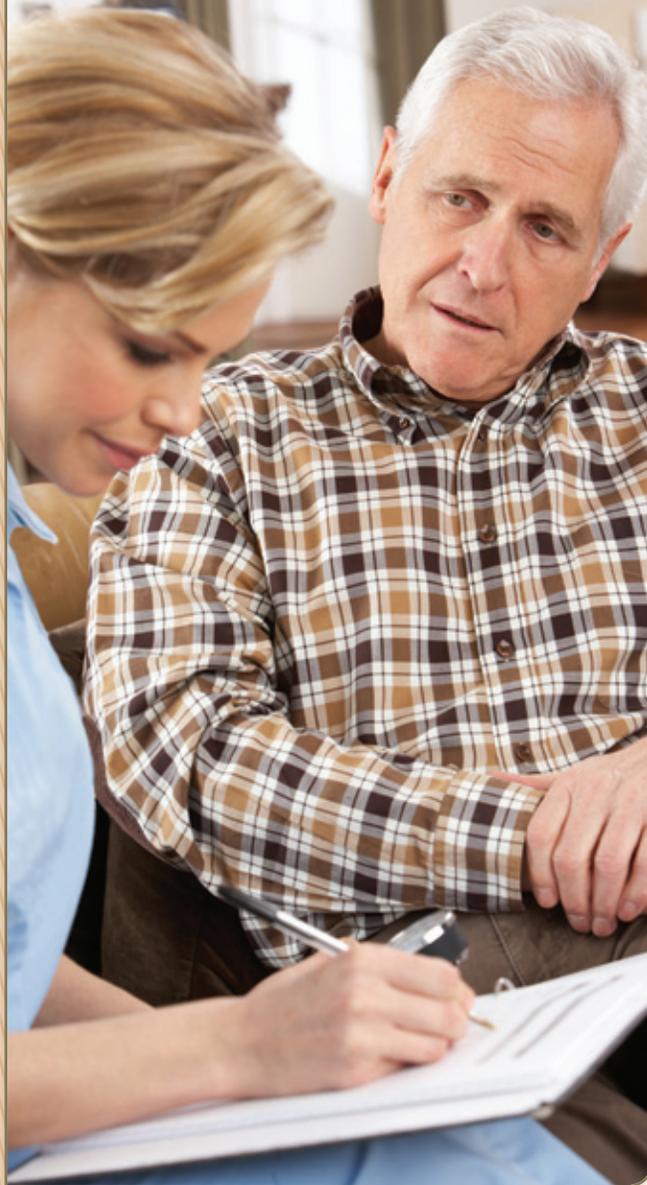
Discharge Summary

The IPF discharge summary should be completed within a reasonable timeframe and provide:

- ❖ A recapitulation of the patient's hospitalization;
- ❖ A summary of the patient's condition on discharge; and
- ❖ Recommendations for appropriate services for follow-up or aftercare.

The discharge summary must include:

- ❖ The reasons for the patient's admission to the IPF;
- ❖ Nursing and health care providers' notes (e.g., social workers);
- ❖ A plan that outlines psychiatric, medical, and physical treatment and medication modalities, as applicable;
- ❖ A list of medication records;
- ❖ Documentation that the patient received electroconvulsive therapy, if such treatment was provided;
- ❖ Documentation that the patient was in seclusion or physically restrained, if such use was performed;
- ❖ Evidence of the patient's and family's response to treatment interventions;
- ❖ Health care providers' discharge summaries (e.g., nurse practitioners or physicians);



INPATIENT PSYCHIATRIC FACILITIES (IPF) (continued)

Discharge Summary

- ❖ Documentation that a complete history and physical examination and psychosocial evaluation was performed at discharge;
- ❖ Discharge disposition (e.g., outpatient follow-up services and arrangements with treatment and other community resources for the provision of follow-up services, including prior verbal and written communication and exchange of information with such resources);
- ❖ The extent to which the patient achieved treatment goals during hospitalization;
- ❖ A baseline of the physical, psychosocial, and behavioral functioning of the patient at discharge; and
- ❖ Appropriate services and resources that will be effective on the day of discharge.

The discharge summary must be documented in the patient's medical record.



LONG-TERM CARE (LTC) FACILITIES

LTC Facilities, also called Nursing Facilities (NF) or Skilled Nursing Facilities (SNF), are primarily engaged in providing the resident either skilled nursing care and related services or rehabilitation services (based on his or her needs).

Discharge Planning

A LTC Facility must complete discharge planning when it anticipates discharging a resident to a private residence, another NF or SNF, or another type of residential facility. Discharge planning includes:

- ❖ Assessing the resident's continuing care needs, including:
 - Consideration of the resident's and family/caregiver's preferences for care;
 - How services will be accessed; and
 - How care should be coordinated among multiple caregivers, as applicable;
- ❖ Developing a plan designed to ensure that the resident's needs will be met after discharge from the facility, including resident and family/caregiver education needs; and
- ❖ Assisting the resident and family/caregivers in locating and coordinating post-discharge services.



LONG-TERM CARE (LTC) FACILITIES (continued)

Discharge Summary

The LTC discharge summary must include:

- ❖ A recapitulation of the resident's stay;
- ❖ A final summary of the resident's status at the time of discharge. This summary will be available for release to authorized individuals and agencies, with the consent of the resident or the resident's legal representative; and
- ❖ A post-discharge plan of care (POC), developed with the resident's and his or her family's participation. The post-discharge POC assists the resident in adjusting to his or her new living environment.

The discharge summary should be documented in the resident's medical record.





SWING BEDS

Swing Beds are hospitals, as defined in Section 1861(e) of the Social Security Act, or Critical Access Hospitals (CAH) with a Medicare provider agreement that includes Centers for Medicare & Medicaid Services (CMS) approval to furnish Swing Bed services, who may use their beds as needed to provide the patient with either acute or Skilled Nursing Facility-level care.

Discharge Planning

A hospital or CAH must complete discharge planning when it anticipates discharging a patient from a Swing Bed. Discharge planning includes:

- ❖ Assessing the patient's continuing care needs, including:
 - Consideration of his or her and family/caregiver's preferences for care;
 - How services will be accessed; and
 - How care should be coordinated among multiple caregivers, as applicable;
- ❖ Developing a plan which ensures that the patient's needs will be met after discharge from the facility, including patient and family/caregiver education needs; and
- ❖ Assisting the patient and family/caregivers in locating and coordinating post-discharge services.

SWING BEDS (continued)

Discharge Summary

The discharge summary must include:

- ❖ A recapitulation of the patient's stay;
- ❖ A final summary of the patient's status at the time of discharge. This summary will be available for release to authorized individuals and agencies, with the consent of the patient or the patient's legal representative; and
- ❖ A post-discharge plan of care (POC), developed with the patient's and his or her family's participation. The post-discharge POC assists the patient in adjusting to his or her new living environment.

The discharge summary should be documented in the patient's medical record.



RESOURCES

The chart below provides discharge planning resource information.

For More Information About...	Resource
Discharge Planning	<p>“Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html on the CMS website</p> <p>Appendices of the “State Operations Manual” (Publication 100-07) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html on the CMS website</p>
All Available Medicare Learning Network® (MLN) Products	<p>“Medicare Learning Network® Catalog of Products” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right</p> 
Provider-Specific Medicare Information	<p>MLN publication titled “MLN Guided Pathways to Medicare Resources Provider Specific Curriculum for Health Care Professionals, Suppliers, and Providers” booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website</p>
Medicare Information for Beneficiaries	<p>http://www.medicare.gov on the CMS website</p>

